Riverside Healthcare Limited

Cheswold Park Hospital

Inspection report

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Date of inspection visit: 11 Jul to 13 Jul 2023 and 26 Jul 2023
Date of publication: 15/12/2023

This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

Overall rating for this location	Inadequate
Are services safe?	Inadequate
Are services effective?	Inadequate
Are services caring?	Inadequate
Are services responsive to people's needs?	Inadequate
Are services well-led?	Inadequate

Summary of findings

Overall summary

Our rating of this location went down. We rated it as inadequate because:

- The service did not provide safe care. The wards did not have enough nurses and support staff. Staff did not assess and manage risk well or manage medicines safely or follow good practice with respect to safeguarding.
- The service placed people at risk of harm by not ensuring that all staff were up to date on their physical intervention training, intermediate life support training and basic life support training.
- Staff did not develop holistic, recovery-oriented care plans informed by a comprehensive assessment. Care plans, risk assessments and positive behaviour plans were not updated including after any incident. The electronic records system was not fit for purpose.
- Managers did not ensure that all patients had suitable access to Section 17 leave or activities on and off the ward. Patients were restricted to the ward for extended periods of time.
- Managers did not ensure that staff had received appropriate training, supervision, or appraisal. Staff and patients did not receive appropriate debriefs following incidents.
- Not all staff understood or discharged their roles and responsibilities under the Mental Health Act 1983 or the Mental Capacity Act 2005. The service did not appropriately audit the use of the Mental Capacity Act 2005.
- Staff did not always treat patients with compassion and kindness, respect their privacy and dignity, or understand the individual needs of patients. They did not actively involve patients and families and carers in care decisions.
- The service was not well led, and the governance processes did not ensure that ward procedures ran smoothly.

Letter from the Chief Inspector of Hospitals, Dr Sean O'Kelly:

"I am placing the service into special measures. Services placed in special measures will be inspected again within six months. If insufficient improvements have been made such that there remains a rating of inadequate overall or for any key question or core service, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. The service will be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary another inspection will be conducted within a further six months, and if there is not enough improvement, we will move to close the service by adopting our proposal to vary the provider's registration to remove this location or cancel the provider's registration."

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Forensic inpatient or secure wards	Inadequate 	Our rating of this service went down. We rated it as inadequate. See the summary above for details.

Summary of findings

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Background to Cheswold Park Hospital

Cheswold Park Hospital is a purpose-built hospital in Doncaster. Riverside Healthcare Limited is the provider. The hospital is an independent mental health hospital that provides 9 low and medium secure accommodation for male and female patients over 18, with mental disorder, learning disabilities and autism spectrum disorder with an offending background, who require assessment treatment and rehabilitation within a secure environment. At the time of our inspection there were 86 patients at the hospital.

The hospital is registered with the Care Quality Commission to provide the following regulated activities:

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

The hospital did not have a registered manager at the time of inspection. The provider was served a fixed penalty notice for failing to ensure this registration requirement was met. Following the inspection, a registered manager was appointed in October 2023. The registered manager, along with the registered provider, is legally responsible and accountable for compliance with the requirements of the Health and Social Care Act 2008 and associated regulations. The hospital had a controlled drugs accountable officer on site. Controlled drugs accountable officers are responsible for all aspects of controlled drugs management within their organisation.

The hospital has 3 medium secure wards and 6 low secure wards:

- Esk is a 12-bed low secure male ward.
- Aire is a 12-bed low secure male acute admissions ward.
- Foss is a 12-bed low secure male pre-discharge ward.
- Calder is a 16-bed low secure male personality disorder ward.
- Wentbridge is a 7-bed low secure ward for males with a diagnosis of autism.
- Hamilton is a 12-bed medium secure pre-stepdown male ward.
- Brook is a 16-bed medium secure male ward.
- Bronte is a 12-bed medium secure female ward.
- Don is a 12-bed low secure ward for males with a personality disorder.

We last inspected the hospital in July 2021. We rated this service as 'requires improvement' overall with ratings of 'good' in the caring and responsive key questions and 'requires improvement' in the safe, effective, and well led key questions. The hospital was in breach of the following regulation:

- Regulation 18 Health and social Care Act 2008 Staffing

We also suggested some actions which the provider could take to improve the service, including ensuring all incidents were reported consistently, that all clinic rooms and equipment were organised, and that systems in relation to staffing and supervision were monitored to ensure effectiveness.

What people who use the service say

We spoke to 34 patients across the hospital. Most patients told us that most permanent staff on the wards were doing a great job in a difficult situation due to the lack of staff available, however, they did not always feel safe on the wards and

Summary of this inspection

that they did not make complaints as previous concerns were not listened to or acted upon when they had been referred to senior management. Patients across the hospital told us their ward was overly restrictive for the security designation it had been given and a significant reduction on access to external leave had a negative impact on their care pathway. Patients also told us that staff did not always treat them with respect, as some staff made fun of them, did not always knock before entering their bedrooms and bathrooms, and they could also be vindictive and act inappropriately towards patients. Patients were unhappy they had not been involved in the provider's new policy on leave or the upcoming ban on electronic cigarettes throughout the service.

Patients told us that when our inspection team were on site there were more staff on the wards and the food provided was better than usual.

How we carried out this inspection

During the inspection visit, the inspection team:

- visited all 9 wards at the hospital, looked at the quality of the ward environment and observed how staff were caring for patients,
- spoke with the CEO and four directors including the director of nursing and operations and the director of clinical services,
- spoke with 49 other members of staff including the ward managers, service managers, 15 support workers, 16 registered nurses, the occupational therapy team, the psychology team and 2 doctors,
- spoke with 34 patients who were using the service,
- spoke with 16 family members or carers of patients who were using the service,
- looked at 6 patients' care and treatment records,
- reviewed 22 patient prescription charts,
- reviewed a sample of seclusion and long-term segregation records,
- attended handover meetings, the daily hospital status and escalation meeting and 5 multidisciplinary meetings,
- looked at a range of policies, procedures and other documents relating to the running of the service and,
- spoke with a range of external stakeholders such as the advocacy service, pharmacist and the South Yorkshire and Bassetlaw forensic provider collaborative.

You can find information about how we carry out our inspections on our website: https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

Areas for improvement

Action the service MUST take is necessary to comply with its legal obligations. Action a service SHOULD take is because it was not doing something required by a regulation, but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the service MUST take to improve:

- The provider must ensure that there is enough staff, with the required knowledge and experience, to keep patients and staff safe. (Regulation 18(1))
- The provider must ensure that all staff receive appropriate training, support, supervision, and appraisal in line with the provider's policy. (Regulation 18(2)(a))

Summary of this inspection

- The provider must ensure that all regulations relating to the prescribing and administration of controlled drugs are followed. (Regulation 12(1)(2)(b)(g))
- The provider must ensure that all Section 17 leave is based on patient need as required by the Mental Health Act Code of Practice. (Regulation 13(4)(b)(d))
- The provider must ensure that patients always have free access to drinking water. (Regulation 14(4)(a))
- The provider must ensure that their complaints process and accompanying processes and policies are fit for purpose and ensure all complaints can be reviewed appropriately. (Regulation 16(1)(2))
- The provider must ensure that patients have access to appropriate and meaningful activities 7 days a week, on and off the ward and that this is documented. (Regulation 9(1)(2)(3)(a)(b))
- The provider must ensure that all wards at the hospital hold regular ward community meetings with the patients and they are documented. (Regulation 9(1)(2)(3)(a)(d))
- The provider must ensure that the Keepmoat and Lakeside seclusion suites are fit for purpose and maintain the privacy and dignity of patients. (Regulation 15((1)(a)(c))
- The provider must ensure that all doors in rooms used by patients have observation panels with integrated blinds/ obscuring mechanisms. (Regulation 15(1)(c))
- The provider must ensure that all staff and patients receive appropriate debriefs following incidents and that these are recorded. (Regulation 20(1)(2))
- The provider must ensure that all blanket restrictions are reviewed and documented whilst complying with the Mental Health Act. (Regulation 17(1)(2)(a)(f))
- The provider must ensure that the hospitals care record system is fit for purpose and all patient care records, risk assessments and positive behaviour plans are completed and updated as needed. (Regulation 17(1)(2)(c)(f))
- The provider must ensure that the use of the Mental Capacity Act is audited, and staff are provided with effective training on its use. (Regulation 17(1)(2)(a)(b)(d)(f))
- The provider should ensure that all hospital areas have up to date ligature risk assessments in place. (Regulation 17(1)(2)(a)(b)(f))
- The provider must ensure that all policies relating to the safe care and treatment of patients have been reviewed and updated as required. (Regulation 17(1)(2)(a)(d)(ii))

Action the service SHOULD take to improve:

- The provider should consider reviewing the hiring processes of the hospital to ensure newly employed staff have the knowledge and experience to complete their roles effectively.
- The provider should ensure that windows are not obscured in the nurses' station on each ward.
- The provider should ensure that that they consider the needs of patients' families and carers and involve them in the patient's care where appropriate.

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Forensic inpatient or secure wards	Inadequate	Inadequate	Inadequate	Inadequate	Inadequate	Inadequate
Overall	Inadequate	Inadequate	Inadequate	Inadequate	Inadequate	Inadequate

Inadequate

Forensic inpatient or secure wards

Safe	Inadequate
Effective	Inadequate
Caring	Inadequate
Responsive	Inadequate
Well-led	Inadequate

Is the service safe?

Inadequate

Our rating of safe went down. We rated it as inadequate.

Safe and clean care environments

Wards were not always clean, well equipped, well furnished, well maintained or fit for purpose.

Safety of the ward layout

Staff did not always complete and regularly update risk assessments of all wards areas and staff did not always know about any potential ligature anchor points or how to mitigate the risks to keep patients safe. Ligature risk assessments were not always accurate or up to date and frequent movement of staff around wards meant staff were not always aware of each wards potential ligature points. Brook ward's ligature risk assessment had not been updated since November 2022 and the rooms and areas listed on the risk assessment did not correspond to the actual ward environment. We received an updated ligature risk assessment that had been completed in July 2023 following inspection. On Bronte ward, a medium secure ward, we found a ligature risk assessment from May 2022 alongside a ligature risk assessment from 2021. The provider's policy stated, "ligature assessments will be carried twice a year in medium secure services (Standards for Forensic Mental Health Services: Medium Secure Care Royal College of Psychiatrists) and annually for other services or more frequently if significant changes occur" but this was not always followed.

Patients on Don ward who had progressed to self-medicating had medicines boxes fixed to their bedroom walls, although the ward ligature risk assessment had identified these as a risk and the assessment to progress on to self-medicating included patients having the medicine boxes in their rooms. This was a risk that had been created by the hospital when other options to store the patients medicine were available and had not been explored. Some staff had also told us they had not seen the ligature assessment for this ward.

Staff could not always observe patients in all parts of the wards. On Bronte ward's ligature risk assessment there were two bedrooms, a bathroom and a corridor that were labelled as "acute care" (for patients experiencing an acute episode of mental illness) but the rooms were not visible from the nurses' station. However, at the time of inspection, they were being used for more independent patients. Part of the nurses' station window on Esk ward was blocked with paperwork which could obscure the view of patients.

Inadequate

Forensic inpatient or secure wards

Patient bedroom doors throughout the hospital used a “spy hole” for staff to complete observations of patients. Although some doors across the wards had been updated to the recommended observation panels as defined by the Quality Network for Forensic Services, and all bedroom doors on Hamilton ward and Bronte ward had been updated, this was not consistent throughout the hospital. The hospital's estates plan did not mention any plans to update the doors. Senior leadership told us they were being updated alongside other renovations but there was no specific timescale in place. Some patients told us that staff members would open their bedroom doors and turn on the lights to complete their regular nighttime observations which had a negative impact on their ability to sleep.

Staff had easy access to alarms and patients generally had easy access to nurse call systems. However, on Wentbridge ward, the communal bathroom had a call bell alarm placed to the side of the bath which could not be easily reached when patients were bathing. When we asked how the service would mitigate against this risk, they advised that either someone would be in the bathroom with them, or they would check on the patient every 5 minutes. The provider’s policy stated that, “all patients using the bathroom will be doing so with the awareness of the nursing team, who will carefully observe for patient safety from outside the bathroom door, unless the care plan denotes other observation strategies.” The bathroom did not have an observation panel on the door so it would have to be opened to complete observational checks. The bathroom door opened straight on to the communal area and would potentially impact on patients’ privacy and dignity. The services pod on Foss ward did not have a nurse call point.

Maintenance, cleanliness, and infection control

Communal ward areas were not always clean and well maintained. Although the hospital used dedicated cleaning staff who made sure cleaning records were up to date, the wards were not always clean. We attended a handover in the dining room of Bronte ward which was dirty with food deposits that had not been cleaned away. There were also food deposits on the dining room floor on Esk ward. Ward areas were not always well-furnished or fit for purpose. On Brook, Bronte, and Foss wards there was minimal furniture in the communal areas, with very basic décor. Foss ward had a sofa in the communal area that had been torn which potentially compromised infection prevention control.

Patient bedrooms were not always clean and well maintained. On Brook ward, two out of the three bedrooms reviewed by the services environmental and infection control audit in July 2023 were not meeting the providers standard of cleanliness and repair. It had been an action on the wards developmental action plan since April 2023. From March 2023 onwards the service also found that multiple bedrooms on Brook, Don, and Esk wards were not adhering to the services patient property policy, and this was still an outstanding action. During inspection we observed one vacant bedroom on Foss ward that had a polystyrene food container in one of the drawers and old food inside. The toilet was stained and there was no quilt in the room. The patient’s toilet in the long-term segregation unit was also unclean.

Staff did not always follow the infection control policy, including handwashing. The services monthly hand hygiene audit repeatedly found on Brook, Aire, Hamilton, Esk, and Don wards that not all staff were up to date with their hand hygiene training. The provider’s dress code policy and “bare below the elbow” posters were not followed by all staff and not always enforced by management. The policy stated that staff members must not wear wrist watches or wrist jewellery, but we observed some staff wearing these items (including smart watches which could be used to make phone calls, send text messages, and read email) during our visit of the hospital and our review of closed-circuit television. The provider’s policy stated that no one in clinical areas were allowed to wear wrist watches or wrist jewellery, and the provider’s policy on mobile communications stated that any staff who breached the policy may be subject to disciplinary action. However, we saw no staff being reminded by management of this requirement. We observed staff working on the wards wearing shorts, facial piercings and blue jeans which were all classed as unacceptable in the provider’s dress code policy. Our inspection team sometimes struggled to differentiate between patients and staff as not all the staff wore the required lanyards around their neck to identify themselves and we had concerns this could also be problematic for patients too.

Inadequate

Forensic inpatient or secure wards

Seclusion rooms

The hospital had 4 off-ward seclusion areas and 1 long-term segregation area which all wards could access. There was also a seclusion room on Bronte ward and an area used for long-term segregation on Foss ward. At the beginning of our inspection there were 3 people in seclusion and 1 person in long-term segregation. The suites allowed clear observation and two-way communication. They had a toilet and a clock.

Keepmoat and Lakeside seclusion suites were located off ward. Both comprised a single room containing a bed, toilet, and shower. Staff were not able to provide privacy for patients when using the toilet or shower. Keepmoat and Lakeside seclusion suites were next to each other, separated only by a wall, and shared a main observation room where staff sat. Although only 1 seclusion suite was occupied on the days we visited, patients told us that sometimes both rooms were in use, and they could hear clinical conversations between the patient in the adjacent room and the staff observing them. This meant that staff did not ensure patients' privacy, dignity, or respect were maintained.

Clinic room and equipment

Clinic rooms were not always fully equipped with accessible resuscitation equipment and emergency drugs and staff did not always check these regularly. There were 4 emergency bags (red bags) across the hospital; one each on Don ward, Bronte ward, Wentbridge ward and one in the reception area. Staff ensured the bags were within 4 minutes reach away as per the Resuscitation Council UK's guidelines. The service held regular drugs, therapeutics, and medical devices committee meetings. The notes of the meeting in April 2023 stated that clinic rooms were failing. In June 2023, it was noted that red bag checks were inconsistently being completed and that the whole process of checking them and the current stocks available needed improving. On Wentbridge ward the clinic room was very small and we found expired equipment in the emergency kit including a child defibrillator pad which had expired in December 2022, and 2 adult defibrillator pads which had expired in February 2023. There were also multiple missed red bag checks in March 2023, June 2023, and July 2023.

Staff did not always check, maintain, and clean equipment. The provider had added the clinic room audit to their own risk register in June 2022, stating "If we fail to address the continuous 6 months of failures (evidenced by RED gradings) in clinic room audits… we risk being unable to demonstrate safe care of patients." This risk had been reviewed again in February 2023 stating, "Feels like no progress or indeed it's got worse, so rating has increased" and again in June 2023 stating, "Risk deemed to be increasing given the lack of progress although some comfort taken from the internal audit clinic room inspections and actions being cleared from those audits." The disposal bin on Wentbridge ward had been labelled to say it had been opened on 04/12/2018 on Don ward and the sharps bin had not been labelled. The sharps bin in the clinic room on Bronte ward was not dated or signed when it was assembled. On Aire ward, there were multiple gaps in the clinic room and fridge temperatures from January 2023 until July 2023. On Hamilton ward the fridge had been broken since January 2023. Although we saw some "I'm clean" stickers in Brook ward clinic room, we did not see these being used on Wentbridge or Bronte wards.

Safe staffing

The service did not have enough nursing and medical staff, who knew the patients and they did not all receive basic training to keep people safe from avoidable harm.

Nursing staff

The service did not have enough nursing and support staff to keep patients safe. In June 2023, the hospital reported not filling shifts across all wards apart from Aire ward.

- Bronte ward had not filled 15 shifts,
- Brook ward had not filled 10 shifts,

- Calder had not filled 6 shifts,
- Don ward had not filled 21 shifts,
- Esk ward had not filled 16 shifts,
- Foss had not filled 6 shifts,
- Hamilton had not filled 28 shifts and,
- Wentbridge had not filled 3 shifts.

Across the whole service from July 2022 to June 2023, the service had not filled 577 shifts.

Staff worked 11.5-hour shifts but there were some shorter shifts, such as 9 am to 5 pm. The figures provided by the hospital were based on all shifts being 11.5 hours and was not a true reflection of actual staffing numbers.

Whilst on inspection, we observed multiple gaps in staffing and the staffing rotas were not reflective of the actual staffing observed on each ward. Some staff told us they did not feel safe working with the current staffing numbers. Our inspection team also felt unsafe at times due to the shortage of staff on some wards. On 11 July 2023 on Foss ward, the only staff available were 2 support workers who were on their 3rd week of induction and a support worker who had passed their probation only 3 months ago. There was no registered nurse on the ward. We observed one preceptorship nurse (a structured period of supported transition which enables clinicians to develop confidence and competence in their new role) supporting Wentbridge ward and another preceptorship nurse supporting Brook ward without any other nurse on either ward. On the first day of our inspection the daily hospital status sign with regards to staffing numbers across the hospital had not been updated since the previous day.

There were only 2 support workers and no registered nurse on Calder ward at the time of our visit. On the evening we observed Don ward had no registered nurse on the ward but instead was being supported by 2 support workers and 1 nursing associate (a nursing associate supports the registered nurse). We were told the ward was being supported by a nurse on Esk ward. On 12 July 2023, Brook ward was staffed by 2 preceptorship nurses who had been at the service for only 6 months. When we asked what their safe staffing numbers were, they were unable to tell us. On 13 July 2023 on Aire ward, there was no registered nurse on the ward and staff could not tell us where the nurse had gone. We were told this was a regular occurrence. After 15 minutes the registered nurse came back to the ward. A patient was delayed for a medical appointment due to the service not having the required number of 3 staff members available to support them which was stipulated within their leave form. The nurse in charge of the ward was completing the ward observations and had also been allocated as the security person and response person for the ward as the originally allocated support workers were off site. We observed three patients waiting at an external door to access the garden for their electronic cigarette allotted time. Despite there being set times for electronic cigarettes, the patients had to wait due to a lack of staffing. This caused them to become angry and upset with the support staff. Staff told the patients they did not have enough staff to support their electronic cigarette break. We observed and were told that there is only one nurse allocated to each ward which left wards without nurse cover when a nurse was on their break or responding to other demands off the ward. On 26 July 2023 on Aire ward there had not been a nurse or ward manager on the ward for most of the morning shift due to nurse responsibilities off the ward. The nurse had reported this to senior management, but no cover or support was put in place. The senior management team told us they were not aware of the need to have a nurse on the ward all the time.

Nurses in charge of wards were on a rota system to provide staffing oversight to the other wards within the hospital. This system was called the Mike1 role. Following our inspection, we raised concerns about the staffing levels and served a Notice of Decision to Riverside Healthcare Limited to stop any further admissions to the hospital. The hospital had made changes following receipt of the Notice of Decision, which included taking printers onto each of the wards, arranging provisions to be brought to the wards and money to be collected daily from the wards, all of which had previously been tasks which took staff off the wards. On our return to site on 26 July 2023 we were informed that the role of Mike1 had

been taken off the nurses in charge of wards and instead were an additional resource to benefit the wards and staff. The provider advised us that although the service had attempted to keep the Mike 1 role as an additional role, due to continued staffing shortages this role was sometimes reverted to being allocated to a nurse in charge of a ward. From July 2022 to June 2023 the service had used agency staff for 70 shifts and external bank staff for 1329 shifts. However, multiple shifts continued to be unfilled.

The service had low vacancy rates. The providers website stated in July 2023 and August 2023 that "we are very proud to be a fully staffed hospital for nurses and support workers and we currently have no vacancies." However, data provided by the hospital stated that there were vacancies in July 2023.

Managers made sure all bank staff had a full induction and understood the service before employment started at the hospital. However, if a staff member was moved from their current ward to another, they did not receive an induction in relation to the ward to which they had moved or to the patients they would be supporting. The provider's induction policy stated that all new members of staff, including bank staff, must attend the corporate induction and the local induction. However, staff were frequently moved across wards and staff did not receive an induction for each ward when this was done. During our inspection we found some staff could not locate the wards ligature risk assessment, were unable to give us a tour of the ward as they were unfamiliar with the layout and did not know the safe staffing numbers for the ward they were covering.

There had been a significant safeguarding concern on Wentbridge ward in December 2022. The provider's investigation report acknowledged that one of the staff members was new to the hospital; had been moved to Wentbridge ward and had not been provided with a handover in terms of the reasons patients had been put on observations. Due to staff shortages, this new staff member had been completing two sets of observations at the same time.

The service had high turnover rates. From July 2022 to June 2023 the hospital had a 62% turnover with 143 people leaving the organisation. There had been 42 leavers in the previous 3 months but only 2 exit interviews had been completed. The hospital had also hired 192 new starters in this time. Retention of staff had been added to the provider's risk register in June 2022. The staff turnover figures included staff who had been dismissed.

Levels of sickness were low. The hospital had 2% sickness for non-ward-based staff for the previous 12 months. Ward based staff sickness for the previous 12 months was 7%. However, managers did not always support staff who needed time off for ill health. Both managers and staff within the service told us that staff were not able to pick up additional shifts if they had taken a sick day in the previous 4 weeks. The provider's policy stated, "If staff cancel shifts at short notice (e.g., less than 24 hours' notice) the staff member will not be permitted to undertake further bank shifts for a period of 4 weeks following the absence."

Managers did not accurately calculate and review the number and grade of nurses, nursing assistants and healthcare assistants for each shift. Staff told us they were frustrated by the staffing numbers as they were not told how the staffing for each shift was decided. The senior management team were unable to tell us where the numbers for the service's safe staffing levels had come from and they did not use a staffing matrix to ensure there were enough staff with the required skill mix on each ward.

The ward manager could not adjust staffing levels according to the needs of the patients. All requests to adjust staffing levels had to be agreed with the non-clinical CEO by 4:30 p.m. the day before the staffing was required, or on a Friday before the weekend. The service had a rota team off the ward who decided which patients could have access to leave.

Inadequate

Forensic inpatient or secure wards

Patients did not always have a regular one to one session with their named nurse. One care record we reviewed on Bronte showed a one-to-one session with a psychologist that month, but no sessions with their named nurse had been recorded. Another care record mentioned one to ones in the daily notes, but we were unable to locate any documents to confirm. Some staff and patients told us there were not enough staff for patients to have regular one to one time with their named nurse. A patient on Calder ward told us they had never had a one-to-one session with their named nurse and could not remember the name of their nurse. However, a patient on Don ward said they regularly met with their named nurse.

Patients often had their escorted leave and activities cancelled when the service was short staffed. The hospital reported that there had been 18 incidents documented of escorted and unescorted leave being cancelled due to staffing levels at the hospital since January 2023. Following our inspection, in August 2023 and September 2023, there had been 16 reports of leave being cancelled across Brook, Calder, Aire, Hamilton, Don, and Wentbridge wards, all due to the service being short staffed. Most of the carers we spoke to were aware of a lack of staffing at the service and said there was a high turnover of staff, frequently cancelled visits, activities, and Section 17 leave due to this.

The service did not always have enough staff on each shift to carry out any physical interventions safely. Training compliance for prevention management of violence and aggression was 69% for nursing management and 64% on Don ward. Breakaway training compliance was 50% for Esk ward and 0% for Bronte ward. The service designated staff members across the hospital to be part of a response team if support was needed. Whilst on inspection, we saw a nurse in charge of one ward respond to an incident on another ward, and another nurse in charge had been allocated to the response team as well as doing the ward observations and the ward security, due to the allocated response and security staff members being off the ward at that time.

Staff usually shared key information to keep patients safe when handing over their care to others during their handover meetings. We observed multiple handover meetings on our second visit to the hospital and they were comprehensive. However, due to the lack of an effective IT system it took staff a long time to obtain all the information they needed whilst also doing their ward duties. When staff moved wards during their shift, we did not observe a handover being provided.

Medical staff

The service had enough daytime and nighttime medical cover and a doctor available to go to the ward quickly in an emergency. There were 4 associate specialists who provided out of hours cover on a rota basis. Doctors could access an overnight room at the hospital if they lived far away from the service.

Mandatory training

The service had a training and development team who monitored mandatory training and alerted staff when they needed to update their training. However, staff had not completed and kept up to date with their mandatory training.

Across the hospital there was a compliance rate of 76% for immediate life support training, with 64% compliance from the nursing management staff, 67% compliance from Calder ward staff, 43% from Don ward staff, 67% from Esk ward staff and 25% from Wentbridge ward staff.

Basic life support training compliance was low on Aire ward at 60%, Brook ward at 63%, Don ward at 67%, Esk ward at 62%, and Bronte ward at 71%. The quality standards for mental health inpatient care published by the Resuscitation Council UK states that all healthcare staff must undergo resuscitation training at induction and at regular intervals thereafter to maintain knowledge and skills and that training must be to a level appropriate for the staff members expected clinical responsibilities.

The nursing management team compliance was 62% for mandatory security training.

The mandatory training programme was not comprehensive and did not always meet the needs of patients and staff. Some staff told us they had not received any training on the services electronic care records system, and it was not listed as a mandatory training course on the hospital system that we reviewed. The quality compliance team did complete an audit of care plans on the electronic care records system and at the time of our inspection Wentbridge ward had only achieved 54% compliance whilst Bronte ward had only achieved 67% compliance.

Some of the wards were being ran by registered general nurses rather than registered mental health nurses with no mental health nurse for support. Some of these staff members told us they were required to fulfil mental health duties, such as admission and discharge, without any previous experience or suitable training.

Assessing and managing risk to patients and staff

Staff did not assess and manage risks to patients or themselves well. They did not achieve the right balance between maintaining safety and providing the least restrictive environment possible to support patients' recovery. Staff did not always have the skills to implement good positive behaviour support plans or follow best practice in anticipating, de-escalating, and managing challenging behaviour. The ward staff participated in the provider's restrictive interventions reduction programme.

Assessment of patient risk

Staff did not always complete risk assessments for each patient on admission, using a recognised tool, and did not review this regularly, including after any incident. Training in the risk assessment tool was 67% for nurse management, 63% for Brook ward, 71% for Esk ward, 67% for Bronte ward and 60% for Wentbridge ward. The services internal audit of risk assessments found 4 patients on Wentbridge ward, 2 patients each on Don and Bronte wards and 1 patient each on Calder and Brook wards had not had risk assessments completed and these were still outstanding. Bronte ward had identified an incomplete risk assessment from July 2022 and had still not actioned it by July 2023 when we inspected the service. One patient in seclusion had an incomplete risk assessment and it had not been updated for over 7 months.

Management of patient risk

Staff did not always know about any risks to each patient or act to prevent or reduce risks. Ward staff told us they were not included in the assessment of potential patients so were unaware of risks before admission. In relation to one of the secluded patients, staff had not updated their risk assessment to reflect that they were in seclusion and the risk management plan had very limited detail. We saw no evidence that patient's risk assessment on Bronte ward had been updated following incidents or that their management plan had been reviewed after July 2022. On Brook ward we found it hard to locate a patient's risk assessments and when these were found they had minimal information on. Staff had not completed a risk formulation within the risk assessment document for a patient in long-term segregation.

Staff did not always identify and respond to any changes in risks to, or posed by, patients. We observed patients using their electronic cigarettes in the communal area of the wards on multiple occasions without any staff intervention. We asked the senior management team why the hospital policy was not implemented with regards to patients smoking electronic cigarettes inside the hospital building. They advised that smoking inside the building was one of the highest reported type of incidents across the hospital and as they believed it was not a high-risk issue, they would not enforce it directly but instead not allow the patient to charge up their electronic cigarette. However, we observed a patient over multiple days using their electronic cigarette which staff continually recharged for them.

The provider was due to implement a ban on the use of all electronic cigarettes from 2 October 2023 due to the hospital's insurance provider not being assured that the hospital was safe. The hospital has had 2 fires since opening in

2011, although not electronic cigarette related, the insurance company advised they would only provide insurance coverage if the hospital could evidence that patients did not use their electronic cigarettes in the building, and that hospital staff were responsible for the charging of electronic cigarettes. However, over the last 2 years the service consistently failed to evidence that patients' using electronic cigarettes only did so outside the building and that patients did not charge their electronic cigarettes themselves. The senior management team advised there were regularly 6 to 8 false fire alarms per month due to the smoking of electronic cigarettes within hospital premises.

There were multiple blanket restrictions within the service. The Mental Health Act Code of Practice states, "1.6 Restrictions that apply to all patients in a particular setting (blanket or global restrictions) should be avoided. There may be settings where there will be restrictions on all patients that are necessary for their safety or for that of others. Any such restrictions should have a clear justification for the particular hospital, group, or ward to which they apply. Blanket restrictions should never be for the convenience of the provider. Any such restrictions, should be agreed by hospital managers, be documented with the reasons for such restrictions clearly described and subject to governance procedures that exist in the relevant organisation."

The provider's Section 17 leave policy for the hospital specifically stated the restrictions on leave were due to staffing numbers at the hospital regardless of patient needs. Patients and staff also told us that the new policy was to ensure safe staffing numbers and that leave was often cancelled due to lack of staff. On Aire ward, the blanket restriction register stated that patients would lose their Section 17 leave if they did not hand their electronic cigarettes in to staff when not on an electronic cigarette break. The register did state this restriction was to be removed, however this had not been done. We served Riverside Healthcare Limited with a warning notice in relation to their Section 17 leave policy as they were failing to comply with the relevant requirements of the Health and Social Care Act 2008.

There were multiple restrictions across the hospital regarding patient access, due to the low and medium secure designation of the wards some of these were deemed acceptable risk management processes. However, we saw the doors to access the garden areas locked on Aire and Wentbridge wards, which were low secure wards. Both Aire and Wentbridge wards blanket restriction registers stated there were no restrictions on access to the garden and that there were no set times for access to fresh air. Restrictions had been listed about patients accessing the garden for electronic cigarette times, but we did not see the door on Aire ward unlocked for any other purpose, and we saw no patients accessing the garden on Wentbridge ward. Staff said Aire ward did not feel like a low secure ward due to the number of restrictions in place. Wentbridge ward had all doors to the sensory room, kitchen, garden, and laundry locked. Drinking water and fresh fruit had to be requested by patients due to them being in the locked kitchen. Access to the sensory room on Wentbridge was not listed on the ward blanket restriction register.

The activity room doors were locked on Aire, Calder, and Don wards which were all low secure wards. Don wards blanket restriction register stated that the activity room was to be closed at midnight and re-opened the next morning as requested by the patients, but it was locked during our inspection.

The dining room door was locked on Bronte ward, and this had not been listed on the wards' blanket restrictions register. The kitchen doors were locked on Aire, Wentbridge, and Hamilton wards. Aire ward and Wentbridge ward both identified this blanket restriction and stated patients would be individually risk assessed to access, however, they had stated that patient access to hot drinks was not restricted but patients could only access hot drinks via the locked kitchen so were restricted. Hamilton ward had not identified this restriction on their blanket restrictions register.

Staff followed provider policies and procedures when they needed to search patients or their bedrooms to keep them safe from harm. Personal searches were either dictated by the patient's care plan or by a patient pushing a randomiser button at reception when they returned from leave. The service had a search suite with closed circuit television and 2

members of staff were present for the search. Patient bedrooms were searched when a concern had arisen, and the multidisciplinary team had agreed for the search to be completed. However, the hospital had a compliance rate for search training of 77% with 69% for nursing management, 67% for staff from Aire ward, 68% for staff from Don ward, 61% for staff from Esk ward, and 64% for clinical staff.

Use of restrictive interventions

Levels of restrictive interventions were low. From May 2022 to May 2023, the hospital told us they had used physical restraint 66 times, and mechanical restraint (the use of a device such as a belt or cuff to prevent, restrict or subdue movement of a person's body, or part of the body, for the primary purpose of behavioural control) 32 times and the hospital had a policy on the safe and exceptional use of mechanical restraint. Staff participated in the provider's restrictive interventions reduction programme and the use of restrictive practices were monitored in the hospitals monthly reducing restrictive practice committee and put into the hospitals positive and safe newsletter. The provider's policy for the positive and safe management of violence and aggression referenced an external training programme for restrictive interventions, however, the hospital no longer used this training.

Staff made every attempt to avoid using restraint by using de-escalation techniques and restrained patients only when these failed and when necessary to keep the patient or others safe. All staff we spoke to told us that de-escalation was always their first response to patients when required.

Staff followed the National Institute for Care Excellence guidance when using rapid tranquilisation. From May 2022 to May 2023, the service had used rapid tranquilisation 7 times. The hospital provided information for staff in the June 2023 patient safety bulletin about the need for physical health monitoring following rapid tranquilisation and actions that should be taken depending on patient presentation.

During our inspection, a CQC (Care Quality Commission) Mental Health Act reviewer completed a Mental Health Act monitoring visit of all seclusion and long-term segregation areas of the hospital. We found that when a patient was placed in seclusion, staff did not always keep clear records or follow best practice guidelines. Between 1 January 2023 and 12 July 2023 there had been 65 episodes of seclusion for 27 different patients. Whilst reviewing 3 patients seclusion records, we found staff had not completed all statutory reviews as required by the Mental Health Act. A complaint made in May 2023 stated that a patient had been secluded for 1 hour without a doctor visit and no required paperwork being completed. This complaint had been upheld.

Staff followed best practice, including guidance in the Mental Health Act Code of Practice, if a patient was put in long-term segregation. There was one patient in long-term segregation who had been there for just under 7 weeks and a patient in seclusion had been transferred there from long-term segregation, which had been initiated 6 days prior to the inspection. There was an appropriate rationale and justification for the commencement of and current need for long-term segregation for each patient.

The provider used a safety cross system to identify areas of restraint and seclusion across the hospital. However, the safety cross that was displayed in the hospital was from February 2023 and not the most recent one from June 2023.

Safeguarding

Staff did not always understand how to protect patients from abuse and the service did not always work well with other agencies to do so.

Staff were kept up to date with their safeguarding training and the hospital had a safeguarding adult's policy and a safeguarding children policy. The hospital had a compliance rate of 87% for safeguarding adults training and for

safeguarding children training. All staff received safeguarding level 3 training following their induction and this was repeated annually. There were 16 members of staff in managerial and qualitative roles who had completed safeguarding level 4 training. The hospital had completed a training week analysis with 18 participants and had found that none of the participants knew that The Care Act 2014 underpinned the safeguarding of adults. This information was shared with staff across the hospital in the services June 2023 patient safety bulletin. Out of the 28 patients who responded to a service user satisfaction survey conducted in October 2022, 11 patients reported that staff had not explained to them what to do if they felt unsafe or if something was worrying them.

Staff followed clear procedures to keep children visiting the hospital safe. Children were not allowed access beyond the visitors' room of the hospital which was located next to the reception area. The hospital had a policy in place and a social work team who had a responsibility to ensure all appropriate risk assessments and checks had been completed prior to any visits from children.

Staff knew how to recognise adults and children at risk of or suffering harm and knew how to make a safeguarding referral and who to inform if they had concerns. However, these were not always responded to appropriately or reported to the appropriate organisations or third parties, including the Care Quality Commission. During our inspection we became aware of an alleged safeguarding concern of a vulnerable patient on Don ward. The service did not act quickly and effectively to ensure the patient was kept safe from any further concerns until we advised them that we were concerned no action had been taken. We also became aware that there had been an internal investigation into restrictive practices that had occurred between September 2022 and October 2022 on Bronte ward. There had been two internal whistleblowing concerns raised anonymously with one being reported via the provider's freedom to speak up guardian. These concerns and the investigation were not reported to the local authority safeguarding team or to the Care Quality Commission. The first whistleblowing reported 16 concerns which included blanket restrictions, individual restrictions, general restrictions, and concerns regarding patients' care. The second whistleblowing reported 10 concerns which included breaches of the provider's policies, concerns about the culture on the ward, and the mistreatment of patients. This followed an incident in 2022 in which a patient had repeatedly been denied sanitary products and unauthorised medical testing was carried out. An internal investigation had been conducted and the Care Quality Commission and the local safeguarding team were not informed of this. The Bronte investigation found 15 potential indicators of a closed culture and concerns relating to care and treatment on Bronte ward and recommended 37 actions to the senior leadership team and advised them to "consider the need to report the findings to the Care Quality Commission, local authority safeguarding department and more widely if considered appropriate." The actions on the plan were to be included in the Bronte departmental action plan but this had not been done. When we asked the senior management team for their actions regarding staff named in the report, we were advised that there were multiple challenges to the accuracy and the evidence within the reports as the clinical team on Bronte ward strongly believed they had clinical rationale in place for some of the practices.

Staff access to essential information

Staff did not have easy access to clinical information, and it was not easy for them to maintain high quality clinical records – whether paper-based or electronic.

The service used a combination of electronic and paper records, but staff did not make sure they were up-to-date and complete. Patient notes were not comprehensive, and staff could not access them easily. We observed many delays when staff attempted to log on to one of the systems. We were unable to read several handwritten medical reviews for patients in seclusion. This was of particular concern for a patient whose 15-minute observations for that day showed them to be settled and engaging appropriately with staff. Without the medical review, it was unclear why the patient remained in seclusion and there was nothing in the electronic notes for that day to explain this either. On Brook ward

there were positive behaviour support file that still had plans in for patients who had been discharged. Some of the paper Section 17 leave forms we reviewed on the wards were out of date and differed from the copy on the electronic care records system. We found information within the hospitals systems were hard to locate and understand and as a result we were only able to review a limited number of patient records fully.

Medicines management

The service did not always use systems and processes to safely prescribe, administer, record and store medicines. Staff did not regularly review the effects of medicines on patient's mental and physical health.

Staff did not always follow systems and processes to prescribe and administer medicines safely. Training compliance for medicines assessments was 70% for nursing management, and for controlled drugs (drugs that are subject to high levels of regulation because of government decisions about those drugs that are especially addictive and harmful) assessments it was 67% on both Hamilton and Wentbridge wards. The provider's policy on medication management was due to be reviewed in May 2023 but this had not been done. On Wentbridge ward, there was a single nurse for the administration of controlled drugs and there was no second nurse to support despite the providers policy stating, "Administration of controlled drugs requires two nurses to be present throughout the administration, one to administer the medication and the other to act as a witness." Staff told us there had been a number of medicines incidents, however when we requested medicines incidents for the last 6 months, staff told us the number of incidents or medicines errors recorded for one member of staff was inaccurate. The hospital was unable to explain this.

Staff did not always complete medicines records accurately or keep them up to date. The providers policy stated that, "it is necessary to have a recent photograph of the patient in the Kardex folder," however, on Esk ward the photos of 3 patients had been taken in 2020.The hospital did not always review patients' medicines regularly, including the effect of each patients' medicines on their physical health in line with NICE guidance. Advice to patients and carers were often not provided. One patient on high dose antipsychotic therapy had a combined dose of regular prescribed medicines and "as needed" antipsychotic medicines which was over the 100% of the British National Formulary maximum dose guideline. This had been in place for over a month before our visit and the patient used both regular and "as required" medicines on most days. The patient was receiving urgent treatment under Section 62 of the Mental Health Act having withdrawn their consent to take their medication. The Section 62 form kept with the patient's prescription chart on the ward was not the current one. The newest Section 62 form was in the hospital's Mental Health Act office, however, the newest form referred to 200% of the maximum dose whilst the one on the ward referred to 100% of the maximum dose. There was no information about the high dose antipsychotics in the patients care plan or a plan of how to manage it. We asked the service to rewrite the Section 62 form and review the high dose. On our return 2 weeks later, this had not been done. The hospital had a policy on Pharmacological Management of Acute Disturbance Policy / Rapid tranquillisation which referenced the use of high dose antipsychotics but there was no policy specific for this or guidance on the monitoring of high dose antipsychotics to ensure concerns could be acted upon.

On Bronte ward, a medicine was prescribed for a patient on an "as needed" basis but was being given daily. Another patient had two medicines prescribed as needed but there was a lack of clarity of which medicine was to be used for what. There was no evidence of these being reviewed.

Staff did not always store and manage all medicines and prescribing documents safely. On Hamilton ward we were advised that there were no controlled drugs on the ward. We looked inside the locked controlled drugs cupboard and found a white tablet in a pot with no description or information about it. The cupboard also contained 3 police evidence bags dated 2019 with unknown substances in 2 of them from Brook ward. The provider's policy on reporting incidents to the police was due to be reviewed in June 2020 but this had not been done. Following our inspection, the service

completed an investigation into the items found in the controlled drugs cupboard and were unable to establish why the police bags were stored in the hospital for a prolonged period or how they had been moved from Brook ward to Hamilton ward. The provider subsequently contacted the police about the substances and further investigations were due to be conducted.

The hospital documented that on 26 March 2023 a packaged tablet was found on the floor in the observing area of the Keepmoat and Lakeside seclusion suites. This seclusion suites were not located on a ward. The pill was a prescribed drug called buprenorphine which is taken as a replacement in the treatment of heroin and methadone addiction. The provider completed an investigation into the incident called a root cause analysis. This investigation was not started until 3 July 2023 and both patients who had been in seclusion were not spoken to for various reasons. Only one of the two members of staff present at the time of discovery was interviewed. No root cause was identified, including where the medicine had come from.

The service did not ensure that people's behaviour was not controlled by excessive and inappropriate use of medicines. On 26 May 2023 and 31 May 2023, a patient on Calder ward was given prescribed medicine for pain relief above the British National Formulary guidelines on two occasions. Both members of staff were new to that ward and the prescription chart had not been written in the usual way to ensure understanding by staff administrating medicines.

Staff sometimes learned from safety alerts and incidents to improve practice. Learning had been shared with staff in the March 2023 patient safety bulletin about the recall and replacement of a particular medication.

Track record on safety

The service did not have a good track record on safety.

We were told by staff that restricted access to electronic cigarette breaks and Section 17 leave were the main cause of incidents at the hospital. We observed one member of staff receiving verbal abuse from a patient due to the restriction on electronic cigarette breaks.

The service had 9 serious incidents in the last 6 months with 5 investigations still ongoing at the time of our inspection. However, each completed investigation report rarely identified the root cause of the incident. One investigation that led to an allegation of gross misconduct had not ensured that closed circuit television footage of the incident had been requested in a timely manner and because of this, the footage had been erased in line with the provider's 10-day retention policy.

The service documented a serious incident investigation on 21 March 2023 on Bronte ward when a patient was dragged to the seclusion room. The initial incident was reported via the provider's incident reporting system on the 21 March 2023 but no concerns about the incident were reported. Following a review of the incident using closed circuit television, the reviewers' observed that staff had not used approved prevention management of violence and aggression techniques and that the patient had been dragged to seclusion. There were 4 staff members, including 2 nurses, involved in the incident and all were referred to a disciplinary hearing for gross misconduct.

The service documented a serious incident investigation on 21 May 2023 where a patient alleged that whilst in seclusion, appropriate Mental Health Act Code of Practice seclusion requirements were not followed, which included not being visited by a doctor and documentation not being completed. Multiple staff members were also noted as raising this same concern. The investigation was still in progress at the time of our inspection.

Inadequate

Forensic inpatient or secure wards

Reporting incidents and learning from when things go wrong

The service did not always manage patient safety incidents well or recognise incidents and report them appropriately.

Some staff knew what incidents to report and how to report them, but this was not always done. The hospital had introduced a new incident reporting and management system in February 2022. On Aire ward, a security item had been missing from the locked ward safe for 4 days before it was reported by ward staff to management. A full ward lockdown and search was completed and although other contraband items were found, the security item that had initiated the search was not found. Three days later the security item had been returned to the locked ward safe, but the provider could not identify who had returned the item. The provider highlighted this incident in their June 2023 patient safety bulletin to share learning about the importance of notifying management about missing high risk items.

Staff understood the duty of candour, but they were not always open and transparent or gave patients and families a full explanation if and when things went wrong. The multiple allegations of patient abuse and neglect on Bronte ward had not been reported to either the local safeguarding team or to the Care Quality Commission despite the hospitals policy on being open and the duty of candour stating that notification forms must be submitted "within 48 hours of the incident being detected or reported." We reviewed all 9 serious incident investigations from the previous 6 months and all reports had a section on "Involvement of Service User, Family or Carers (Duty of Candour)" with detailed guidance on what information should be included within this section. On 5 of the reports the text did not align with the guidance and on 3 reports the section had been left blank.

Managers did not always debrief and support staff after any serious incident. The service's psychology team had introduced reflective practice sessions which were offered to staff on each ward once a month from January 2023 to July 2023, however, none of the sessions were able to go ahead on Aire, Brook, or Don wards due to low staffing levels and no additional staff to cover. Calder, Bronte, Esk, and Hamilton wards all had at least 1 session of reflective practice since January 2023, however, staffing issues resulted in not all the sessions being attended. Staff and patients told us they had not received debriefs following incidents, this included incidents where patients had been restrained in front of other patients. Doctors we spoke to told us that the psychology team would facilitate any debriefs following incidents, called hot or cold debriefs Version 2e – 14 February 2022 18 depending on how quickly after the incident the debrief was facilitated. However, the psychology team told us that all debriefs were conducted by ward management.

Managers did not always investigate incidents thoroughly. Patients and their families were rarely involved in these investigations. Staff did not always receive feedback from investigation of incidents, both internal and external to the service. Only 1 of the 4 completed and approved investigations that had been completed in the last 6 months stated what the arrangements were for sharing learning with staff.

Staff met to discuss the feedback and look at improvements to patient care. Following the inspection feedback, the service leaders met to discuss changes that needed to be made. However, this had not been done previously when patients and staff had fed back concerns with staffing and the complaints process. Staff and patients told us that the senior leadership team regularly did not respond to requests.

Managers shared learning with their staff about never events that happened elsewhere. The provider produced a monthly patient safety bulletin which discussed a range of safety related issues, this included incidents at other hospitals, how to implement certain safety protocols, and knowledge reminders for staff about the legislation and regulation of mental health services.

Inadequate

Forensic inpatient or secure wards

Is the service effective?

Inadequate

Our rating of effective went down. We rated it as inadequate.

Assessment of needs and planning of care

Staff did not always assess the physical and mental health of all patients on admission. They did not always develop individual care plans which were reviewed regularly through multidisciplinary discussion or updated as needed. Care plans did not always reflect patients' assessed needs, and were not always personalised, holistic or recovery oriented.

Staff did not regularly review and update care plans when patients' needs changed. Staff told us that each patient had a positive behavioural support plan created by the psychology team when they were admitted to the service. Once completed the plan was then given to the ward team to continue to review and update, however, not all positive behaviour support plans had been implemented or updated. A patient in seclusion had a risk assessment that identified the need for a positive behaviour support plan which would be essential in reducing risk, but there was not one in place. On Bronte ward, a positive behaviour support plan we reviewed had been implemented in May 2021 and had not been updated and a physical care plan and a mental health care plan we reviewed had not been updated since July 2022. The same patient also had a safety care plan which had not been reviewed as required in February 2023. The hospital's care planning policy was due to be reviewed in March 2023, but this had not been done.

Clinic rooms on the wards were small and could not house an examination couch, we were told by staff that patients requiring a physical examination would either be seen in their bedrooms or in the physical health clinic which was situated off the ward.

Staff did not always develop a comprehensive care plan for each patient that met their mental and physical health needs. We reviewed one care plan on Bronte ward that had out of date patient information and referred to the patient using a mixture of their previous and current name and gender.

Best practice in treatment and care

Staff did not provide a range of treatment and care for patients based on national guidance and best practice. They did not always ensure that patients had good access to physical healthcare or support them to live healthier lives.

Staff did not always provide a range of care and treatment suitable for the patients in the service. During our inspection we did not observe activities happening on any of the wards, apart from one baking session on Hamilton ward and a staff member playing pool with a patient on Esk ward during an evening inspection. Patients' activities consisted of regular electronic cigarette breaks to the garden and watching television. We reviewed closed circuit television footage of Wentbridge, Foss and Calder wards and saw patients only accessing one of either of those two activities.

The provider monitored patients' activity using the 25 hours a week of meaningful activity guidance. The data provided showed that in the last 6 months out of 86 patients, only 62.5 patients were getting any type of meaningful activity a week. The weekly average for those who were getting meaningful activity was 1.95 hours. Occupational therapists worked Monday to Friday, and we were told that ward activities were not the responsibility of the occupational therapy

department. The occupational therapy department felt that the reason there were low numbers for meaningful activity was that not all staff, including ward staff, were documenting on the electronic patient system when an activity had occurred, such as leave from the hospital. However, staff, patients, and carers told us that the patients were bored and had nothing to do.

On Aire ward there was an action from the June 2023 community meeting to arrange more activities on the ward, but this had not yet been completed. We observed the activity rooms on Aire, Calder, Foss, Bronte, Brook, Esk and Don wards were locked, and we were told by patients and carers that when ward activities were offered, they were usually not age appropriate or person-centred. Interactions between staff and patients were minimal and usually instigated by the patient. On Wentbridge and Foss wards, staff were observed sitting and watching television without supporting a patient. Staff told us the lack of activities on the ward was due to the low staffing numbers and they used to be able to interact and engage with patients when there was more staff on the wards.

There was a social space in the hospital called Chesbucks Café which was open to patients for 2 hours on a Tuesday and 2 hours on a Friday. Patients required staff to support them to visit the café. Staff told us that members of the occupational therapy team were able to take 3 patients from medium secure and 4 from low secure at any one time as long as there was enough room in the café. There was also an onsite shop called “Chescos” and each ward were given specific times that their patients could attend. Due to the leave restrictions and limited opening times for the café and shop, staff told us that patients would often opt for personal leave or shop leave over taking part in occupational therapy.

We requested a sample of activity planners from 12 patients across the hospital. Of those 12, only 3 had an activity planner in place. The individual weekly planners evidenced patient specific activities for only 1 to 2 hours a week. There was an occupational therapy ward activity planner for July 2023 to September 2023 for the whole hospital which listed 19 patients as being scheduled for a 1 to 1 session across the 3 months. Activities included cooking, visiting the services shop, and rapport building. There were 86 patients at the hospital and 67 did not have any activities scheduled.

Staff did not always identify patients’ physical health needs or record them in their care plans. One patient with dysphagia (swallowing difficulties) had been referred to an independent speech and language therapist since the beginning of 2023. However, we were advised by staff that another patient had choked on their food the previous week and their care plan did not reflect their needs or that appropriate referrals had been made. We requested the patient’s care plans, but this was not received. The service had a physical healthcare suite that was supported by a registered general nurse and a support worker. There was a local GP who visited the hospital two days a week. Outcomes from these visits were e-mailed to the service and staff told us that this meant the information could be difficult to access as the visit outcome was not put onto the service’s own care records system and staff were not given access to the GPs system.

Staff did not always make sure patients had access to physical health care, including specialists as required or meet patients’ dietary needs or assess those needing specialist care for nutrition and hydration. On Bronte ward, staff did not have any information about how to submit a referral for dietician support and a physical care plan we looked at had not been reviewed since July 2022. On Bronte ward and Brook ward, 4 patients care records had noted patient weight gain, but there was no evidence of a dietician being requested. One patient in long-term segregation and one patient in seclusion had empty food and fluid charts, including for one patient who had dysphagia. Staff told us this patient’s dietary needs were not well documented within their care plan.

However, patients on Don ward told us they were supported in their dietary needs due to physical health conditions.

Inadequate

Forensic inpatient or secure wards

Staff did not always help patients live healthier lives by supporting them to take part in programmes or giving advice. Out of the 28 patients who responded to the service user satisfaction survey completed in October 2022, 16 said they had not been offered any advice on nutrition or diet. Some patients told us the food supplied was mainly chips and meat with limited vegetables and that they had limited access to the hospital gym due to its small space and access times. Patients could access a gym in the community, but this was restricted due to the restrictions on section 17 leave. Some carers told us their relative had put weight on and that the food choices were not healthy.

Staff used recognised rating scales to assess and record the severity of patients' conditions and care and treatment outcomes. On admission, patients were rated against the Health of the Nation Outcome Scales which is a method of measuring the health and social functioning of people with severe mental illness. It comprises 12 scales that measure behaviour, impairment, symptoms, and social functioning. The Dynamic Appraisal of Situational Aggression tool was used during handover of staff for each patient based on their previous 24 hours.

Staff did not always use technology to support patients. Closed circuit television was only kept for 10 days which had a negative impact on the provider's ability to robustly investigate complaints and incidents. The services electronic care system was not fit for purpose. However, computer tablets were used by support workers sitting outside of the hospital visiting rooms to monitor the meeting whilst still providing privacy to the patient and their visitors.

Ward staff did not take part in clinical audits, benchmarking, or quality improvement initiatives. Although monthly audits were completed by the quality compliance team, who were situated away from the wards, managers did not always use the results from these audits to make improvements. Each ward had a departmental action plan which continued to find the same concerns and issues during each monthly audit. Managers advised us that there was a clinical audit schedule for medications, however, the doctors we spoke to were not aware of this.

Doctors at the service did take part in a peer review network for long term segregation with a neighbouring NHS trust.

Skilled staff to deliver care

Managers did not make sure they had staff with the range of skills needed to provide high quality care. Managers did not always support staff with appraisals and supervision.

The service had access to a full range of specialists to meet the needs of the patients on the ward. Staff could refer patients to an external speech and language therapist to support their needs if required, however, only 1 referral had been made in the previous 6 months. Although there was a member of staff who had been identified as the speech and language therapy assistant and who received external speech and language supervision, there was no plan for them to gain a qualification as a speech and language therapist. Staff and patients told us that there was an urgent need for more social work support at the hospital and some patients said the limited social work resources available was delaying their progress.

Managers gave each new member of staff a full induction to the service before they started work. All new starters received a 3-week induction, the first 2 weeks were off the ward and the third week was ward-based and feedback was generally positive. Senior managers also attended the induction and welcomed the new starters to the hospital. We observed multiple staff members on wards in their third week of induction. However, external agency staff were only provided with an induction on how to use their keys and alarm with no orientation to the ward or the patients.

Managers did not consistently support permanent staff to develop through yearly, constructive appraisals of their work. The hospital had recorded a 62% compliance rate for appraisals in June 2023, 47% in May 2023, and 32% in April 2023. Of these percentages:

- Wentbridge ward had a compliance of 17% in June 2023, 16% in May 2023, and 25% in April 2023
- Calder ward had a compliance of 65% in June 2023, 62% in May 2023, and 60% in April 2023
- Hamilton had a compliance of 25% in June 2023, 28% in May 2023, and 0% in April 2023 and,
- Aire ward had a compliance of 31% in June 2023, and 0% in both May and April 2023.

We were told the recording period for appraisals had changed about 4 months before our inspection so there was a back log of appraisals required. However, at our previous inspection we found that between 1 July 2020 and 1 July 2021, compliance rates for appraisals for nursing staff and support workers across the hospital was also low at 50%.

Managers did not consistently support staff through regular, constructive managerial supervision for all staff or clinical supervision for qualified staff. The hospital had achieved 69% compliance for supervisions in June 2023, 61% in May 2023, and 70% in April 2023. Of these percentages:

- Wentbridge ward had a compliance of 16% in June 2023, 26% in May 2023, and 14% in April 2023
- Hamilton ward had a compliance of 44% in June 2023, 69% in May 2023, and 60% in April 2023
- Brook ward had a compliance of 48% in June 2023 and 28% in May 2023 and,
- Aire ward had compliance of 55% in June 2023, 58% in May 2023, and 26% in April 2023.

The senior management team said that clinical and managerial supervision were completed as one session as per their policy. However, when we spoke to managers across the hospital, they advised that clinical and managerial supervision were done separately on two separate documents. Supervision differed across the hospital as some staff told us they had regular supervision which was documented, and other members of staff told us they were not sure when they last had a supervision.

Staff attended regular handover meetings and there was a monthly support worker forum, monthly nurse meetings, weekly service manager meetings and monthly ward manager meetings. The audit schedule board had no information about team meetings across the wards, apart from Wentbridge ward which had been marked as “Fail.”

Managers did not always identify any training needs their staff had or give them the time and opportunity to develop their skills and knowledge. Staff across all but Foss ward were not compliant with all the training requirements set out by the provider.

Managers did not always make sure staff received any specialist training for their role. There were multiple registered general nurses running the wards at the hospital. They had not been given any additional training specific to mental health nursing to support them in their duties on a mental health ward.

Managers recognised poor performance, could identify the reasons, and dealt with these. There had been 31 staff dismissed since January 2023, 24 of these were still within their probationary period. The reasons for dismissal for those on probation included not attending work, sleeping whilst on shift and not completing observations of patients as required.

Multi-disciplinary and interagency teamwork

Staff did not always support each other to make sure patients had no gaps in their care. The ward teams did not always have effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation.

Staff held regular multidisciplinary meetings to discuss patients and improve their care. We observed a ward round on Bronte ward. The discussions observed were in depth and solution focussed with all aspects of the patients' care discussed.

Staff made sure they shared clear information about patients and any changes in their care, including during handover meetings. Management met every weekday morning for their daily hospital status and escalation meeting. We attended handovers on all wards and saw detailed information shared between the ward staff with all information documented for further review if needed. However, the handovers tended to be held in the wards dining room which meant patients did not have access to this room during that time.

Ward teams did not always have effective working relationships with other teams in the organisation. Specialist teams, such as psychology and occupation therapy, sat away from the wards and ward staff had limited knowledge or understanding of their roles. We did observe members of the specialist teams on the wards during our inspection and they provided thorough handovers to the ward staff. However, some patients told us it was rare to see them on the wards unless they were completing an assessment.

Ward teams did not always have effective working relationships with external teams and organisations. The provider regularly met with the South Yorkshire and Bassetlaw forensic provider collaborative to discuss the service which included admissions, however, there had been issues with regards the funding of the service. The advocacy teams within the service said there had been delays when requests had been made and this had been raised with the hospital manager.

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

Staff did not always understand their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice or discharge these well. Managers did not make sure that staff could explain patients' rights to them.

Most staff had received, and kept up to date, with training on the Mental Health Act and the Mental Health Act Code of Practice and could describe the Code of Practice guiding principles. The hospital had achieved an 87% compliance rating for mental health legislation training; however, the nursing management team had a compliance rating of 69% for mental health legislation, mental capacity act, consent to treatment, nearest relative and patient rights training.

Staff had access to support and advice on implementing the Mental Health Act and its Code of Practice. Staff knew who their Mental Health Act administrators were and when to ask them for support. The hospital had a designated Mental Health Act office where all records relating to the Mental Health Act were received, scrutinised, and stored.

The service did not have up-to-date policies and procedures that reflected all relevant legislation and the Mental Health Act Code of Practice. The service had created a Section 17 leave (permission to leave the hospital) policy named, "Guidance to ensure the hospital remains safely staffed when leaves are planned," which did not reflect the Mental Health Act Code of Practice as it restricted patients' access to Section 17 leave based on staffing numbers and not on the individual risk assessment and needs of patients. Staff did not make sure patients could take Section 17 leave when this was agreed with the responsible clinician and/or with the Ministry of Justice. We served the hospital with a warning notice in relation to their Section 17 leave policy as it was not based on an individual risk-based assessment for each patient. Following receipt of the warning notice, the provider sent us the numerical data of number of Section 17 leaves taken by patients in the first 2 weeks of July 2023. There were 86 patients across the hospital and the average number of

unescorted or escorted leaves were 2.8 per person over the 2-week period. The data supplied did not state whether the leave was on or off the hospital grounds, whether the leave was for a medical appointment or what therapeutic activity had occurred. The provider responded to the warning notice by removing the guidance and implementing a Section 17 leave policy that was in line with the Mental Health Act Code of Practice.

Patients had easy access to information about independent mental health advocacy and patients who lacked capacity were automatically referred to the service. Some patients told us the advocacy service was good whilst others told us it was not. All the wards used the same advocacy service, whilst Bronte ward, the female ward, used a gender specific advocacy service.

Staff did not always explain to each patient their rights under the Mental Health Act in a way that they could understand, repeat the rights as necessary or record them clearly in the patient's notes each time. We found that 3 patients in seclusion and 1 patient in long-term segregation had not been given information about their rights in a timely manner. Patients were provided with this information at 14 days after admission, 22 days after admission and 28 days after admission contrary to the Mental Health Act which states that it "…must be done as soon as practicable after the start of the patient's detention", whilst another patient had not received any information on their rights for 11 days when their detention had been extended.

Staff requested an opinion from a Second Opinion Appointed Doctor (SOAD) when they needed to. SOAD requests were recorded on the patients' electronic data sheet.

Staff did not always store copies of patients' detention papers and associated records correctly and staff could not always access them when needed. We were unable to locate an Approved Mental Health Practitioners report on Bronte ward for one patient and another patient on Brook ward. The Approved Mental Health Practitioners coordinates the assessment of individuals who are being considered for detention under the Mental Health Act 1983.

Care plans did not always include information about after-care services available for those patients who qualified for it under Section 117 of the Mental Health Act. We could find no reference to Section 117 aftercare on 2 care plans on Bronte ward and 1 on Brook ward. Some of the senior leadership team we spoke to said they were not aware if the care plans had this information in.

Staff completed audits of how the service applied the Mental Health Act correctly by completing audits and discussing the findings. However, the audits were completed as a sample with only 3 patients off a ward being audited each month. From January 2023 issues were found with the Mental Health Act paperwork for patients on Calder, Don and Esk wards. These issues included the registered clinician not fully completing treatment certificates, the registered clinician not updating the patient's notes on the electronic care record system and there not being a valid Section 17 leave form in place. The actions from the issues found were still outstanding when we inspected and were repeatedly listed by the service on each monthly audit.

Good practice in applying the Mental Capacity Act

Some staff did not always support patients to make decisions on their care for themselves. They did not always understand the provider policy on the Mental Capacity Act 2005 or assess and record capacity clearly for patients who might have impaired mental capacity.

The service had a policy on the Mental Capacity Act but some staff we asked about this Act responded that the Deprivation of Liberty Act Safeguards (circumstances when a person's freedom is taken away) were not used at the hospital, with no understanding that the Act covered all adults who are aged 16 or over and not just for those who

required this additional protection. Some staff did understand it was applicable to all adults and was designed to protect and empower people who may lack the mental capacity to make their own decisions about their care. Where a detained patient under the Mental Health Act lacks capacity to consent to treatment other than for a mental disorder, the decision-maker will need to act in accordance with the Mental Capacity Act. Although the providers policy was not due for review until April 2024, it had not been updated when changes to legislation occurred, such as the pausing of the implementation of the Liberty Protection Safeguards which were due to be launched in or around April 2022 but had not yet happened.

Some staff received, and were up to date, with training in the Mental Capacity Act and had a good understanding of at least the five principles. The hospital had achieved 87% compliance for Mental Capacity Act training. However, the nursing management team had only achieved a compliance rating of 69%.

Staff gave patients all possible support to make specific decisions for themselves before deciding a patient did not have the capacity to do so.

Staff assessed and recorded capacity to consent clearly each time a patient needed to make an important decision. The provider had a record of assessment of capacity recording template and a record of actions taken to make a best interests decision within their Mental Capacity Act policy for staff to use. Staff assessed patients as not having capacity, they made decisions in the best interest of patients and considered the patient's wishes, feelings, culture, and history. There had been 2 incidents in the previous year where the provider had assessed the capacity of patients involved.

The service did not monitor how well it followed the Mental Capacity Act or make changes to practice, when necessary, as staff did not audit how they applied the Mental Capacity Act. The provider told us that the Mental Capacity Act was audited within the Mental Health Act audit. However, we reviewed the Mental Health Act audit and found all questions were in relation to only the Mental Health Act and its relevant sections only.

The Mental Health Act Code of Practice states "20.40: Those working under the Act with people with learning disabilities or autism should bear in mind the following general points: practitioners require a good understanding of the MCA (Mental Capacity Act). In particular, the requirement to assist people to make decisions for themselves where possible; the need to respect a decision by a person who has capacity which may be seen as unwise; and to offer care that is the least restrictive of people's rights. This should be audited as part of the quality monitoring within hospitals and other settings." Wentbridge ward was a low secure service for men with a primary diagnosis of high functioning autism, and other associated mental health needs and there were patients diagnosed with autism on other wards within the service. This meant that by failing to undertake audits of the use of the Mental Capacity Act within the service, which included autistic people, the provider was not following this requirement of the Mental Health Code of Practice.

Is the service caring?

Inadequate

Our rating of caring went down. We rated it as inadequate.

Kindness, privacy, dignity, respect, compassion, and support

Staff did not always treat patients with compassion and kindness. They did not always respect patients' privacy and dignity. They did not always understand the individual needs of patients or supported patients to understand and manage their care, treatment, or condition.

Inadequate

Forensic inpatient or secure wards

Staff were not always discreet, respectful, or responsive when caring for patients. During our inspection of Bronte ward, we observed two male support workers stand in front of a crying female patient whilst other patients were present, discussing who would conduct the patients' observations for that evening. There was no interaction with the patient and the language used was disrespectful and showed no care for the patient's obvious distress. We observed 2 staff members in their coats sat with drinks in front of the ward communal television, ignoring a patient that was sitting near them, and talking in whispers. Patients across the hospital told us that staff could be vindictive and that some staff bullied them and made derogatory comments towards them and about their family members.

Staff did not always understand or respect the individual needs of each patient. Staff did not always give patients help, emotional support or advice when they needed it. During the first 3 days of our inspection, we heard continuous distressing crying from a patient on Aire ward which was a significant distance away from the inspectors' briefing room. The inspection team frequently visited the ward to ensure the safety and care of the patient. When we asked staff what support had been put in place for the patient, they said the on-call doctor had told them to seclude the patient which they had done the week before we arrived. We observed the patient in the communal areas in distress and being given no support. We served Riverside Healthcare Limited with a warning notice in relation the care and treatment being provided to patients and the skills of the staff providing that care as they were failing to comply with the relevant requirements of the Health and Social Care Act 2008.

Staff did not always support patients to understand and manage their own care treatment or condition. There was no evidence that the care plans for 2 patients on Bronte ward and 3 patients on Brook ward had been written with the patients input and in a way the patient would understand. Six patients from across the hospital told us they had not been involved in the creation of their care plan. However, 2 patients on Don ward told us they were involved in the creation of their care plan and worked with staff to set goals.

Staff did not always direct patients to other services or support them to access those services if they needed help due to the shortage of staff on the wards.

Patients said some staff treated them well and behaved kindly. However, patients told us that some of the other staff members had their favourite patients and that the treatment at the hospital was more punitive than restorative. Patients on Hamilton ward told us that staff eat in the ward dining room and patients are not allowed in as it ruins the staff members peace and quiet.

Some staff did not always feel that they could raise concerns about disrespectful, discriminatory, or abusive behaviour or attitudes towards patients. Although the service had a Freedom to Speak up Guardian and posters with details about an external whistleblowing service, there had been an incident where a whistleblowers information had been made public to the rest of the staff at the hospital.

Staff did not always follow policy to keep patient information confidential. In June 2023, a staff member had been dismissed following an incident where they had disclosed confidential information to a patient about another patient on the ward.

Involvement in care

Staff did not always involve patients in care planning and risk assessment or actively seek their feedback on the quality of care provided. They ensured that patients had easy access to independent advocates.

Inadequate

Forensic inpatient or secure wards

Involvement of patients

Staff introduced patients to the ward and the services as part of their admission. The hospital had a patient induction and orientation policy.

Staff did not always involve patients or give them access to their care plans and risk assessments. On Bronte ward there was no evidence that a patient had been involved in their risk assessment, care plan or leave planning. The service completed a monthly audit of care plans with actions required. The audits identified the following issues:

- From April 2023, 8 patients on Aire ward had not signed their care plans,
- From May 2023, 8 patients on Bronte ward had not signed their care plans, 3 patients had not received a copy of their care plan and 2 care records lacked patient views and,
- From May 2023, all 7 patients on Wentbridge ward had issues with their care plans, including not signing their care plan, carers views not included within the plan and no evidence patients had received a copy of their care plan.

The actions associated with these findings were still outstanding and showed as repeatedly not being completed on the service's departmental action plans. A service user satisfaction survey was sent to patients in October 2022 and 15 patients said they were as involved in decisions about their care as much as they want, whilst 10 patients said they were not.

Some staff made sure patients understood their care and treatment (and found ways to communicate with patients who had communication difficulties). A patient on Don ward used mood cards to quickly and easily show staff how they were feeling and what they needed to communicate to staff. A patient in long-term segregation had detailed information in their care plan about their communication needs. They had a communication passport, communication cards and a positive behaviour support plan.

Staff sometimes involved patients in decisions about the service, when appropriate. Some patients had the opportunity to be involved with staff recruitment, however, in the last 6 interviews completed by the hospital there was no evidence of patient involvement. Patients had not been involved in the decision to limit Section 17 leave or the removal of their ability to access electronic cigarettes.

Patients could not always give feedback on the service and their treatment and staff did not always support them to do this. A service user satisfaction survey was sent to patients in October 2022. A total of 28 patients across the hospital took part whilst 54 patients did not. There were 26 patients who said they felt able to express their views at meetings and 25 patients who said staff provided them with information in a way they could understand. There was a hospital wide monthly patient engagement meeting with staff and a monthly ward community meeting for patients and ward staff. A poster displayed about the patient engagement council listed the next meeting as being for June 2023 even though we did see meeting minutes from a meeting that had already happened in July 2023. The quality standards for forensic mental health services state that ward community meetings should happen on a weekly basis unless agreed with the patient group. There was no evidence on any of the wards to support the patients agreeing to a monthly meeting. On Bronte ward there were no ward community meetings in May 2023 and on Wentbridge ward there were no ward community meetings in the previous 3 months documented, although some patients did tell us these happened weekly.

The wards all had "You said, we did" notice boards. However, on Aire ward, their own internal audits had found that from March 2023 until June 2023 the board had not been updated and was still showing as an outstanding action on their action plan. In July 2023, on Esk and Don wards it was noted that the "You said, we did" boards needed updating. During our inspection we saw that the "You said, we did" boards were blank on Wentbridge ward and Foss ward.

Inadequate

Forensic inpatient or secure wards

There was a service user newsletter produced in May 2023 and was available to visitors to view in reception.

Staff supported patients to make advanced decisions on their care and made sure patients could access advocacy services. The providers Mental Capacity Act policy referenced the use of a lasting power of attorney and advanced decisions for people over the age of 18.

Involvement of families and carers

Staff did not always inform and involve families and carers appropriately.

The services family and friends' information which was available on the hospital website stated that they followed the standards set out by the Triangle of Care, (The Care Act 2014, NHS (National Health Service) England Carer Support, and Involvement in Secure Mental Health Services), which describes a therapeutic relationship between the patient, staff member and carer that promotes safety, supports communication, and sustains wellbeing. The service also had a policy on "Working with Carers and Significant Others," however, we saw no communication or reference to this resource during our inspection. The senior management team told us that they recognised that the carer involvement required further improvement and they were actively recruiting a patient and families involvement lead.

Staff did not always support, inform, or involve families or carers. Out of the 28 patients who responded to the service user satisfaction survey completed in October 2022, 10 said that the service did not keep their family involved with their care or keep them updated on their progress and 14 patients said they had not received the help they needed from staff to organise their home situations.

We spoke to 16 carers and 5 told us that the service was not responsive to their requests and did not involve them in their relative's care. They stated that communication was the biggest issue they had with the service. Whilst other carers were happy with their amount of involvement and said the staff were always helpful and supportive. The minutes from the hospital's patient engagement council held in February 2023 and March 2023 stated that the hospital planned to introduce something more effective to involve the help of family and friends, to support patients through their treatment pathway. However, this had not happened at the time of our inspection.

Families were given the opportunity to give feedback on the service. The hospital sent out 48 family and friends feedback forms in June 2023 and received 7 responses back. Out of 196 questions, 123 were answered with responses of the service being outstanding or good in a particular area of the service, such as "the environment and equipment I see are well maintained", "I know how to raise any problems I may witness," and "the person I visit is supported to get the help they need when they need it such as an advocate (people who can speak on their behalf)." There were 59 questions that were not answered and 14 answers of either inadequate or requires improvement in relation to "staff communicate with me, in the way I need them to" and "I know who the ward manager is, and anyone else in charge."

Staff gave carers information on how to find the carer's assessment. The service had an online welcome booklet that included information on how a carers assessment could be accessed, along with details about the service.

Is the service responsive?

Inadequate

Our rating of responsive went down. We rated it as inadequate.

Inadequate

Forensic inpatient or secure wards

Access and discharge

Staff did not always plan or manage patient discharge well.

Bed management

Managers produced a monthly governance data sheet which documented the length of stay of each patient at the service. The original information given to us by the provider was incorrect. Following the review stage of the report, the service was able to provide correct information. The average length of stay across the service was 2.8 years, with Esk ward and Calder ward at over 4 years each. The service highlighted the ten patients with the longest stays within the report, which ranged from over 6 years to over 12 years.

The service had low out-of-area placements. The forensic provider collaborative for South Yorkshire and Bassetlaw met on a weekly basis to look at any referrals, bed numbers and bed capacity.

Managers and staff worked to make sure they did not discharge patients before they were ready.

When patients went on leave there was always a bed available when they returned and patients were moved between wards only when there were clear clinical reasons, or it was in the best interest of the patient. We observed one patient moving from a medium secure ward to a low secure ward who was spending time on the new ward daily to support their integration.

Staff did not move or discharge patients at night or very early in the morning.

Discharge and transfers of care

Managers monitored the number of patients whose discharge was delayed and knew which wards had the most delays. From July 2022 to July 2023 there had been 2 delayed discharges from Wentbridge ward, 3 delayed discharges on Don ward, 1 delayed discharge on Esk ward, and 2 delayed discharges on Foss ward. None of the care records we observed had an estimated date of discharge or plan for discharge. Some relatives of patients told us that their family member had no plan for discharge. The NHSE (NHS England) medium secure service specification 5.2.8 which applies to Brook, Hamilton, Foss and Bronte wards, states that, “all patients must have an estimated date of discharge identified within 4 weeks of admission to the service. The estimated date must be reviewed as often as required…” A quality review of the service completed by the local provider collaborative found that most patients on all 9 wards did not have an estimated discharge date identified and had received assurance from the hospital that all patients would have this by September 2023.

We requested the length of delayed discharge for the 8 patients who were delayed and the reasons for the delay. The provider provided a document which gave the reason for delay for 4 patients with delays from October 2022 to July 2023. The report stated the date that the clinical decision was taken that the patient was fit and ready for discharge, but external factors had prevented the discharge taking place. The reasons included no suitable place to move to and awaiting a care package to be set up in their own home. There were 4 other patients who had not been listed.

Staff did not always carefully plan patients’ discharge or work with care managers and coordinators to make sure this went well. The care records we reviewed had little to no evidence of discharge planning on Bronte and Brook wards. However, a patient on Calder ward told us they had plans in place for discharge and regularly attended a community placement and the advocacy service told us discharge was planned well by the hospital.

Staff supported patients when they were referred or transferred between services.

Inadequate

Forensic inpatient or secure wards

The service followed national standards for transfer.

Facilities that promote comfort, dignity, and privacy

The design, layout, and furnishings of the wards did not always support patients' treatment, privacy, and dignity. Each patient had their own bedroom with an en-suite bathroom and could keep their personal belongings safe. There were quiet areas for privacy. The food was usually of good quality, but patients could not always make hot drinks and snacks at any time.

Each patient had their own bedroom. On Bronte and Book wards the communal décor was sparse but the bedrooms on Bronte ward that we saw had been personalised whereas the bedrooms we saw on Brook ward were not. On Brook ward, there was very basic décor, and the activity room was sparse. Bedrooms on other wards lacked personalisation by the patients. When we asked staff if rooms could be personalised, we were told 'within reason'. However, Don ward had personalised bedrooms and communal area with patients choosing the wallpaper for the lounge and activity room.

Patients did not always have a secure place to store personal possessions. All wards had lockers to hold contraband or risk items that patients could access with support from staff. However, some patients told us they had things taken from their room and did not have a secure place in their bedroom to store their possessions securely.

The service did not always have a full range of rooms or equipment available to support treatment and care. On Calder and Don wards, the dining room was used for the fortnightly ward round and patients were unable to access the dining room or kitchen to get a drink or snack at this time. If the ward round ran over lunch time, the patients had to wait until the meeting was finished to have their food. This blanket restriction was on both wards' blanket restriction registers, however, the register states that this restriction would not have a negative impact on patients as they can still access the kitchen for food and drink, but patients told us this was not true.

On Wentbridge ward, a low secure service for men with a primary diagnosis of high functioning autism, and other associated mental health needs, there were no visual prompts or information on display for patients and all doors were locked including the sensory room which was sparsely furnished. During our inspection we reviewed the suitability of the environment against National Institute for Health and Care Excellence (NICE) guidance (CG142) around best practice treatment for autistic people. This included a checklist that was endorsed by NICE and the national autistic society. This gave providers guidance on how they can make environments more autism friendly. During our inspection we found that by benchmarking against this guidance, the environment was especially noisy. This included continuous ringing of the phone in the nurses' station and a high number of new inductees on the ward doing shadow shifts.

The Forensic Mental Health Services Quality Standard developmental review of the hospital in April 2022 recommended that the service contact the charity 'Hospital Rooms' to see how they could support the provider to make the ward more welcoming and homely and gather patient feedback to see what they would like to see on the ward. This had not been done. Patients on the ward told us the ward was loud and echoed a lot. The senior management team told us patients had raised these concerns previously and as a result they had contracted an external company to carry out an acoustic design review. However, the design review was in relation to building regulations and carried out in November 2021.

The service had quiet areas and a room where patients could meet with visitors in private. The hospital had a visitors' room which was located next to the reception area. We observed patients visiting with members of their family whilst staff members watched from a tablet computer outside the room.

Patients could make phone calls in private. Access to mobile phones were individually risk assessed and the provider had a patient access to phones and mail management policy in place.

The service had an outside space, but patients could not access it easily. Each ward had access to its own garden, but most wards had the door locked and needed staff supervision to gain entry. The ward gardens were sparse with very little furniture or flowers. The front of the hospital had flowers displayed, and the service had a polytunnel (a long, curved plastic structure that plants are grown under) on the grounds of the hospital which patients could visit if they had section 17 leave authorised.

Some patients could not always make their own hot drinks and snacks and were dependent on staff. On Wentbridge, Bronte and Foss wards, patients were unable to access the wards water coolers as they were in rooms which were kept locked, so they were reliant on staff to provide them with refreshments. This was particularly concerning given the lack of staff on the wards throughout the day. The provider advised that patients could access water via their ensuite bathrooms if required. Members of our inspection team became ill due to the high temperature and lack of accessible water on some of the wards. We requested that the water coolers be put on all the wards in areas that were freely accessible to patients, and this was done. However, when we returned to Foss ward there were no cups for the patients to use as they were locked away. Some staff told us that there were times patients could not get a drink because there was not enough staff to facilitate it. Only Aire ward had a patient that may need additional support with regards their access to drinking water, but a water cooler was in the open communal area of this ward. When we returned to the hospital on 26 July 2023 all the wards had free access to water for patients. Calder ward enabled free access to fresh fruit, drinking water and cordial.

The service did not always offer a variety of good quality food. A service user satisfaction survey was sent to patients in October 2022 and out of 28 patients, 15 said they did not like the meals offered. There were not always hygienic food practices in place; on Foss and Esk wards we observed loaves of bread that were out of date. On Esk ward, we observed frozen chicken defrosting above other food in the ward fridge. On Calder ward, the fridge and freezer had unlabelled food making it hard to know when food was opened, when it was due to expire, and if the food belonged to a specific patient. In the fridge there was food that had expired. For a patient in seclusion and a patient in long-term segregation there was limited evidence of food and drink being offered either on the food and fluid charts or on the service's 15-minute observations recording document. Some patients told us that the food was terrible, undercooked, and raw. Some patients and carers told us that patients who required a specific diet for religious or dietary reasons were given the same meal repeatedly on consecutive days. One patient we observed in seclusion required their food blending due to a diagnosis of dysphagia, however, the food provided did not meet the guidelines for a soft diet. Following the inspection, a concern was raised by patients and staff that during a buffet meal they had been served raw chicken. The kitchen staff were in the process of developing a recording sheet of concerns and asked that all concerns be raised with the kitchen as soon as possible so they could rectify any issues.

Patients' engagement with the wider community

Staff supported patients with activities outside the service, such as work, education, or family relationships.

Patients had access to opportunities for education and work. There was a full-time teacher at the hospital who supported the hospital with education and learning for the patients, including access to online university courses, creative writing, or music. The teacher worked with patients either on a one-to-one basis or in group settings. There had been a number of patients who had recently received a recognised qualification or were in the process of achieving one. Some patients told us they had access to the recovery college and to work opportunities outside of the hospital. Patients were also supported to take jobs at the hospital which included working at the hospitals coffee shop or cleaning the fish tank.

Staff encouraged patients to develop and maintain relationships both in the service and the wider community. There was a poster on Foss ward that gave information on the befriender service who visited the hospital for 2 hours every fortnight. The poster advised patients to speak to the ward social worker, but Foss ward did not have a ward social worker due to the depleted workforce in that department. All carers we spoke to said they had no issues being able to contact their relative due to the use of patient mobile phones.

Meeting the needs of all people who use the service

The service did not always meet the needs of all patients – including those with a protected characteristic. Staff helped patients with communication, advocacy, and cultural and spiritual support.

The service could usually support and adjust for disabled people and those with communication needs or other specific needs. We observed one patient using equipment that supported them to shower. However, between January and July 2023, patients had made numerous requests during patient engagement council meetings for posters to be displayed across the hospital which met the needs of patients who were dyslexic, and this had not been addressed at the time of our inspection.

Wards were not dementia friendly, however, there were no patients with a diagnosis of dementia at the hospital and staff advised us people with dementia would not meet the referral criteria.

Staff did not always make sure patients could access information on treatment, local services, their rights and how to complain. Foss ward had a staff information board, but no names had been entered alongside the job allocations. Brook wards staffing board did not reflect the staffing for that day and had incorrect patient leave information on it. Both Brook and Bronte wards had limited to no information available for patients. The information board on Don ward had accurate information on about each patient and whether they were on the ward.

Managers made sure staff and patients could get help from interpreters or signers when needed. The service was able to access interpreting services over the telephone and had information available in different languages and easy read formats.

Patients sometimes had access to spiritual, religious, and cultural support. On Foss ward there was a poster to state that the hospital chaplain would be on the ward for 3 hours every 3 weeks and a poster about access to holy communion. Both posters advised patients to speak to the ward social worker for further information, but Foss ward did not have a ward social worker due to the depleted workforce in that department. There was a multi-faith room in the hospital where the chaplain was also available every fortnight. However, some patients told us they had not seen an Iman when requested and the service did not always provide a variety of food to meet the dietary and cultural needs of individual patients with some patients telling us that the halal and vegetarian food provided was often repeated over several days with very limited choice being given.

Listening to and learning from concerns and complaints

The service did not always treat concerns and complaints seriously.

The service did not always clearly display information about how to raise a concern in patient areas. During our inspection we found some wards did not have information available to patients, including how to contact the Care Quality Commission with any concerns. On Bronte ward there was a Care Quality Commission contact posted but it was in the nurses' station and faced inwards away from the patients. On a follow up inspection, we confirmed that this information had been made available on all the wards.

Inadequate

Forensic inpatient or secure wards

Some patients, relatives, and carers knew how to complain or raise concerns. The service had received 59 complaints in the 6 months prior to the inspection, of which, 41 were not upheld. The complaints that had not been upheld included:

- Concerns from patients around ward restrictions,
- Short staffing effecting patients access to section 17 leave,
- Section 17 leave policy restricting patients access to leave,
- Nurses not being available to administer medicines,
- Staff being rude, bullying of patients and other staff, and being aggressive,
- Breach of patient confidentiality,
- Food choices not supporting religious needs,
- Upcoming ban on electronic cigarettes, and,
- Possessions being stolen

One complaint that was not upheld was in relation to the new policy and restrictions on section 17 leave at the hospital. Although the complaint had not been upheld, the concerns were factually correct including that there was no escorted leave out of the grounds on bank holidays or on Saturdays or Sundays.

Some staff understood the policy on complaints and knew how to handle them. Patients were able to submit complaints to the ward team and if the complaint could not be resolved locally, the complaint was submitted as a formal complaint to the provider's complaints team. However, on Bronte ward there were no complaint forms and staff could not tell us where they could be found. Patients told us that complaints were a waste of time as they were not always investigated; were generally not upheld and no reason for the complaint not being upheld was provided. Patients also told us that complaints took a long time to receive a response, with monthly letters from the provider stating they need an additional 20 days to review with no reason given for the delay.

Managers investigated complaints but did not identify themes and did not share feedback from complaints with staff. The provider only stored closed circuit television footage for 10 days before it was erased, but the provider's policy said that they aimed to conclude all investigations within 20 working days. This caused problems when needing to review closed circuit television footage as part of a complaint investigation. One complaint raised in September 2022 was not fully responded to until July 2023.

Staff did not always protect patients who raised concerns or complaints from discrimination and harassment. Some patients told us they would be punished for putting a complaint in about the hospital and one patient said the hospital had told them that putting in complaints was a sign they were unwell. During the Bronte investigation in 2022, a ward manager shared details of a complaint made by a patient on the ward via e-mail to all the Bronte ward staff which was a breach of the patient's confidentiality.

The service used compliments to learn, celebrate success and improve the quality of care. The service had received 25 compliments in the previous 6 months. There were 9 compliments which came from feedback about staff from the patient engagement council and advocacy services, 6 were patients thanking staff or teams, and the rest were from staff recognising other staff. All compliments were logged with the quality compliance team and then discussed at the hospital's regular governance meeting.

Inadequate

Forensic inpatient or secure wards

Is the service well-led?

Inadequate

Our rating of well-led went down. We rated it as inadequate.

Leadership

Leaders did not always have the skills, knowledge, and experience to perform their roles. They did not always have a good understanding of the services they managed and were not always visible in the service or approachable for patients and staff.

The service last had a registered manager in March 2022. The provider was issued with a fixed penalty notice for failing to ensure they had met the regulations for registration. Some senior managers were unaware that there was no registered manager in place. This regulation ensures that people who use services have their needs met because a fit and proper person manages the regulated activity. Following our inspection, a registered manager was appointed.

Staff told us that the senior management team rarely visited the ward areas, and the registered manager told us they had not been on the wards in the previous 18 months. Not all staff followed the provider's dress code policy and mobile communications policy, but the senior management team told us they did not always enforce these policies.

Vision and strategy

Staff knew and understood the provider's vision and values but did not always apply them to the work of their team.

Staff told us that the CEO of the company would attend the 3-week induction and go through the values of the hospital which included people and families, care and compassion, and dignity and respect. Unfortunately, this was not always observed whilst on inspection and there were no references to the values of the hospital within the ward areas.

Culture

Staff did not always feel respected, supported, or valued. They could not always raise any concerns without fear.

Ward managers and service managers were not provided with the appropriate amount of autonomy. The person acting as the registered manager for the hospital required ward managers to seek approval from themselves in relation to staffing requirements for the next day.

Some staff and patients told us the hospital was focused on making money and not on providing safe care and treatment.

The provider's internal investigation into restrictive practices that had occurred between September and October 2022 on Bronte ward had not been reported to the appropriate authorities and details of the whistleblowers and complainants were shared with staff which breached confidentiality.

On Don ward, an incident in relation to a staff member was included in the wards daily handover when there had not yet been an investigation into the allegations made.

Inadequate

Forensic inpatient or secure wards

Governance

Our findings from the other key questions demonstrated that governance processes operated ineffectively at team level and that performance and risk were not managed well.

Staffing was not safe and did not meet the needs of the patients. Restrictions on patient leave were irrespective of the Mental Health Act and there were multiple issues found with the electronic care records system which included being unable to find documentation and information not being up to date or relevant.

The number of blanket restrictions with no effective governance process in place meant that patients were overly restricted without justification. There was also no audit process in place to ensure staff correctly applied the Mental Capacity Act.

Each ward had a developmental action plan in place to highlight areas of improvement following the service's monthly audits. However, the action plans repeatedly found the same issues each month that had not been adequately addressed or improved upon.

There were multiple policies that had not been reviewed by the services own review date and we frequently saw out of date forms being used.

Management of risk, issues, and performance

Teams did not have access to the information they needed to provide safe and effective care or use that information to good effect.

The provider had used an external supplier's electronic patient record software which had crashed in August 2022 and the hospital was currently working between 3 systems. The system issue had occurred 11 months prior to this inspection but the integration of patients records onto the new systems had still not been completed.

The service required all section 17 forms to be taken to the Mental Health administrators and authorised before a patient could take their leave which could add delays to a patient being able to leave the service. This was contrary to the mental health act code of practice and this step was not required on a weekend. Senior leadership told us this step in the process was due to possible MOJ restrictions but could not advise why this was not needed on a weekend.

Following our initial feedback following inspection the service created a rapid assurance action plan with a focus on clinic rooms, safer staffing and other concerns that had been raised. The South Yorkshire and Bassetlaw forensic provider collaborative visited the hospital frequently to ensure the safety of patients and staff. Although the provider was open to the feedback from inspection, there had been no real changes to the concerns raised at the time of writing this report.

Information management

Staff did not collect analysed data about outcomes and performance. The hospital did not always engage actively in local and national quality improvement activities.

There was no internal monitoring of the outcomes of care and treatment for patients. The provider also told us it was difficult to compare their outcomes with other services due to no other hospital having the same specifications and that no data sets from governing bodies, such as the NHS, were provided.

Inadequate

Forensic inpatient or secure wards

Engagement

Managers did not always engage with other local health and social care providers to ensure that an integrated health and care system was commissioned and provided to meet the needs of the local population.

The hospital engaged positively with the South Yorkshire and Bassetlaw forensic provider collaborative following our inspection and took on board the ideas and insights of the team. However, prior to the inspection, the hospital had not always engaged with these outside organisations, including the NHS. Senior management told at the hospital told us there had been issues with finance at the service due to contractual disagreements with the NHS for the last 3 years.

Learning, continuous improvement and innovation

Providers of forensic services must be members of the Royal College of Psychiatrists Quality Network Standards for Forensic Care and participate in their annual peer review process. The last review was completed in April 2022 and the next one was due after our inspection.

The provider told us they had arranged for a leader from a different independent hospital to come and offer advice and support regarding patient property. They also advised that they had invited the Chief Nurse from the local mental health trust for their feedback. However, these had not yet been completed.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The provider did not ensure that all regulations relating to the prescribing and administration of controlled drugs were followed.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 20 HSCA (RA) Regulations 2014 Duty of candour The provider did not ensure that all staff and patients received appropriate debriefs following incidents and that these were recorded.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance The provider did not ensure that all blanket restrictions were reviewed and documented whilst complying with the Mental Health Act. The provider did not ensure that the hospitals care record system was fit for purpose or that all patient care records, risk assessments and positive behaviour plans were completed and updated as needed. The provider did not ensure that the use of the Mental Capacity Act was audited, or that staff were provided with effective training on its use. The provider did not ensure that all hospital areas had an up to date ligature risk assessment in place.

This section is primarily information for the provider

Requirement notices

The provider did not ensure that all policies relating to the safe care and treatment of patients had been reviewed and updated as required.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment The provider did not ensure that all Section 17 leave was based on patient need as required by the Mental Health Act Code of Practice.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 14 HSCA (RA) Regulations 2014 Meeting nutritional and hydration needs The provider did not ensure that patients always had free access to drinking water.

Regulated activity	Regulation
Treatment of disease, disorder or injury Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures	Regulation 18 HSCA (RA) Regulations 2014 Staffing The provider did not ensure there was enough staff, with the required knowledge and experience, to keep patients and staff safe. The provider did not ensure that all staff received appropriate training, support, supervision, and appraisal in line with the provider's policy.

Regulated activity	Regulation

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints The provider did not ensure that their complaints process and accompanying processes and policies were fit for purpose or ensure all complaints were reviewed appropriately.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care The provider did not ensure that patients had access to appropriate and meaningful activities 7 days a week, on and off the ward and that this was documented. The provider did not ensure that all wards at the hospital held regular ward community meetings with the patients and they were documented.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment The provider did not ensure that the Keepmoat and Lakeside seclusion suites were fit for purpose or that they maintained the privacy and dignity of patients. The provider did not ensure that all doors in rooms used by patients had observation panels with integrated blinds/ obscuring mechanisms.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	S29 Warning Notice Failing to comply with Regulation 9, (1)(a)(b)(c)(3)(a)(b)(h)(i), Person-centred care, of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and Regulation 18, (1), Staffing, of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Section 31 HSCA Urgent procedure for suspension, variation etc. Conditions have been imposed on the providers registration in respect of the above regulated activities. We have taken this urgent action as we believe a person will or may be exposed to the risk of harm if we do not do so. The registered provider must not admit any new patients to Cheswold Park Hospital without the prior written agreement of the Care Quality Commission.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 5 (Registration) Regulations 2009 Registered manager condition Between 25 March 2022 to the 10 November 2022 and 18 April 2023 to the 13 August 2023 no person was registered to manage the regulated activities in accordance with the conditions of registration.

This section is primarily information for the provider

Enforcement actions

We served a fixed penalty notice on Cheswold Park Hospital at Cheswold Lane, Doncaster, South Yorkshire, DN5 8AR whilst providing the below regulated activities on 27th September 2023 for failing to comply with a condition of registration. A fine totalling £4,000 has been paid.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	S29 Warning Notice Failing to comply with Regulation 13, (4) (d), Safeguarding service users from abuse and improper treatment, of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.