Cheswold Park Hospital

Quality Report

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

Ratings

Overall rating for this location	**Inadequate**
Are services safe?	**Inadequate**
Are services effective?	**Requires improvement**
Are services caring?	**Requires improvement**
Are services responsive?	**Requires improvement**
Are services well-led?	**Inadequate**

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

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

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

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

Summary of findings

Overall summary

We are placing Cheswold Park Hospital in 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.

We rated Cheswold Park Hospital as inadequate because:

- When we inspected the hospital in August 2015, we found breaches of four regulations and rated it overall as 'requires improvement'. Although the hospital had made some efforts to improve services, not enough had been done to remedy the breaches and to maintain improvements in the long term. We also found new problems that the hospital needs to put right, which resulted in our lower rating of 'inadequate'.
- Staff did not monitor patients' physical health regularly and effectively and the hospital still did not have an effective system for monitoring patients' physical health. Staff had not assessed all risks to patients with long-term health conditions and those self-medicating. They had not prepared comprehensive care plans to ensure that they received the right support, care and treatment to meet their physical health needs, enable safe self-medication and keep them safe.
- Staff did not manage medicines correctly. They did not ensure that all medication was stored appropriately or securely. They did not keep records on stock acquired from other wards and so might not have been able to identify any stock discrepancies. Staff did not always ensure that patients took the medication they were given.
- Records to ensure that patients were kept safe and to manage and mitigate risks to them did not contain sufficient information or all of the relevant information. Positive behavioural support plans did not contain information to enable staff to de-escalate incidents. Environmental risk assessments did not always identify risks or contain plans to manage or reduce them. One audit of ligature anchor points (places to which patients intent on self-harm could tie something to strangle themselves) was inaccurate and some staff were unaware of ligature risks.
- Staff did not follow safety procedures. This included observation of patients, checking electrical equipment and contents of first aid boxes. The provider had undertaken work to remove fixed ligature anchor points from patient ensuite bathrooms. However, four communal bathrooms continued to have standard taps and the provider had not improved the ability for staff to see patients in their bedrooms.
- The hospital imposed a number of blanket restrictions on patients' freedom when restrictions should be based on individual risk assessments. Staff on Brook and Don Wards restricted shaving times. Some staff and patients on Don Ward told us that punitive measures were used for patients deemed not to conform to behavioural rules. Staff used physical and mechanical restraint to control and restrict a patient that was not always proportionate to the harm or risk of harm posed by the patient. This was not in line with the Mental Health Act and the code of practice.
- Staff searched all patients on return from section 17 leave (granted to patients detained for treatment).
- The provider did not ensure that areas of the hospital were clean or well maintained. Areas of the hospital were visibly unclean, with debris on floors and surfaces. Ward kitchens were worn and tired.
- The Isle Suite used for long-term segregation did not promote recovery, comfort, dignity and confidentiality, and did not meet the requirements of the Mental Health Act code of practice. The suite was not clean and contained debris and stains in all areas. There was

no cleaning schedule for the suite and there were no hand washing facilities for staff. The suite did not have any furniture except a mattress. It did not contain the patient's personal items, except for stickers on the walls and curtains and the patient was unable to make telephone calls in private. The hospital had not sought an external review of the patient's circumstances and records did not show evidence that staff had informed the local safeguarding team of the commencement of long term segregation. Documentation of some multidisciplinary reviews contained language relating to continuing seclusion; it was not clear on one record whether an approved clinician had completed the review. Records did not show input of any structured programmes of therapy and activity.

- The care and treatment records for one patient did not show how staff had assessed the patient's capacity to make decisions not applicable to their detention under the Mental Health Act. The provider's policy did not clearly explain the rights of the Lasting Power of Attorney or the scope of their role.
- Staff prescribed medications for mental disorder for some patients that did not match those stated on consent to treatment forms. This was not in accordance with the Mental Health Act and code of practice. Reviews completed by a community pharmacy identified 47 errors in relation to Mental Health Act paperwork and prescribed medicines between July and September 2016.
- Some patients raised concerns about their experience of using the service. They had concerns about the quality and variety of food provided, did not like the way that staff treated them, and were not happy with their involvement in meetings about their care and treatment. Some carers raised concerns about communication and their involvement in meetings. Over half of patients' care plans reviewed did not show evidence of patient involvement or reflect the views of patients. Twenty five percent of patient care plans contained vague and ambiguous statements. Observations showed some staff did not maintain professional boundaries with patients. Community meeting minutes for some wards showed mainly information that staff communicated to patients and not the involvement and views of patients.
- The hospital's leadership and governance structure was unclear and complex. Governance committee meeting minutes did not provide assurance that actions were completed. The provider's systems and processes did not ensure that staff carried out their responsibilities. Staff, including senior managers, did not understand the duty of candour. The records of investigations and serious incidents records did not show evidence of the duty of candour being applied. Staff investigating serious incidents did not follow the provider's policy and investigations completed did not show evidence of lessons learned. The registered person did not submit notifications to the Care Quality Commission of statutory notifiable incidents in five cases and a further two incidents were submitted with delays.
- Systems and processes were ineffective and did not ensure that the provider had oversight to ensure that staff files were up to date with the required registrations, qualifications, references, and disclosure and barring service checks to ensure they were fit and proper to carry out their roles. Staff did not receive the necessary training to meet the care certificate standards and not all staff received regular supervision and appraisal.
- The provider had not obtained the required information to meet the requirements for the fit and proper persons for the organisations directors.
- The paper-based system for patient care and treatment records was cumbersome. This meant that staff could not easily access records when needed.
- The provider had not updated some of its policies to reflect changes in the organisation.
- Team meeting minutes did not contain sufficient information to be an accurate record of meetings and the minutes for Don Ward did not promote morale and engagement of staff.
- The hospital audit programme was not fit for purpose. Staff had not completed actions including re-auditing later, not all audits had action plans and those that had did not all have timescales.
- Staff did not uphold the privacy and dignity of patients as they administered patients' medication through a hatch from clinic rooms; other patients and staff could see patients taking their medication.

However:

- The provider had reduced the number of restraint and seclusion episodes significantly since the introduction of a No Force First approach.

Summary of findings

- The hospital provided a range of psychological therapies. Dedicated trained staff ran a dialectical behavioural therapy based helpline.
- Patients participated in providing positive behavioural support training to staff.
- An occupational therapy activity timetable and a dedicated recovery college provided a range of activities and courses.
- Senior managers in the organisation were visible and accessible to patients and staff. Ward representatives attended weekly meetings to report ward performance to the senior management team.

Summary of findings

Our judgements about each of the main services

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

Summary of findings

Contents

Inadequate

Cheswold Park Hospital

Services we looked at

Forensic inpatient/secure wards

Summary of this inspection

Background to Cheswold Park Hospital

Cheswold Park Hospital is a purpose-built hospital in Doncaster. Riverside Healthcare Limited is the service provider. The hospital provides low and medium secure accommodation. It provides services for men with mental disorders and an offending background or whose mental health needs require assessment, treatment and rehabilitation within a secure environment. Patients are aged from 18. The hospital has the capacity to provide care and treatment for up to 109 patients detained under the Mental Health Act.

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

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

The hospital has a registered manager. It has three medium secure wards, five low secure wards and an autism spectrum disorder unit that consists of five beds in an annex and one long-term segregation suite.

The wards are:

- Aire 12-bed low secure mental illness assessment
- Brook 15-bed medium secure mental illness/ personality disorder
- Calder 16-bed low secure personality disorder rehabilitation
- Don 12-bed low secure personality disorder assessment
- Esk 12-bed low secure mental illness
- Foss 12-bed low secure mental illness
- Gill 12-bed medium secure learning disability and annex Wilton unit autism five bed spectrum disorder unit.
- Hebble 12-bed medium secure learning disability
- Isle suite one bed long-term segregation suite

We last inspected Cheswold Park Hospital in August 2015. At that inspection, we rated it as overall requires improvement. We rated safe as requires improvement, effective as requires improvement, caring as good, responsive as good and well-led as requires improvement.

Following that inspection, we told the provider it must take the following action to improve the forensic inpatient and secure services provided:

- The provider must ensure there is an appropriate timescale for how long it will take to remove the ligature points in the bedrooms and en suite bathrooms and improve the ability for staff to see patients in their bedrooms at night.
- The provider must ensure staff improve infection control procedures and protect patients against the spread of infections by ensuring staff are trained to carry out the cleaning in the communal areas at weekends. In addition, the provider must ensure that the toilets in the seclusion suites meet infection control standards.
- The provider must improve the administration of medication. For example, the hospital had not followed new guidance and checked patients' physical health when administering high doses of medication. Nine patients on Foss ward did not have care plans in place to instruct staff about how the patients had to administer their own medication. Following induction, the hospital did not provide updates of medication training.
- The provider must ensure all wards have sufficient numbers of qualified, competent, skilled and experienced staff deployed at all times.
- The provider must ensure all members of the multidisciplinary team share, and have access to, an accurate, complete and contemporaneous record in respect of each patient. This must include a record of the care and treatment provided to the patient and decisions taken in relation to that care and treatment.
- The provider must ensure the hospital has policies in place relating to the duty of candour and that staff are aware of their obligations.

We told the provider that it should make the following actions to improve the forensic inpatient and secure services provided:

Summary of this inspection

- The provider should ensure that the prohibited and restricted items policy reflects staff practices and the differences between low secure and medium secure wards.
- The provider should ensure the hospital has a clear written protocol to assess the patient's physical health needs following admission.
- The provider should ensure that staff complete the Mental Health Act and Mental Capacity Act training.
- The provider should make sure that all staff have the necessary supervision to enable them to carry out their role safely.
- The provider should ensure staff follow a consistent approach when completing discharge planning documentation, so that the patients' understand their pathway towards discharge.
- The provider should make sure minutes of the operational and clinical risk meetings have information about when staff will complete actions. In addition, where staff have carried out the investigation of serious incidents and made recommendations, the provider should ensure measurable action plans are in place.

We issued the provider with four requirement notices requiring it to remedy breaches of the Health and Social Care Act (Regulated Activities) Regulations 2014 relating to:

- Regulation 12 – Safe care and treatment
- Regulation 17 – Good governance
- Regulation 18- Staffing
- Regulation 20 – Duty of candour

During this inspection, we found that the provider had not dealt with some of the breaches of regulations found during our previous inspection in August 2015.

- The provider had not taken timely action to remove ligature risks from communal bathrooms or increased the ability for staff to see patients in their bedrooms at night.
- It had not improved the administration of medication, ensured that patients self-medicating had all of the required documentation or completed monitoring of patients' physical health.
- Despite the provider introducing training and a policy on the duty of candour, staff continued to lack understanding of their duty and did not follow the correct procedures.
- The provider had not ensured that policies clearly outlined the different between low and medium secure services in relation to practices.
- The provider had not ensured that all staff had the necessary clinical supervision.
- The provider had not ensured that the investigation of serious incidents made recommendations and ensured measurable action plans were in place.

However, we found that the provider taken the following actions to improve:

- The provider had replaced ligature points in patient bedrooms.
- The provider had ensured that seclusion suites were clean.
- The provider had implemented a safe staffing levels tool and had ensured that wards had the minimum staffing required.
- The provider had ensured that all patient care and treatment documents were stored on the ward. However, these were cumbersome and problematic to locate documents quickly when needed.
- The provider had ensured that staff received training in the Mental Health Act and the Mental Capacity Act. However, during this inspection we identified issues with the application of the Mental Health Act and Mental Capacity Act.
- The provider had trained staff in infection control.

Our inspection team

The team that inspected the service comprised two CQC inspection managers, five CQC inspectors, one CQC pharmacist specialist, one CQC assistant inspector and three specialist advisors. The specialist advisors had experience as a consultant psychiatrist, an occupational therapist and a mental health nurse. This inspection was led by Honor Hamshaw, Inspector, Care Quality Commission.

Summary of this inspection

Why we carried out this inspection

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

How we carried out this inspection

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

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

Before the inspection visit, we reviewed information that we held about the location, asked a range of other organisations for information and sought feedback from patients and staff at 10 focus groups.

During the inspection visit, the inspection team:

- visited all eight wards and the autism spectrum disorder unit including the Isle Suite at the hospital, looked at the quality of the ward environments and observed how staff were caring for patients
- spoke with 32 patients who were using the service and collected feedback from 20 patients using comment cards spoke with the registered manager and managing director of the hospital and five other directors
- spoke with 62 other staff members including: clinical operations manager, ward managers, deputy ward managers, doctors, nurses, student nurses, an advanced nurse practitioner, assistant practitioners, a staffing co-ordinator, forensic psychologists, a trainee forensic psychologist, a practice development nurse, two pharmacists, recovery college teachers, social worker, occupational therapists, occupational therapy assistant, support workers, senior support workers and a housekeeper
- received feedback about the service from two commissioners
- spoke with an independent mental health advocate and chaplain
- spoke with six carers and relatives
- attended and observed 13 meetings which consisted of: one catering meeting, one multi-disciplinary morning meeting, three care programme approach meetings and eight ward round meetings
- attended and observed four activity and psychological sessions
- looked at 36 care and treatment records of patients
- carried out a specific check of the medication management on all wards
- reviewed six investigation files of serious incidents
- reviewed five investigation files of complaints
- reviewed three disciplinary files
- looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the service say

During our inspection, we gained feedback from people who use the service and their carers through interviews, focus groups and comment cards. We spoke with 32 patients and received feedback on comment cards from 20 patients. Patients provided mixed feedback about their experience of using the service including the way that staff treated them.

Of the 20 comment cards received from patients, nine provided positive feedback, six provided mixed feedback, four provided negative feedback and one was neutral. The positive feedback that we received on comment cards from patients included: five comment cards commented on cleanliness of the hospital and wards and others commented on access to section 17 leave, staff

Summary of this inspection

being friendly, supportive and helpful, productive multidisciplinary team, positive about access to activities and occupational therapy. One comment card stated that patients felt listened to by staff.

The negative feedback that we received on comment cards from patients included: discharge being a prolonged process, dissatisfaction with food, patients did not feel listened to by staff. These patients felt that wards needed more staff, raised concerns that staff receive abuse from patients, told us patients were treated unfairly by staff, reported that there were no nurses on some shifts, and told us that there was an impact on leave due to low staffing. One comment card referred to the provider not spending money to maintain the hospital.

During our inspection, we spoke with 32 patients. Patients provided mixed feedback about the way that staff treated them. Some patients told us that they thought that staff were not friendly or respectful, that staff were demanding, targeted them and felt that staff stood together when concerns were raised. Other patients told us that staff treated them well, with respect, valued their privacy and were caring and committed.

Patients told us that they did not think that there was enough staff on shift. Three patients told us that would like to have male staff on shift as some aspects of their care and treatment they would prefer male staff to deliver. Nine patients that we spoke with raised concerns about the choice and quality of food provided. Two of these patients told us that all meat was suitable for a halal dietary requirement, which they did not require. These patients told us they did not have a choice.

Patients also told us that staff always searched them on return from any type of section 17 leave. Most patients that we spoke with told us that they had not been involved in the development of their care plans. Some patients told us that they felt that staff did not listen to them and rushed multi-disciplinary meetings about their care and treatment.

However, patients provided positive feedback about their experience including understanding their section 17 leave. They also told us that staff informed them regularly of their rights under the Mental Health Act and patients were aware of independent mental health advocates.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Inadequate

We rated safe as inadequate because:

- Staff did not assess, manage and monitor risks to patients effectively. Risk assessments contained insufficient information to show how staff managed and mitigated individual patient risk. Two risk assessments did not contain essential risk information. Staff did not complete risk assessments for self-medicating for three patients and one patient did not have a care plan for self- medicating. Staff did not review all patients' risk assessments regularly. This meant that staff might miss potential opportunities to reduce harm to patients and others.
- Staff did not follow procedures to keep patients safe. One clinic room contained medication, which was not stored securely. Staff obtained medication stock from other wards, however, these wards did not have any documentation to show how this was signed into the receiving ward. This meant that medication stock discrepancies may not be identifiable. Staff did not check the contents of first aid boxes regularly on three wards. A clinic room contained staff cups.
- Safety systems and processes were not fit for purpose. The provider had replaced all of the taps in patient bedrooms with anti-ligature taps. However, they had not taken all of the required actions to remove fixed ligature anchor points from all of the communal bathrooms. Four communal bathrooms on low secure wards had standard taps and a schedule had shown that two of these should have been replaced and they had not. The provider had not increased staff ability to see patients in their bedrooms. Some staff did not have sufficient knowledge about ligature risks including on the ward they worked on. The ligature audits for four wards did not contain information to show how staff managed and mitigated the risks of ligatures. One ligature audit was not accurate and listed ligature points, which the provider had removed. Environmental risk assessments did not identify risks or detail management and mitigation plans.
- The provider had not completed a risk assessment to assess the implications of having two emergency grab bags and defibrillators for the entire hospital and the movement through the secure environment. Practice and emergency drills completed did not detail whether staff achieved the one minute target according to the policy. After practice and actual medical

emergencies, records did not state which staff were responsible for actions and when they should be completed. The provider did not ensure that all electrical medical equipment used by staff and patients was safe to use.

- We observed one staff member undertaking observations of patients at a time later than the observations should have been completed. The staff member then inaccurately recorded the time they completed these observations as the time that they should have been completed and not the time that the observation was actually made. Staff provided conflicting information about the completion of safe observation of patients in their bedrooms.
- An episode of long-term segregation did not meet the requirements of the Mental Health Act and the Mental Health Act code of practice. The hospital had not sought the review of an external hospital every three months; records did not show evidence of staff informing the local safeguarding team of the commencement of long term segregation. Records of reviews showed that staff did not consider removing the patient from long-term segregation. It was not clear if one review was completed by an approved clinician.
- The facility used for long-term segregation did not meet the requirements of the Mental Health Act code of practice. The suite did not have a relaxing lounge area; there was no programme of structured activities, limited access to occupational therapy and no evidence of psychological intervention.
- The provider did not ensure that care premises were clean and well maintained. The Isle Suite was visibly unclean and covered in debris. The provider did not have a cleaning schedule in place for this area of the hospital and staff did not clean this area in response to the frequency that this was required. Other areas of the hospital were unclean with debris on surfaces and floors. The provider did not provide cleaning staff on weekends. The Isle Suite was in poor condition with no furnishings with the exception of a mattress, bedding and curtains. The mirrors and observation panels in two seclusion suites were scratched which obscured staff observation. Ward kitchens were worn and tired and some furniture required repairing or replacing due to damage.
- Staff used physical and mechanical restraint to control and restrict one patient, which was not always in response to, or proportionate to the risk of harm posed. Punitive measure were in place on some wards including access to leave being restricted, cigarette breaks being cancelled where staff perceived patients not behaving.

Summary of this inspection

- When something went wrong, staff did not always inform patients and ensure they received an apology. Staff including senior managers did not understand the responsibilities of the duty of candour. Serious incident investigations files did not contain information to show that staff involved and communicated with patients in line with this duty.
- Safety systems and processes did not ensure the safe delivery of care and treatment. Staff did not ensure the safe and proper management of medication. The provider reported a significant amount of medication errors. The provider did not ensure that staff received regular update training and assessment of competencies despite this being in their action plan as completed.
- Staff routinely searched all patients on return from section 17 leave. Two wards had set shaving times. This was not in relation to the level of security of the ward or as a proportionate response to individual patient risk.
- Staff did not follow the provider's policy when investigating serious incidents. Serious incident investigations did not contain lessons learnt. The hospital did not have a clear process to share lessons learnt with staff at all levels.
- Staff did not report incidents to the Care Quality Commission as part of their statutory responsibility.
- Positive behavioural plans did not contain individualised information to enable staff to de-escalate situations.

However:

- A response team reached the required location promptly when staff raised an alert for assistance.
- Despite the lack of individualised positive behavioural support plans, the hospital had reduced the use of restraint and seclusion significantly.
- Staff had up to date training in the mandatory training requirements set by the provider.
- Seclusion records complied with the Mental Health Act code of practice ensuring that staff knew what was required of them to review and record information.

Are services effective?

Requires improvement

We rated effective as requires improvement because:

- The hospital did not have an embedded and effective system to monitor the physical health of patients. Staff did not monitor the physical health of patients effectively including those taking high dose anti-psychotic medications. Staff had not completed

an audit after implementing new monitoring tools and guidance for physical health. The system did not enable them to identify where they had not completed physical health monitoring.

- Patients with long-term conditions did not have care plans in place with all of the information required to meet their needs. This included the monitoring of diabetes and action staff should take in response to epileptic seizures. Records showed three examples of patients with diabetes that did not receive the care and treatment required.
- For some patients, staff prescribed medications for mental disorder which were not in accordance with the consent to treatment documents in line Mental Health Act and code of practice. Reviews completed by a community pharmacy identified 47 errors in relation to Mental Health Act paperwork and prescribed medicines between July and September 2016.
- The provider's policy on the Mental Capacity Act did not explain the rights of the Lasting Power of Attorney as decision maker or the scope of their role.
- Care and treatment records for one patient did not show how staff had assessed their mental capacity to make decisions outside of their treatment under the Mental Health Act.
- Eight out of 32 patient care plans contained vague and ambiguous statements.
- The paper-based system for patient care and treatment records in place was cumbersome and this meant that staff could not easily access records when needed.
- Prescribers made errors in prescription writing and prescribers that we spoke with could not refer to best practice guidance they followed.
- The hospital audit programme was not effective, as staff had not completed actions including re-auditing later.
- Team meeting minutes did not contain sufficient information to be an accurate record of meetings.
- Training did not meet the requirement of six out of 15 of the care certificate standards.
- In a 12-month period, only 58% of non-medical clinical staff and 45% of non-medical support staff had an appraisal of their performance.

However:

- The hospital provided a range of psychological therapies and interventions recognised by guidance from the National Institute of Health and Care Excellence. Dedicated trained staff operated a dialectical behavioural therapy helpline for patients to access when needed.

Summary of this inspection

- Staff measured patient outcomes using a range of different recognised tools.
- Staff told us that they had access to additional training where this was appropriate to their role.
- Staff representatives from each ward attended a multi-disciplinary handover meeting with members of the senior management team.

Are services caring?

Requires improvement

We rated caring as requires improvement because:

- Over half of care plans across the wards did not show evidence of how patients had been involved in the development of their care plans and these plans did not contain the views or the voice of the patient. These care plans contained complex language, which would not be easy for patients to understand.
- Observations showed that some staff did not maintain professional boundaries and some staff displayed tactile behaviours and used informal names such as, “mate”, when interacting with patients. Staff did not address tactile behaviours displayed by patients towards them. This was not in line with the See Think Act guidance published by the Royal College of Psychiatrists’ Quality Network for Forensic Mental Health.
- Some patients told us that they did not feel that staff treated them with respect and felt that staff targeted them, were demanding and that staff stood by each other. They also told us that they felt meetings about their care were rushed and felt that they could not raise information in meetings.
- Carers told us that they had concerns about how staff communicated with carers. Carers felt that they did not receive information to enable them to be fully involved in meetings. One carer told us that they felt that staff placed a consequence in response to a misunderstanding.
- Some patients that we spoke with told us that sometimes there were only female staff on shift, which they felt could not provide support with some tasks and would be more comfortable with male staff.
- Community meeting minutes for some wards mainly showed information communicated from staff to patients and not the involvement and views of patients.

However:

Summary of this inspection

- Gill and Hebble wards used easy read documentation to involve patients in planning, understanding and recalling information discussed in multidisciplinary meetings that took place about their care and treatment.
- Patient representatives attended catering meetings, reducing restrictive practice meetings and took part in co-delivering positive behavioural support training to staff.
- The hospital provided leaflets to inform patients of therapies available. These provided information to patients on how they could access these therapies and this meant that patients could be more involved in decisions made about their care and treatment.
- Patients had access to advocacy services.

Are services responsive?

Requires improvement

We rated responsive as requires improvement because:

- The Isle Suite facilities did not promote recovery, comfort, dignity and confidentiality. The suite did not have any furniture or patient's personal items except for stickers on the walls and curtains. The patient could not make or receive telephone calls in private.
- Staff administered medication to patients through the clinic room door, which meant others could see patients when taking their medication and this practice did not uphold privacy.
- Nine patients that we spoke with raised concerns about the quality and choice of food provided.

However:

- The hospital had a range of rooms and facilities available and off ward areas to provide activities to promote recovery.
- Activities were available on wards, through an occupational therapy timetable and a dedicated recovery college. Activities and courses on offer promoted education, sports, recreational activity and independent living skills. The managing director of the hospital taught a session as part of one of the courses provided by the recovery college.
- A mood board was in place on Hebble ward for record their feelings for the day through use of pictorial facial expressions.
- A chaplain visited the hospital every two weeks. Local parishioners attended and led carol services at the hospital each year.

Are services well-led?

Inadequate

We rated well-led as inadequate because:

Summary of this inspection

- Governance systems did not ensure improvements were actioned and embedded into the service and delivery of care. They did not clearly define specific responsibilities.
- The provider did not have an effective system to ensure the registered person submitted statutory notifications to the Care Quality Commission without delays. Policies were unclear to staff whose responsibility this was.
- Systems did not ensure that the provider had updated staff files to ensure that staff were fit and proper people with the relevant checks and qualifications required to be employed and to continue with the role they were employed and throughout their employment. They did not ensure that staff received regular clinical supervision and appraisals.
- Four of the directors' files did not meet the requirements of fit and proper persons. The provider had not obtained the required checks on directors.
- Processes in place had not improved medicines management. Staff did not ensure they managed medicines safely and correctly. The hospital's systems and processes had not identified these issues.
- Staff did not follow the provider's policy on investigating serious incidents. Findings of investigations did not lead into lessons learned and we did not examples of how the provider shared learning with all staff.
- An ineffective system was in place, which did not ensure that staff monitored the physical health of patients. Where staff did not complete physical health monitoring, the system could not identify this.
- The provider had not updated some policies to reflect changes within the organisation.
- The audit programme was not comprehensive; staff did not repeat some audits and some audits did not have action plans with timescales.
- Team meeting minutes for Don Ward did not promote morale and engagement of staff.
- Staff did not understand the duty of candour and there was no evidence that they had demonstrated this in practice.

However:

- Staff reported that they regularly saw and could speak to senior managers.
- Staff attended a weekly meeting with the senior management team to report on ward performance.
- Staff told us they could raise their concerns without fear of reproach or victimisations.

Summary of this inspection

- The provider was in the early stages of commissioning for quality and innovation targets for reducing restrictive interventions and physical health.
- The provider had participated in research of patient experience of multi-disciplinary meetings and had plans to participate in research involving staff.

Detailed findings from this inspection

Mental Health Act responsibilities

Ninety three percent of staff had completed training in the Mental Health Act and the Mental Health Act code of practice. Staff had a variable level of understanding in the Mental Health Act. We found that some staff had detailed knowledge whereas others had limited knowledge of the Act. Staff told us that they could seek advice from the Mental Health Act office.

Despite staff awareness of blanket restrictions and informing us that the hospital did not operate any, we found staff imposed blanket restrictions on Brook and Don wards which had restricted shaving times.

Staff informed patients of their rights under section 132 of the Mental Health Act on admission and every three months afterwards. Patients' records contained current and detailed section 17 leave forms. We saw evidence that staff had assessed the capacity of a patient where they had refused a tribunal to ensure they had the capacity to make that decision.

At the time of our inspection, staff provided care and treatment to one patient in long-term segregation. At the time of our inspection, this long-term segregation had lasted several years. The records showed that the hospital had not sought a review of the patient's personal circumstances from an external hospital every three months and did not show evidence that staff had informed the local safeguarding team of the commencement of long-term segregation. Care plans did not contain information about what would be required of the patient to end the long-term segregation. Reviews by the multi-disciplinary and independent multi-disciplinary reviews mostly took place by an approved clinician and support staff who were on shift. The records of some independent and multidisciplinary reviews referred to continuing with the seclusion of the patient. On one occasion, staff led a review and it was not clear whether this staff member was an approved clinician. Reviews completed did not show consideration of removing the patient from long-term segregation as outlined within the code of practice. Staff had a planned approach to the use of physical and mechanical restraint of a patient, which was not always proportionate to the risk posed to or from this individual. The patient's care and treatment records referred to the long-term segregation continuing for a prolonged period that was not in line with the Mental Health Act code of practice.

The facilities of the Isle Suite were not in line with the code of practice. The code states that patients should have access to a relaxing lounge area. The lounge area of the Isle Suite did not contain any furniture or items apart from a pair of curtains and stickers on the wall. It had no items that the patient could use to relax except a mattress. The code of practice also states that there should be a range of activities of interest and relevance to the person and patients should not be deprived of therapeutic interventions. We reviewed care and treatment records and found that there was no programme of structured activities in place. Records showed activities were infrequent and often took place through a hatch; the patient often completed these alone or initiated these. Occupational therapy sessions took place fortnightly and consisted of preparing a food item through the hatch and there was no evidence of psychological interventions.

The hospital had a central Mental Health Act office with administrators. Staff told us that they provided advice and information to them when required about the application of the Mental Health Act and the code of practice. During our inspection, we reviewed detention documentation. We found that most care and treatment records contained valid and up to date documentation. Where any files did not contain the most up to date record, staff requested this from the Mental Health Act office and we saw that they provided this promptly to the requestor who then stored them appropriately.

Mental Health Act audits completed included audits of section 17 leave, informing section 132 rights and part four of the Mental Health Act, which is in relation to consent to treatment, and the associated requirements of this.

We looked at 36 patient records. Most of the records that we reviewed showed evidence that doctors and social workers completed assessments of capacity where appropriate. The types of assessments completed

included consent to treatment, understanding rights under the Mental Health Act, and refusing a tribunal. Records contained evidence of assessment of capacity of consent to treatment under the Mental Health Act where appropriate. We reviewed consent to treatment documentation and found in three cases; staff prescribed medicines for mental disorder, which were not included on the relevant T2 or T3 certificate. This meant patients received treatment, which was not in accordance with the Mental Health Act and the Mental Health Act code of practice.

Between July and September 2016, the provider submitted information that showed staff made 47 errors in prescribing medication and ensuring all documentation was in accordance with the Mental Health Act and the Mental Health Act code of practice.

The hospital had access to a local independent mental health advocacy service.

Mental Capacity Act and Deprivation of Liberty Safeguards

The Mental Capacity Act is legislation that maximises an individual's potential to make informed decision wherever possible. The Act and associated code of practice provide guidance and processes to follow where someone is unable to make capacitated decisions. As part of our inspection, we looked at the application of the Mental Capacity Act.

All patients admitted to low or medium secure services are detained under the Mental Health Act. This meant that the hospital did not provide care and treatment to patients under Deprivation of Liberty Safeguards. We did not inspect adherence to Deprivation of Liberty Safeguards as part of this inspection.

The provider had a policy on the Mental Capacity Act. Whilst the provider's policy referred to Lasting Power of Attorney, the policy did not explain the rights of the attorney as the decision maker within the scope of their role.

Staff had a variable understanding of the Mental Capacity Act. Most staff had detailed or working knowledge of the Act. However, six of the staff had limited understanding. These staff worked in support worker roles. We found that these staff could not explain the purpose or principles of the Act. However, staff that we spoke with told us that if they needed to seek advice about the Mental Capacity Act they could ask social workers, doctors or their managers for advice and refer to the quality management system for resources.

Most patient records contained evidence of assessments of mental capacity where appropriate. A patient's record contained information that explained that the individual was not involved in decisions about their care and treatment as staff had implemented these and explained this afterwards to the patient. Some of the care and treatment provided formed part of detention under the Mental Health Act and we saw that this record contained evidence of mental capacity assessments completed for consent to treatment and for understanding rights under the Mental Health Act. However, for other decisions made which were part of the patient's wider health, social care and recreational needs the records did not contain any evidence that staff had completed any other assessments of capacity. For example, assessment of a patient's capacity to make decisions about physical health monitoring and observations where a patient refused these. This was not in line with the Mental Capacity Act or the code of practice.

The hospital did not audit the application of the Mental Capacity Act.

Overview of ratings

Our ratings for this location are:

Detailed findings from this inspection

	Safe	Effective	Caring	Responsive	Well-led	Overall
Forensic inpatient/ secure wards	Inadequate	Requires improvement	Requires improvement	Requires improvement	Inadequate	Inadequate
Overall	Inadequate	Requires improvement	Requires improvement	Requires improvement	Inadequate	Inadequate

Inadequate

Forensic inpatient/secure wards

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

Are forensic inpatient/secure wards safe?

Inadequate

Safe and clean environment

Cheswold Park Hospital had eight low and medium secure wards which were laid out in a similar design. These wards contained a nurses' station, which had a line of sight over the lounge areas, the bedroom corridors and other spaces available on the ward. Rotas had staff allocated to complete observation of patients at assessed intervals.

The Wilton Unit was accessible from the main hospital corridor through Gill ward. This meant that patients entering the Wilton Unit entered through Gill Ward and the Wilton Unit used the clinic room on Gill Ward. This unit was a u-shape in design. This meant that there were blind spots in the ward area. However, this unit had staff presence in all areas and a high ratio of staff to patients. Staff undertook observations to mitigate the risks of blind spots. The Isle Suite was a long-term segregation suite unit, which consisted of a lounge, sleeping area, bathing area and an external secure garden area. The Isle Suite had a staff observation area. This area had windows to enable staff to observe all internal parts of the suite.

After our last inspection, we told the provider that they must take action to ensure that there were appropriate timescales to remove potential ligature anchor points in bedrooms, ensuite bathrooms and communal bathrooms and to improve the ability for staff to see patients in their bedrooms at night. The provider's action plan showed that the action to replace the taps. The tap replacement programme detailed timescales for the replacement of taps for ensuite bathrooms and communal bathrooms across eight of the wards. Since our last inspection, the provider had undertaken work to reduce and remove fixed ligature points from patient ensuite bathrooms by replacing taps with anti-ligature taps. However, the programme stated that two wards would have their communal bathroom taps replaced by the time of our inspection; but we found that these had not been removed. On Brook and Don ward, staff that we spoke with did not have a detailed understanding of ligature risks. Brook ward did not have a copy of the current ligature audit. Staff on this ward told us that the doors on the ward were not a ligature risk. However, the ligature audit had identified these as being a ligature risk.

We requested copies of ligature audits from the provider for all patient accessible areas. The provider submitted ligature audits for eight of the wards. Staff had not completed these audits in a standardised way. The audit for Aire, Brook, Calder and Foss wards contained codes to represent ligature ratings and compensatory factors rating with an aggregated risk score. There was no explanation of what the mitigation or management of risk actions were. The ligature audit for Calder ward was not accurate as it listed sink taps in patient bedrooms as a ligature risk. At the time of our inspection, the provider had replaced these with anti-ligature taps. Three of the ligature audits reviewed did not contain any action plans.

After the inspection in August 2015, we told the provider that they must improve the ability for staff to see into patient bedrooms during the night. On this inspection, the provider had not made improvements to observation in patient bedrooms. The bedroom doors had spy holes, which did not allow clear lines of sight into the bedrooms, and staff could not easily observe patients at night. There was no mention of this in the provider's action plan or patient environment action team assessment. Staff did not

know of any plans or timescales for the provider to address this. Staff had different practice when observing patients during the night, some opened the door and some used the spy hole.

Cheswold Park Hospital provides services for male patients only. The provider complies with the guidance on same-sex accommodation.

Eight wards each had a clinic room. There was a physical health suite on the main corridor. The clinic room on Gill ward was used for patients in the Isle Suite and the Wilton Unit. The hospital had supplies of emergency medicines, equipment, oxygen and a defibrillator held on Aire and Foss wards. The provider submitted a copy of their resuscitation policy. This copy contained added comments, which would usually occur when a policy was under review. The provider's resuscitation policy stated that this equipment should be available within one minute of a 'code blue' medical emergency; for example, when an individual required resuscitation. We were concerned this would not be achievable for wards that did not hold their own supply due to the constraints of moving through the secure environment. The provider had not carried out a risk assessment to assess the impact of sharing emergency medicines and equipment across the hospital site on patient safety. Staff carried out regular checks of emergency medicines and equipment to ensure they were fit and ready for use. However, bags of emergency medicines were not sealed or tamper evident. The provider's policy stated that staff would complete a simulated cardiac arrest drill every three months to assess the timings and the effectiveness of the response. We requested copies of the outcomes for the last four drills completed. It was not clear from the reports submitted by the provider whether the reports related to practice emergency scenarios or actual medical emergencies. Three out of four reports did not contain information to show whether staff met the one-minute target for emergency equipment reaching the medical emergency. Three reports identified actions following the medical emergency but these did not state who should complete the actions and by when.

The hospital had three dedicated seclusion suites named Jarrow, Lakeside and Keepmoat. These were accessible from the main hospital corridors. The seclusion suite facilities did not comply with the guidance in the Mental Health Act code of practice. The mirrors and panels to complete observation in Lakeside seclusion suite were scratched and the observation panel for Jarrow suite was also scratched. This could have obscured the clear vision of patients in seclusion. At the time of our inspection, the communication intercom for Keepmoat seclusion suite was not working. Staff had reported this for repair to the maintenance team. During our inspection, we saw that the ceiling of the Lakeside suite had a stain from a substance. The provider addressed this immediately and we saw that cleaning staff had cleaned this area in response. The natural light to Keepmoat and Lakeside seclusion suites was through skylights in the ceiling.

We observed that ward areas were not clean with debris and dust on floors and surfaces. The kitchens on Gill, Calder and Don wards had debris on worktops, sinks and floors. The de-escalation room on Brook ward had an unpleasant odour and was cold. Staff on Brook ward provided conflicting information about whether they used this room or not.

Housekeeping rotas showed that the hospital employed a cleaning team which worked Monday to Friday each week at various hours between 7am and 4pm. The hospital did not have cleaning staff that worked over weekends. This cleaning rota did not cover the Wilton Unit and the Isle Suite and the hospital had no set cleaning schedule for these areas. However, since the inspection, the provider has told us that housekeeping staff clean the Wilton unit on the same rota and schedule as Gill ward. Cleaning schedules showed staff had completed cleaning tasks. However, there was visible debris on surfaces and floors. One member of staff told us that they completed more cleaning tasks than the cleaning schedule for the ward stated as they felt the schedule was not sufficient to ensure the cleanliness of the ward area. The kitchen on Wilton unit had some aerosols in an unlocked cupboard. These items were not stored in accordance with the Control of Substances Hazardous to Health Regulations 2002.

The Isle Suite was unclean and visibly dirty. The suite had stains and residue on the floors,

walls and ceilings. The ceilings contained stains in the lounge and sleeping areas which consisted of a brown substance. Records showed that the Isle Suite areas required frequent cleaning. This included the hatches between the suite and the staff observation area. We reviewed the records for the Isle Suite and these showed between 04 January 2017 and 08 February 2017 that staff

entered the Isle Suite to complete the cleaning tasks of mopping of the floors and on one occasion sweeping the floors. Records did not show any other cleaning performed of the Isle Suite. Staff mopped the floors on some days but records showed that they did not complete this task in line with the requirements of the suite. Staff used the hatch to provide support including the provision of food and fluids; there were no records to show that staff cleaned the hatch area. This meant that food and fluids could be contaminated with bacteria. This posed an infection control risk. During our inspection, the staff observation area had a soiled towel on the floor which was placed outside of the door to the Isle Suite. There was rubbish in a bag placed on the floor, a sweeping brush and a used mop and bucket in this area.

Information submitted by the provider showed that housekeeping staff did not perform cleaning duties for the Isle Suite or the Wilton unit. However, since our inspection, the provider has told us that housekeeping staff cleaned the Wilton unit as part of Gill ward. The provider did not have a cleaning schedule for the Isle Suite. This meant that there was no information to state what cleaning tasks were required and the frequency that these should take place. The Isle Suite staff completed the cleaning for the Isle Suite. During our inspection, we raised concerns regarding the cleanliness of the Isle Suite to the provider. We also reported the cleanliness of the Isle Suite to the local safeguarding team.

Some areas of wards had worn decoration and small damage including scuffs. The kitchens of Hebble, Gill, Calder, Brook, Esk and Foss wards were to be worn and tired. Staff on some of these wards told us that the provider had plans to upgrade these kitchens. Ward furnishings were mostly adequate with a few items that were in need of replacement. For example, a sofa on one ward was torn and the base had sunken.

The Isle Suite was not well maintained. The suite was worn and in poor condition. It had staining to walls and the observation panels were scratched. Walls had stickers in various places. The Isle Suite did not contain any furniture in the lounge area; the bedroom contained only a mattress, pillow and bedding. The bathing area had only the fixed facilities of the toilet, shower and sink. The suite had two windows, which had curtains held up with duct tape in the bedroom and velcro in the lounge area. The suite had two televisions, one in the lounge area and one in the sleeping area, sunken behind a secure screen. During our inspection, we raised concerns regarding the environment of the Isle Suite to the provider. We also reported the poor environment of the Isle Suite to the local safeguarding team.

The provider submitted an audit and action plan completed after this inspection regarding the cleanliness and environment of eight of the wards. This did not include the Wilton Unit or the Isle Suite. The provider told us that the Wilton Unit was part of Gill ward and the records for Gill ward applied to this area of the hospital. This audit covered hand hygiene, environment including cleanliness and maintenance, disposal of waste, equipment and patient bedrooms. This audit identified a range of issues relating to staff training, equipment, cleanliness, infection control practice, temperature monitoring and condition of fixtures and furniture. This audit had an action plan which identified action required, who was responsible and when they should complete this by. This action plan showed that staff had recorded some remedial actions as completed and others that required a longer-term solution had timescales to reflect when these would be completed.

Most areas of the hospital had hand washing facilities and access to anti-bacterial gel. However, the Isle Suite did not contain any hand washing facilities for staff. Staff told us that they had access to anti-bacterial hand gel but would usually access a nearby ward to wash their hands with soap and water. This meant that staff would come into contact with at least two sets of doors before being able to wash their hands and would be required to use keys to open each set of doors. During our inspection, the physical health suite clinic room sink contained used and washed out staff cups. The purpose of this sink was for clinical use.

The hospital had a nebuliser that had not been tested to ensure that it was safe to use. This meant that the provider had not ensured this was safe to use by staff and patients. Staff told us that they checked electrocardiogram equipment monthly. However, there were no records to show that they had completed this. An annual device check was completed. On Gill ward, we saw that a weekly medical device check sheet was in place. However, staff had not completed entries on this for the last six months.

On some wards, staff did not check the contents of first aid boxes regularly to ensure that items were in date and

replenished when needed. On the following wards the first aid box was not checked, Hebble, Brook and Esk. However, staff on Gill ward had last checked the first aid box in December 2016 and on Don ward in January 2017.

We requested copies of environmental risk assessments for all patient accessible areas. The provider submitted the last environmental assessment, which they completed in May 2016. The head of housekeeping and infection control manager completed this. This assessed areas of the hospital with the exception of the Isle Suite and Wilton Unit on a score of 0 to 5 based on the cleanliness and maintenance of the environment. This document did not identify any environmental risks, management or mitigation of risks or any action plan for remedial actions including timescales or responsible person/s. This assessment recorded that out of the eight wards assessed that: seven required re-decoration, five wards had an unpleasant odour that required addressing, two wards required cleaning and some floor areas replacing and one ward required lights repairing. The provider submitted a document that they told us was an estate strategy. This showed a spreadsheet style planner which described estate work to be completed during the period 2016 and 2017. However, this did not detail which areas would be re-painted and which flooring would be replaced. The earliest date for that work to take place was January 2017.

Reception staff issued all staff with personal alarms and keys on their arrival into the service. Staff wore keys and personal alarms attached by a belt at all times. When staff activated an alarm this notified staff at the hospital reception the location where the alert was raised and reception staff directed a response team to the location needed using a radio system. During our inspection, we saw that staff responded promptly to a response being required.

Safe staffing

According to information submitted by the provider as of 01 October 2016, the vacancy rate for staff was less than 1% across the hospital and across all grades of staff. In the period between September to November 2016, the provider reported that bank or agency staff covered 751 shifts. The provider reported that during this time all shifts were covered.

Between 01 October 2015 and 01 October 2016, the average sickness rate was 3% and the average staff turnover rate was 25% across Cheswold Park Hospital. Staff turnover rate differed across the wards. For example, the ward with the highest staff turnover rate was Don at 60% and represented 18 staff leavers and the lowest staff turnover rate was Hebble at 4%, which represented one staff leaver.

The provider had developed a safe staffing tool which defined the number of nurses and support workers required per day across the hospital. The provider developed the tool by breaking down tasks required, how long the task took and which grade of staff was required to complete. This formed a minimum staffing level. The actual staffing level was reviewed to take into account any additional staff required such as, observations, level of escort required to support section 17 leave. The tool tracked the safe staffing minimum against the actual staffing used. We reviewed three months of recordings of the safe staffing tool and these showed that the hospital had more staff on shift than the minimum staffing tool had identified throughout.

The hospital had a workforce deployment and resource assistant who was responsible for ensuring that there was enough staff of the right grade and experience available. The hospital ran a six week rota and the resource coordinator had access to a bank of zero hours contracted staff and agency to fill shifts when needed. Where possible the hospital aimed to use regular agency staff. One member of staff told us that the wards with the most incidents, Brook and Don wards would be least likely to have agency staff working on shift, as they would allocate agency staff to other wards as a priority.

Each morning at 9am the senior management team, a ward manager or deputy manager from each ward and representatives from the multi-disciplinary team attended a meeting. We observed this meeting and saw that part of this meeting discussed staffing for the next few days. Staff discussed the numbers, skill and gender mix for wards. Staff resource was shared to support wards where needed.

Ward managers told us that they could discuss each day the staffing for their ward and if they needed additional staff. They also told us that they rarely cancelled activities and section 17 leave because of staff shortages. Staff told us that when an urgent staffing situation occurred, members of the multi-disciplinary team would go onto the wards and work within the staffing numbers. An allocated nurse was identified as a point of contact for staff to raise issues to.

Inadequate

Forensic inpatient/secure wards

During our inspection, we saw that staff were present in communal areas of the wards at all times. However, despite information from the provider about maintaining safe staffing levels, some staff and patients we spoke with raised concerns about the amount of staff on shift.

Information submitted by the provider showed that between June 2016 and February 2017 that less than one percent of section 17 leave was cancelled.

The hospital had enough staff to complete physical interventions when required. If a ward did not have sufficient staff to carry out restraint in a safe or effective way, then staff could use their alarm. Reception staff sent out a call across the radios to all wards for urgent assistance. During our inspection, we saw that staff responded quickly to attend a ward in need of assistance.

The hospital had an on call system to access doctors, the first on call was to one of the speciality doctors and a second line on call was to one of the consultant psychiatrists. This was on a rota system. Doctors told us that they stayed nearby when on call and could attend the hospital when needed. The hospital also had an on call overnight room for doctors.

Staff received mandatory training. Mandatory training consisted of hospital security, information governance, duty of candour, safeguarding adults and children, equality and diversity, conflict resolution, No Force First, Mental Health Act, hand hygiene, health and safety, and basic or immediate life support. Health and safety training covered infection control. The average completion rate for mandatory training was 91%.

Assessing and managing risk to patients and staff

Since the introduction of No Force First, the provider had reduced the use of seclusion and restraint significantly. An evaluation report provided a comparison which showed that episodes of seclusion on average reduced. In 2015, across the calendar year the average amount of episodes of seclusion was 20 episodes per month. In 2016, between January and August, this had reduced to an average of 13 episodes per month. This did not report on details of reduction in restraint. However, the provider had reported that this had reduced significantly since the introduction of No Force First.

Information submitted by the provider for the six month period between 01 May 2016 and 31 October 2016 showed that there were 82 incidents of seclusion and three episodes of long term segregation. The highest use of seclusion was on Brook with 33 episodes and Gill with 27 episodes. Two incidents of long-term segregation related to Brook ward and one episode of long-term segregation related to the Isle Suite. At the time of our inspection, there was one active episode of long-term segregation in the Isle Suite, this had commenced some time ago.

Within the same six month period, the provider reported 56 incidents of the use of restraint, of these 15 incidents were in the prone position. The wards with the highest use of restraint were Brook ward with 22 uses of restraint and Gill ward with 23 uses of restraint. The wards with the highest use of prone restraint were Brook with eight incidents and Gill with four incidents.

Staff used physical and mechanical restraint to control and restrict one patient which was not always in response to or proportionate to the risk of harm posed. Records showed that staff had a planned approach to the use of physical and mechanical restraint for one patient which was utilised routinely. The approach to restraint used for this patient was not in response to immediate risk or attempts of the patient to harm themselves or others. The use of mechanical restraint and moving of the patient were not in line with NG10 Violence and aggression: short term management in mental health, community settings guidance from the National institute for Health and Care Excellence.

The provider used the Historical, Clinical Risk Management 20 and the Functional Analysis of Care Environments risk assessment tools to assess patient risk. During our inspection, we reviewed 36 patients' records relating to the assessment and management of risk. Of the records, we found that 28 records contained a recently reviewed functional analysis of care environments risk assessment and 27 records contained a recently reviewed historical, clinical and risk management risk assessment. We found that seven records had a functional analysis of care environments risk assessment which staff had not reviewed regularly. One of these had not been reviewed for 13 months. We found that seven records contained a historical clinical risk management risk assessment which staff had not reviewed regularly. In addition, we found one record

with an out-of-date historical clinical risk management assessment from a previous provider and one further patient record which did not contain a historical clinical risk management assessment.

The content of risk assessments varied. We found that most risk assessments identified a comprehensive current and historical record of risk. However, one risk assessment did not detail information on key forensic risk history that was present in other parts of the patient record. Another risk assessment had scored risk to others as zero. However, an incident log in the record showed that there was a significant and current risk to other individuals that staff had not recorded in the risk assessment.

Records did not contain detailed or individualised risk management plans to manage and mitigate identified risks. Most records contained generic statements on risk management actions such as, review observation levels and staff should report threatening behaviour. The risk management plans did not contain information on individual triggers or actions staff should take in response to aggression, violence, self-harm or relapse. One of the records that we reviewed contained a risk management plan that only stated that the multidisciplinary team review the patient every two weeks or before if needed. One record contained a more detailed risk management plan which outlined regular room searching. However, there was no guidance for staff on how frequently this should take place. We saw that there had been two room searches completed since November 2016 and these were in response to a ward lock down and not the risk management plan.

Each ward had a rota with allocated staff to complete observations. During our inspection, on one ward we observed that one staff member completed the observation of patients on level one general observation 10 minutes in excess of the 60 minutes that was outlined in the provider's policy. We saw that the time staff completed these observations was then recorded as completed at the 60 minute interval which was incorrect and did not reflect the actual time of the observation.

In the provider's presentation to the inspection team, the registered manager stated that the hospital did not operate any blanket restrictions. During our inspection, we found that staff imposed a blanket restriction on some wards. These had set shaving times where patients could access equipment for shaving.

Staff and patients told us that staff searched all patients routinely on return from any leave. This practice did not differ across low or medium secure wards. A search consisted of patients showing items in their possession, a pat down search and a metal detector wand search. The hospital had a dedicated search suite. Patients' individual risk assessments identified potential risks. However, of the 36 risk assessments that we reviewed only one referred to searching as an action required to mitigate and manage individual patient risk. The provider's policy on searching patients and their belongings provided inconsistent information about the practice of searching and the rationale for this. Parts of the policy referred to an individualised patient risk based approach with statements about staff completing searches of patients when they had a reasonable belief that a patient was in possession of a risk item, that staff searched patients in response to individual patients' risk and that staff completed random searches. However, the policy then outlined a blanket approach to searching all patients on return from any section 17 leave. The provider last reviewed this policy in January 2017.

The provider completed an audit of the management of prohibited and restricted items in December 2016 to January 2017. This audit reviewed the practice across the wards. After our inspection the provider submitted a reducing restrictive practice log which listed blanket restrictions in place across each ward and the hospital. On Brook and Don wards, patients had set times for access to risk items including razors and Calder ward had access to phones and lockers at certain times. These restrictions did not relate to the level of security of the wards or individual patient risk. The reducing restrictive practice log was not accurate as it did not list these blanket restrictions for Don ward and Calder ward. The log of blanket restrictions for Brook ward stated that there was a restriction on free access to sharps and the rationale provided was due to the risk of deliberate self harm, potential trading and items being misplaced. This restriction was not based on individual patient risk and the log did not outline that there were set shaving times on the ward. In addition, the reducing restrictive practice log also recorded other blanket restrictions. Examples of these included the withholding of patient's mail unless the patient consented to staff supervising the patient opening and not permitting any patient to be in a relationship with another patient.

These restrictions were not based on individual patient risk. The code of practice outlines that restrictions to incoming or outgoing mail does not promote independence or recovery.

Patients that we spoke with on Don ward told us that they thought the ward had too many restrictions. They told us that they did not have access to metal knives and forks, the ward did not allow unescorted leave and patients could not make their own food. One patient told us that they thought the ward was run like a regime and staff did not allow them to bring in microwaveable food that was to their cultural preference. Two members of staff told us that patients lost access to cigarette breaks and leave if staff perceived a patient to have not behaved for example, displaying verbal behaviour. They told us that this did not appear linked to any risk factors and reinstated with no rationale or learning from this. During our inspection, we saw a poster displayed on Don ward in relation to blanket punitive measures in place.

Records showed that staff had cancelled section 17 leave on Brook ward twice because patients did not attend the morning meeting. Staff rearranged one of these. One patient told us that staff cancelled leave whenever they slept in and restricted their leave if they had not seen them before. They told us that they raised this with the hospital's managing director and they addressed this. One member of staff told us that on Don Ward, some staff prevented off ward access to the hospital shop and pond leave for patients if they were not up in time for certain meetings.

Staff told us that the provider had committed to the use of No Force First initiative. No Force First focuses on prevention and de-escalation of behaviours using positive behavioural support. Ward based staff had received No Force First training and other staff received training in breakaway techniques. Staff that we spoke with told us that they tried to use de-escalation prior to using restraint.

All patients had a positive behavioural support plan. We found that these plans contained mostly unpersonalised statements and actions such as offering one to one time with staff to discuss thoughts and feelings. It was not clear how staff would be able to effectively de-escalate situations based on the information contained within these plans. We identified that the provider needed to develop the implementation of positive behavioural support within the hospital. However, since the introduction of No Force First the amount of episodes of restraint and seclusion had decreased.

At the time of our inspection, staff provided care and treatment to one patient in long-term segregation for the previous three years. Care and treatment records showed that this did not comply with the Code of Practice since the code was introduced in April 2015. The records showed that the hospital had not sought a review of the patient's personal circumstances from an external hospital every three months and did not show evidence that the local safeguarding team had been informed of the commencement of long-term segregation. Care plans did not contain information about what would be required of the patient to end the long-term segregation and reviews by the multi-disciplinary and independent multi-disciplinary reviews mostly took place by an approved clinician and support staff who were on shift. The recording of some independent and multidisciplinary reviews referred to continuing with the seclusion of the patient. On one occasion, staff led a review and it was not clear whether they were an approved clinician. Reviews completed did not show consideration of removing the patient from long-term segregation as outlined within the Code of Practice.

The facilities of the Isle Suite were not in line with the Code of Practice. The code states that patients should have access to a relaxing lounge area. The lounge area of the Isle Suite did not contain any furniture or items apart from a pair of curtains and stickers on the wall. The suite had no items that the patient could use for relaxing in this area. The code of practice also states that there should be a range of activities of interest and relevance to the person and patients should not be deprived of therapeutic interventions. We reviewed care and treatment records and found that there was no programme of structured activities in place and records showed activities recorded were infrequent, often took place through a hatch and were often initiated and completed alone by the patient. Occupational therapy sessions took place fortnightly and consisted of preparing a food item through the hatch and there was no evidence of psychological interventions. This record also showed that a sensory integration assessment was recommended on admission and staff had not ensured that this was completed.

Staff recorded planned entries to the Isle Suite in records. These showed that room entries were infrequent and lasted for a few minutes to mainly completed tasks such as mopping or sweeping the floor. Records showed that most of the care and treatment provided was through a hatch from the staff observation area. The suite did not have an intercom system which meant that when staff and the patient communicated this was completed through the door or the hatch.

Between 01 October 2015 and 01 October 2016, the provider reported two incidents of administration of rapid tranquilisation. Rapid tranquilisation is the name for medicines administered by an injection parenterally (intramuscular or intravenously) to quickly calm a person who is very agitated or displaying aggressive behaviour. Staff told us that they rarely used rapid tranquilisation.

The provider had a seclusion booklet which contained all of the documentation required for an episode of seclusion. The booklet captured the relevant information that the Mental Health Act code of practice outlines is required for the commencement, monitoring and ending of seclusion. Staff audited the seclusion booklets after completion. Afterwards, staff stored these within patients' personal files. We reviewed seclusion records and found that these had information to show that the required staff completed timely reviews and observation logs.

Information submitted by the provider showed that the staff had completed training in safeguarding adults and children. The hospital had a dedicated safeguarding lead and a social work team. Staff we spoke with told us how they recognised potential indicators of abuse and could describe different types of abuse. Ward based staff told us that if they had concerns about alleged abuse they would discuss this with the nurse in charge and would contact the local authority safeguarding teams. On one ward, one member of staff told us that they did not have the contact details to enable them to report to the local authority. However, most staff told us that they could contact the hospital's social work team and the safeguarding lead for advice and the provider's policy on safeguarding adults contained the details of the local authority safeguarding team.

Staff told us that the social work team make contact with external agencies to ensure the appropriate safeguards are in place for visitors including children. The hospital facilitated patient visits off the ward areas in dedicated visiting rooms.

The provider did not ensure the safe and proper management and administration of medicines. Prior to our inspection, the provider submitted information that showed 738 medication incidents between April and September 2016. The provider defined these by type as:

- 487 medication administration errors
- 121 mental health act errors
- 79 prescription writing errors
- 51 patient detail errors

During our inspection, on Brook ward we observed the administration of medication. We saw that there was an occasion where staff administered medication and did not ensure that this had been taken. The hospital's registered manager told us that the hospital had too many medication errors. Following our last inspection, we told the provider that it must improve the administration of medication. At that inspection, we found that staff did not receive any ongoing training in medication administration after their initial induction training. The provider had an action plan which set out an annual medication competency assessment for staff administering medication. The action plan stated that this was fully implemented in April 2016 and all staff would have completed this by July 2016. We requested the provider to submit compliance rates for the annual nurse competency assessments completed for qualified nurses. The provider did not submit this information. Some staff that we spoke with during our inspection told us that a form had been developed but they were not aware if this was actively in use.

The hospital had a service level agreement with a community pharmacy for the supply of medicines. We checked medicines stored in the medicine refrigerators and found they were stored securely with access restricted to authorised staff. Medicines fridge temperatures were on all wards recorded daily on all wards in accordance with national guidance. Calder ward had some gaps in the recent recording of fridge temperatures. However, records on Brook and Don ward indicated fridge temperatures had been outside the recommended range and staff had not taken action to address this. This meant we could not be

sure medicines stored in this fridge were safe to use. Controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse) were stored, managed, and recorded appropriately. We saw evidence of routine balance checks of controlled drugs. However, medication refrigerators on Don and Brook wards contained energy drinks and cooler blocks.

A community pharmacy completed a weekly review of all wards including the physical healthcare suite. In addition, on Gill ward an unlocked cupboard in the clinic room contained some liquid medication. Foss and Gill wards had some medication that was not in the original box packaging. Staff told us that this medication in strips had been given from other wards. These wards did not have any documentation to show how this was signed into the receiving ward. This meant that staff may not be able to identify stock discrepancies, for example, to identify if there had been a medication error.

At our last inspection, we found there was a lack of care plans describing the level of support needed for patients who were administering their own medicines. During this inspection, we checked to see what improvements the hospital had made. The provider's action plan recorded that by May 2016, all patients self-medicating would have a care plan which detailed the level of support required. The provider had a risk assessment template for self-administration of medication. Whilst this risk assessment format had sections to identify risks of self-medicating, the document did not contain any risk management plan or space to record any actions that staff should take to minimise the risks. This meant that staff would not know of any specific support or actions necessary to reduce the risk to the patient self-medicating.

One patient did not have a care plan in place for the application of topical medication which they applied themselves. Topical medication is applied directly an area of the body. For example, a cream. Staff told us that the patient should have a care plan in place for this. We reviewed three other records of patients who administered their own medicines and found staff had not carried out risk assessments to assess the safety of self-administration or the level of individual support required. In addition, staff did not complete monitoring, supervision and reviews to ensure that patients took their medication correctly and that self-administration remained appropriate for each individual. This was not in accordance with the hospital's policy that covered self-administration, and meant we could not be sure staff supported patient adequately to manage their own medicines safely.

Track record on safety

Information submitted by the provider reported that between 15 October 2015 and 06 October 2016 there were 40 serious incidents that required investigation. Of the incidents, the provider categorised 21 serious incidents as severe harm of one or more patients, staff or members of the public. The provider categorised 19 serious incidents as never events. These were not consistent with the NHS England policy and framework 2015 criteria that defines never events.

The never events that the provider reported consisted of the following themes:

- Absence without official leave 6
- Ligature attempt 3
- Security breach 4
- Serious harm or injury 2
- Near miss 3

The provider reported that as of 21 February 2016 that there had been no patient deaths in the previous 12 months.

Reporting incidents and learning from when things go wrong

The provider had an electronic incident reporting system in place. Staff we spoke with told us they had access to the incident reporting system and could explain to us what types of incidents they had a responsibility to report.

The provider's policies on safeguarding, serious untoward incidents and duty of candour contained varying information about whom or what role was responsible for notifying the Care Quality Commission in accordance with the relevant regulations. This did not provide clarity or consistency for staff in understanding their responsibilities. During our inspection, the registered person did not know who was supposed to send in statutory notifications to us. They told us that they thought the social workers did this. Most staff we spoke with knew the hospital should notify the Care Quality Commission but they did not know who should complete and submit this.

Inadequate

Forensic inpatient/secure wards

During our inspection, we were made aware of an allegation of abuse towards a patient which the registered person had not notified us of. On the following dates we received safeguarding outcomes from local authority detailing notifiable incidents that the registered person should have reported to us without delay: 04 October 2016, 24 November 2016, 05 December2016, 08 December 2016, and 13 December 2016. At the time of our inspection, the registered person had not notified us of these incidents. On the 28 February 2017, we received two statutory notifications from the provider. These related to two incidents of allegations of abuse towards patients. These statutory notifications related to allegations of abuse relating to 03 November 2016 and 21 December 2016.

After our last inspection, we told the provider that they must ensure they had a policy and procedure in place for staff to follow regarding the duty of candour. At this inspection, we found that the provider had a policy on the duty of candour and provided mandatory training to all staff on this responsibility. Information submitted by the provider showed that almost all staff had completed this training. Most staff told us that they had a responsibility to be open, honest and transparent when something went wrong. However, staff were not clear whether they would demonstrate this with the patient involved and their families or relatives with patients' consent. For example, one member of staff told us that if something went wrong they would verbally apologise and inform the patient that they could submit a complaint. Despite staff including the registered person explaining this, they lacked understanding that this related to the duty of candour. We reviewed six serious incident files and did not see evidence of staff following the duty of candour in practice. This meant that there was no evidence that staff involved patients when investigating serious incidents, communicated with relevant people or apologised where something went wrong.

The provider had a serious incident policy which stated that the preferred and advised method for investigating serious incidents was through the completion of a root cause analysis to identify the root cause of incidents and failures in systems. During our inspection, we reviewed six serious incident investigation files. Serious incident investigation files showed that staff that had completed investigations had not followed the provider's policy completely and had not used root cause analysis. Investigation files showed that staff had documented information in a section on lessons learnt. However, this information detailed general findings of the investigation and not lessons learnt. Many investigation files did not contain information about the following: contributory factors, documented debrief for staff or patients, recommendations, action plan and none showed evidence of duty of candour with patients or their carers or relatives. It was not clear from investigations how the provider would make changes after serious incidents.

From September 2016, the provider had implemented an updated serious incident template. This contained actions from the investigation of serious incidents. This document showed that the provider did not allocated actions to an identified role or staff member. This meant that there was no individual allocated as responsible for completing an action identified. This would not provide assurance that staff would know of actions that they were responsible for completing.

The hospital did not have a robust system to cascade messages from board to ward about lessons learnt. We reviewed meeting minutes to look at how the provider communicated feedback from investigations. We found that at a senior management level, there was some evidence of themes and trends of incidents discussed but minutes detailed a lack of clarity as to the actions taken by the provider in response to incidents. We reviewed staff team meeting minutes which did not detail information about any the outcome of investigations of incidents or lessons learnt. Two wards meeting minutes referred to a monthly briefing document on lessons learnt that the quality team sent out to wards. None of the staff spoke to during the inspection told us about this method of communication about incidents. Some staff told us that they received a weekly email which updated staff on key messages that they needed to be aware of. Some staff gave us examples of changes that occurred following incidents such as, ensuring that the appropriate staff were on shift and closing office doors. Staff told us that they sometimes received information in handovers and team meetings. However, the team meeting minutes reviewed did not confirm this.

Staff told us that they received a debrief after incidents. In addition, staff from psychology and the quality team also led on debriefs with staff.

Inadequate

Forensic inpatient/secure wards

Are forensic inpatient/secure wards effective?

(for example, treatment is effective)

Requires improvement

Assessment of needs and planning of care

Staff told us that they completed a 72 hour period of assessment of patients on their admission. They said that this involved an assessment of individual risk and a physical examination. The template records for assessments on admissions showed that physical examinations included seeing a GP, physical examination, completion of electrocardiograms, blood pressure, measurements of height and weight and blood testing.

During our last inspection, we identified concerns around the physical health monitoring of patients who were prescribed high dose antipsychotics. The provider had carried out an audit of high dose antipsychotic monitoring in April 2016 and, as a result, had implemented new guidelines and a standardised monitoring chart. However, this had not been re-audited to give assurances staff were following the guidelines by carrying out the required monitoring.

We reviewed 16 records in relation to physical health assessments completed on admission. Fourteen records contained evidence of assessment on admission. Two records did not contain evidence of assessment on admission.

Staff had not completed ongoing monitoring. Six of the records that we reviewed were of patients prescribed a high dose of anti-psychotic medication. Four of these did not contain a monitoring form. In only one of the six cases did the records show that staff completed all of the required investigations and observations. Twenty one records were reviewed of patients who were not on a high dose of anti-psychotic medication. Of those only four records showed fully up to date recording of physical health checks.

The hospital did not have a system in place to identify when staff had not completed patients' physical health monitoring. This meant that patients were at risk of harm from the adverse effects of medications including high dose antipsychotics because staff did not monitor in accordance with national guidance.

The care plans and other documents did not support, remind or prompt staff to meet the specific physical health needs of patients. Some patients had long-term health conditions that included diabetes, epilepsy, a limb injury and pilonidal sinuses. Care plans in place did not always ensure that staff had the information required to complete ongoing monitoring of physical health and staff did not always take the appropriate action. For example, one person on Aire ward was taking medicines for diabetes. Their physical health care plan did not mention diabetes or state how often their blood sugar should be monitored. We saw that staff had checked blood sugar on 19 occasions between 24 December 2016 and 05 February 2017. In addition, the care plan did not state what readings were normal or should prompt a review. Staff recorded high readings on 29 occasions between 23 December 2016 and 09 January 2017 and they had not been escalated for review by the doctor. We found another instance where a patient with diabetes had no evidence of blood monitoring despite the patient's care plan stating staff should complete this twice weekly and further example where staff should have followed up diabetic input and they had not. One patient record referred to a physical injury of a limb which required physiotherapy and the patient's physical health care plan was not completed and so did not refer to this. A care plan was in place for a patient that had epilepsy and we found that this did not provide information about the action that staff should take in response to a seizure occurring. On this ward, one member of staff that we spoke with told us that they had not been aware that this patient had epilepsy until a few weeks prior to our inspection. This meant that staff had not taken all practicable steps to reduce the potential risk of harm to the health and safety of patients.

Staff completed an audit of patient care and treatment records against CG137 Epilepsies: diagnoses and management guidance issued by the National Institute for Health and Care Excellent. This showed that, out of seven patients, none of the records complied fully with the requirements of the guideline. As a result, staff had developed documentation which captured information in

line with this guidance. However, the audit did not have an associated action plan so it was not clear who had responsibility for any actions identified and what timescale the provider aimed to achieve this by.

During our inspection, we reviewed the care plans of 32 patients. We found that staff mostly reviewed patients' care plans regularly. Of the 32 records, staff had reviews 26 patients' care plans regularly, they had not reviewed five patients' care plans for at least one month or more and one record did not contain any care plans. The format for care plans enabled staff to complete an assessment to generate a bespoke selection of different care plan options. Whilst we found that patients had a range of care plans in place, the content of these varied in relation to personalisation, being holistic and recovery orientated. Eight of the 32 care plans that we reviewed contained vague statements including "reasonable time", "normal bedtime" and "support with daily living activities". The plans did not contain further information. The care plans that we reviewed did not contain the necessary information. For example, patients who self-medicated did not always have a care plan in place. One care plan that we reviewed referred to "STARCH psychological therapy", the plan did not explain what this was and why this was appropriate for the patients' care and treatment. However, we found some examples of care plans that staff had written in the first person, contained detail and recovery goals which patients were working towards.

At the time of our inspection, the hospital had a paper-based system for patients' care and treatment records. Each patient had three files that contained different parts of their care and treatment records. These were stored securely in locked cupboards. During our inspection, we found that patient files contained a large quantity of information and it took time to locate specific documentation. However, staff told us that the provider had a plan to implement an electronic patient care records system which they hoped would be easier to access information quicker in the future.

Best practice in treatment and care

Doctors at the hospital prescribed medication. Staff responsible for prescribing told us that they followed best practice guidance but we identified that they did not. However, we saw that copies of the British National Formulary were present during ward round meetings. We requested information from the provider in relation to audits in medicines management. The provider submitted information relating to the period from July 2016 to September 2016. These showed that audits completed by a community pharmacy under a service level agreement identified that staff had made 27 errors in prescription writing. We reviewed the errors identified and found that these consisted of:

- Missing information including: dates, prescriber details, signatures, dosage, brand specification, minimum frequency for as and when required medication, formulation.
- Other errors included: exceeding recommended dosages and duplication in prescribing pain relief, as and when required dose lower than the regular daily dose, time difference between different prescriptions for the same medication.

Patients could access psychological therapies that took place in either group sessions or individual sessions. The main psychological models in use were cognitive behavioural based therapies and eye movement desensitising reprocessing model. Staff delivered cognitive behavioural therapy as well as dialectical behavioural therapy and schema therapy. Staff told us that they could tailor psychological therapies to meet individual needs. Staff aimed interventions towards substance awareness, trauma, contingency, anger management, relapse preventions, offence work, psycho-education, paranoia and thinking skills.

Most patients we spoke with told us they had received or the hospital had offered access to psychological therapy during their admission. Those that received psychological therapy provided positive feedback about how they felt this was beneficial for their progress. One patient's care and treatment records did not show any input from psychology as part of their care and treatment at the hospital.

In addition to group and individual based therapies, patients had access to a dialectical behavioural therapy helpline. Staff who provided the therapy sessions worked on an on call rota to provide the service so patients could access a trained member of staff who could refer them back to using the skills patients had learned within the sessions. Staff told us that patients accessed the helpline appropriately and they felt that this was beneficial in their recovery.

Patients had access to see a GP who visited the hospital two days each week. This ran on an appointment basis. Some patients that we spoke with told us that they sometimes had to wait to see the GP as there was not always an appointment available. Staff and patients told us that they accessed dental care regularly. We saw an example of staff completing assessments of hydration needs in relation to polydipsia. Polydipsia is a medical condition that causes people to feel excessive thirst.

Staff told us that they used a range of methods to measure outcomes including: the recovery star, changes in scoring of functional assessment of care environments risk assessment, health of the nation outcome scales – secure version, pre and post psychometric testing and the model of human occupation screening tool.

The hospital had an audit programme and clinical staff took part in completion of audits. However, the audit programme was not comprehensive as we found aspects of clinical delivery, which the hospital had not effectively audited or were not included in the audit programme. The hospital had completed an audit into physical health. As a result of this, the provider had made some changes to recording and guidance documents. After their implementation, staff had not re-audited physical health monitoring. Our own review of patient records showed that there were still significant deficits in this area of practice. Staff told us that the provider should have audited 25 hours of meaningful activity in quarter three and they had not.

Skilled staff to deliver care

The multi-disciplinary team providing input to the ward included doctors, nurses, student nurses, social workers, forensic psychologists, occupational therapists, recovery college teachers, assistant practitioners, practice nurses and support workers. In addition, the hospital also had the input of a speech and language therapist one day per week, a consultant clinical psychologist and an independent nurse consultant.

Staff told us that could attend most team meetings. They said that this was dependent on the wards having adequate staffing cover. As part of our inspection we reviewed staff team meeting minutes for all wards for the six months leading up to our inspection. Each ward had monthly team meetings. Staff used varying formats to record team meetings. We found that many team meeting minutes did not contain sufficient information to reflect the staff meetings. For example, some records: were handwritten, not legible, did not record the date of the meeting, did not record who attended the meeting, did not discuss previous meeting minutes or outstanding actions, did not have an associated action plan or action owners. This meant that any staff unable to attend the meeting would not have access to the relevant information and staff could not revisit agreed actions and timescales as these were not recorded in the meeting minutes.

Training did not meet the requirements of six out of the 15 care certificate standards as staff did not receive training on: duty of care, working in a person centred way, communication, privacy and dignity, fluids and nutrition and awareness of dementia.

The provider had produced a leaflet to explain clinical supervision to staff. This explained the responsibilities of the supervisor and the supervisee. Information submitted by the provider showed that the target rate for clinical supervision was 90%. In the 12 months leading up to 30 September 2016, the average supervision rate across the hospital was 81%. The areas of the hospital that met the provider's target were: Foss and Hebble wards and psychology department. Information submitted by the provider for the same period reported that 58% of non-medical clinical staff and 45% of non-medical support staff had an appraisal in the same 12 month period.

Staff told us that where they identified training that was applicable and would be beneficial to their work that the provider would acquire and fund training. Two members of staff that we spoke with had secured paid employment throughout their nursing training through the hospital. Other staff gave us examples of additional training which, included management training and level one sensory integration training.

Each ward had staff allocated to key roles as champions. The roles were positive culture, health and safety, environment, quality, health and well-being, education, family liaison and activity.

The provider had policies in place to support, manage and address poor staff performance. During our inspection, we reviewed three disciplinary files. We found that these followed the provider's policy and the documentation was clear. We saw that the provider addressed poor performance appropriately.

Multi-disciplinary and inter-agency team work

Staff and patients attended multi-disciplinary meetings to discuss patients' care and treatment. During our inspection, we observed three care programme approach meetings and the review of eight patients during multi-disciplinary ward round meetings. We saw that different disciplines of the multi-disciplinary team attended and provided a report to update other staff and the patient of progress in care and treatment. Staff from community and commissioning teams attended care programme approach meetings. One of the medical reports was from a previous tribunal and not developed specifically for the care programme approach meeting.

Staff told us that they attended handovers for each shift changeover where staff discussed information that their colleagues needed to know for the next shift. A hospital wide multi-disciplinary meeting took place every morning at 9am. Representatives attended this from each ward, different departments within the hospital and from the senior management team. During our inspection, we attended one of these meetings. Staff at this meeting provided feedback from morning handover meetings. Items discussed included: immediate incidents that occurred on any of the wards, observations, leave, staffing across the hospital.

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

Training in the Mental Health Act and the Mental Health Act Code of Practice was a mandatory requirement for all staff. At the time of our inspection, information submitted by the provider showed that almost all staff had completed this training. Staff we spoke with displayed a variable level of understanding of the Mental Health Act. We found that this knowledge varied with some staff knowing details about different sections of the Act whereas, some staff had limited knowledge of the Act. Staff that knew what a blanket restriction was told us that the hospital did not operate any. However, we found use of blanket restrictions in relation to set shaving times on some wards. They also told us that they could seek advice from the hospital's Mental Health Act office.

The provider's policy on admission did not provide information to staff on what Mental Health Act documentation should be examined on admission and who should complete this.

Patient care and treatment records reviewed contained current section 17 leave forms. These detailed the level of leave, amount of escorts required if appropriate, the locations and durations agreed. Staff and patients told us that staff informed patients of their rights under the Mental Health Act on admission and every three months afterwards. We saw evidence that staff had assessed the capacity of a patient where they had refused a tribunal to ensure they had the capacity to make that informed decision.

The hospital had a central Mental Health Act office with administrators. Staff told us that they provided advice and information to them when required about the application of the Mental Health Act and the Code of Practice. During our inspection we reviewed detention documentation. We found that most care and treatment records contained valid and up to date documentation. Where any files did not contain the most up to date record, staff requested this from the Mental Health Act office and we saw that they provided this promptly to the requestor who then stored the documentation appropriately.

Staff told us that each month ward managers completed audits for a ward they did not have management responsibility of. Mental Health Act audits completed included audits of section 17 leave, informing section 132 rights and part four of the Mental Health Act, which is in relation to consent to treatment, and the associated requirements of this. Each week a meeting took place where ward managers met with the senior management team to discuss performance against audits completed and subsequent updates on the ward performance against these. These meeting minutes did not show how the hospital identified any learning from this. However, managers told us that staff who worked on wards identified as performing well provided support to staff on other wards to improve performance. The provider's audit schedule did not identify any other Mental Health Act audits completed.

Records contained evidence of assessment of capacity of consent to treatment under the Mental Health Act where appropriate. Where an individual is able to give capacitated consent to their medication a T2 document should be in place to explain which treatment the patient has consented to receive. Where an individual does not consent or if unable to provide capacitated consent, staff should request a second opinion appointed doctor from the Care Quality Commission to review the medication

proposed. A T3 document should be in place that outlines agreed medication. We reviewed consent to treatment documentation and found that in three cases staff prescribed medicines for mental disorder that were not included on the relevant T2 or T3 certificate. This meant that staff gave treatment which was not in accordance with the Mental Health Act and the Mental Health Act code of practice. The monthly audit completed into part four of the Mental Health Act was not effective, as it had not ensured that staff had identified and addressed issues with consent to treatment requirements. The other types of assessments completed included understanding rights under the Mental Health Act and refusing a tribunal.

Information submitted by the provider showed that audits completed by a community pharmacy between July 2016 and September 2016 identified 47 errors with medication in relation to the Mental Health Act. This was in relation to discrepancies or missing Mental Health Act paperwork including: no T2 or T3 in place, T2 in place incorrectly, T2 form that does not state all anti-psychotic medication therapy prescribed and missing capacity to consent to treatment assessment.

Patients had access to local independent mental health advocacy services. The advocacy service provided leaflets with information and easy read pictures to explain their role and what service they could provide.

Good practice in applying the Mental Capacity Act

The Mental Capacity Act is legislation which maximises an individual's potential to make decision wherever possible. The Act and associated code of practice provides guidance and processes to follow where someone is unable to make their own decisions. As part of our inspection, we looked at the application of the Mental Capacity Act.

All patients admitted to low or medium secure services are detained under the Mental Health Act. This meant that the hospital did not provide care and treatment to patients under Deprivation of Liberty Safeguards. We did not inspect adherence to Deprivation of Liberty Safeguards as part of this inspection.

Information submitted by the provider showed that 93% of staff had completed training in the Mental Capacity Act. The provider had a policy on the Mental Capacity Act. However, the policy did not explain the rights of the lasting power of attorney as the decision maker for decisions within the scope of their role.

Staff had a variable understanding of the Mental Capacity Act. Most staff had detailed or working knowledge of the Act. However, six staff had had limited understanding. We found that some staff could not explain the purpose or principles of the Act. However, staff that we spoke with told us that if they needed to seek advice about the Mental Capacity Act they could ask social workers, doctors or their managers and refer to the quality management system for resources.

Most patient records contained evidence of assessments of mental capacity where appropriate. A patients' care and treatment records contained information that explained that the individual was not involved in decisions about their care and treatment as staff had implemented their care plans and explained to them afterwards. This included care, which did not form part of their detention under the Mental Health Act such as, the wider health, social care and recreational needs of the individual. These records contained mental capacity assessments in relation to consent to treatment under the Mental Health Act and understanding rights under the Mental Health Act. The records did not contain any evidence that staff had completed any other assessments of capacity for this individual. For example, to assess mental capacity when making decision about physical health monitoring and observations. This was not in line with the Mental Capacity Act or the Code of Practice.

We reviewed the hospital's audit schedule. This did not show evidence that the staff audited adherence to the Mental Capacity Act. There were no other methods in used to monitor the application of the Act.

Are forensic inpatient/secure wards caring?

Requires improvement

Kindness, dignity, respect and support

During our inspection, we observed that some staff did not maintain professional boundaries. Patients and staff displayed tactile behaviour in their interactions. For example, staff members placed their hands on patients' shoulders and allowed patients to do the same. Some staff used informal terms such as "mate" when speaking to patients. The Care Quality Commission had received

notifications containing allegations against staff in relation to professional boundaries. This practice did not promote relational security in line with guidance for secure services in See Think Act published by the Royal College of Psychiatrists Quality Network for Forensic Mental Health.

However, we saw that most staff had a positive approach when engaging with patients and knew the patients well. Staff gave patients time when they approached them and staff knocked on patients' bedroom doors before and asked for permission before entering.

We received mixed feedback from patients across wards about how staff treated them. Some patients told us staff were not friendly or respectful. They told us that staff picked on them and they felt that staff stood by other staff to support each other rather than patients. Other feedback we received included that staff were demanding of patients and some had a bad attitude. Some patients told us that staff did not address behaviours on the wards and one patient told us that they felt that often staff were in their personal space. However, other patients provided positive feedback about staff. They told us that staff treated them well and like adults, staff were respectful and valued their privacy, staff were caring, committed and flexible and wanted to do the best for them.

Three patients told us that sometimes the wards had female only staff on shift. These patients told us that they would prefer to have a male member of staff on shift as to provide some of the support they required.

The involvement of people in the care they receive

Two patients we spoke with told us about their experience of admission. One patient told us they had received information and been shown around and another patient told us they felt they had been left on the ward with limited information about the hospital.

We reviewed the care plans of 32 patients and found there was variable involvement and participation of patients in care planning. Eighteen patients' care plans did not show evidence of how staff had involved patients in the creation and review of their care plans. Although most care plans were written in the first person, the language used did not contain the views of the patient or the patient's voice. The language used was not plain English, which meant that these would be more difficult for patients to understand. However, 12 patients' care plans showed that patients had been involved in the development of their care plans. We found that some of the care plans contained direct quotes from patients to show their views and one patient had written their own care plan. One patient's care plans contained information to explain that the patient had chosen not to be involved in the development of their care plans and another patient record did not contain any completed care plans.

Patients provided mixed feedback about their involvement and participation in risk assessments and planning of their care and treatment. Most of the patients that we spoke with told us they did not have a copy of their care plans by choice. Four patients that we spoke with told us they had a copy of their care plans. Most patients told us that they were not involved in writing their care plans, only four patients that we spoke with told us that staff involved them in writing their care plans. Two patients told us that they chose not be involved in writing their care plans. One patient told us that they had a copy of their care plan but they did not understand the information it contained. One patient told us staff did not frequently involve them in reviewing their care plan.

We received mixed feedback from patients on their experience of meetings about their care and treatment. Some patients told us that they felt that they had a say about the medication they were prescribed, felt the multidisciplinary team were approachable and could share their views. Other patients told us that they felt staff did not listen to them and rushed ward round meetings. One patient told us they felt that they could not raise information in meetings and told us that staff did not give them much notice to be ready and prepared for meetings. One patient told us they felt they did not receive minutes or outcomes from meetings about their care and treatment.

Most patients said staff invited them to take part in meetings about their care and treatment. During our inspection, we observed three care programme approach meetings and multidisciplinary reviews of eight patients at ward rounds. At one care programme approach meeting, staff asked the patient whether they would like to chair their meeting. At all meetings involving patients, we saw staff involved patients, were respectful and courteous. Staff clarified patients' understanding of discussions and decisions and gave patients the opportunity to ask any questions. Hebble and Gill wards had renamed multidisciplinary meetings as my dedicated time to encourage the involvement of patients. We saw easy read

documentation in place to enable patients to prepare information to raise in their multidisciplinary meeting, staff recorded discussions and decisions. Staff gave this document back to patients to keep and refer to after the meeting. Staff told us that this enabled patients with difficulty recalling the meeting something to refer to with staff.

The hospital provided therapy leaflets aimed at patients with brief explanations about the course and what to expect. It also provided patients with directions to speak to staff if interested. This placed more opportunity for patients to play a more active role in their recovery.

The hospital had paid job opportunities for patients. These included positions in: pond maintenance, shop assistant, laundry, library, gym assistant, coffee shop and fish tank maintenance.

Patients told us that they had regular access to advocates. Wards displayed information on local advocacy services and advocates visited the wards to promote their role to patients. Some of the patients we spoke with chose not to engage with advocates. The patients who chose to use advocacy services provided positive feedback on the availability to see or speak with advocates.

Patients with carers and/or relatives told us that they had access to regular visits off the ward using the visitors' room. One patient told us that their family were happy with their progress in recovery and another patient told us that their friends could attend their care programme approach meetings. Carers we spoke with provided mixed feedback. Two carers told us they were involved and invited to attend care programme approach meetings. One carer told us that they did not receive the reports to read prior to meetings. This meant that they could not fully be involved in the meeting, as they had not had time to read the information. Other feedback that we received included a carer felt that staff had unfairly placed a consequence in place in response to a misunderstanding, two carers had concerns about being involved and included in decisions made about care and treatment and felt that staff did not communicate effectively with them.

Patients took part in the delivery of positive behavioural support training to staff and patient representatives attended the reducing restrictive practice group meetings. Each ward held a community meeting for patients to attend. Staff told us that this meeting was an opportunity for patients to make suggestions or raise issues they had. We reviewed minutes from community meetings and found that the minutes from Gill and Hebble wards showed greater involvement of patients in discussions and actions to be completed. Community meeting minutes for other wards contained more information to show issues that staff had reminded patients of and did not contain much information about actions to be completed and by whom. Catering meetings took place monthly where patients could give feedback about food. One patient told us that they raised concerns during the catering meeting and they felt that staff had not addressed these. They also felt that the hospital had not consulted with patients about building works taking place. We observed a catering meeting and saw that a patient representative from most wards attended to raise their views on the food provided. One patient that we spoke with told us that staff had encouraged them to be involved in interviewing prospective staff. However, they had chosen not to participate in this.

We did not see the use of advance decisions in any of the records reviewed. An advance decision is a decision made by someone who has capacity to refuse future treatment when they lack capacity.

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

Requires improvement

Access and discharge

At the time of our inspection, NHS England and NHS Wales commissioned placements at the hospital. At the time of our inspection, a clinical commissioning group commissioned the care and treatment for one patient at the hospital. An admissions and contracts officer managed the contact between commissioners and clinical staff for admission. Staff planned admissions to the hospital following the hospital's admission process. This meant that staff ensured a bed was available on an appropriate ward. Information submitted by the provider showed that no patients had received care from more than one ward

during admission. Staff told us that they would not move patients during admission an episode unless there was a reason, for example, where a patient became unsettled then a seclusion episode may have been required.

Staff planned routine admissions at appropriate times. The hospital had low and medium secure wards. Transfers between wards took place in line with recovery and discharge planning so patients sometimes moved from medium to low secure wards when this was agreed and deemed appropriate with any relevant professionals and agencies. On occasions, staff transferred patients between wards for clinical risk reasons with agreement from relevant agencies.

Following the inspection, the provider told us that the average bed occupancy rate between 01 November 2015 and 30 September 2016 was 85.6%. Prior to inspection, the provider submitted occupancy data. This showed that Calder and Foss wards had a bed occupancy rate of 85% or more and the Isle Suite had 100% occupancy. The Isle Suite was a one bed individual unit.

The average length of stay of patients discharged between 01 November 2015 and 30 September 2016 was 655 days. Gill and Hebble (medium secure learning disability wards) had the highest average length of stay for discharged patients at 1199 and 1100 respectively.

Most patients had discharge plans in place or under development, which detailed their plans and some contained evidence of discussion with relatives. Multi-disciplinary team ward rounds discussed patients' stay and plans. For example, we observed staff and patient discuss potential future placement at long stay rehabilitation services. Some patients told us when they aimed to step down to low secure or long stay rehabilitation services in the future.

Independent panels reviewed the care and treatment of patients with learning disabilities or autism on behalf of NHS England and a clinical commissioning group. Care and treatment reviews are part of NHS England's commitment to transforming services for people with learning disabilities and autism. These provide independent judgements on the care and treatment provided and aims to reduce length of stay in hospitals.

Information submitted by the provider showed that the hospital had three delayed discharges in the six months leading up to our inspection. The provider reported that the reason for these delays was due to a difficulty in finding and securing alternative appropriate placements. These delayed discharges related to Hebble and Foss wards. The information submitted was not clear in identifying which ward one delayed discharge related to.

The facilities promote recovery, comfort, dignity and confidentiality

The hospital had a range of rooms to support the delivery of care and treatment. It had facilities off the ward areas and accessible to patients at set times. These included rooms for: groups, arts and crafts, education and computers, library, patient shop, canteen used twice a week to facilitate a patient café, a sports hall, a social room, a multi faith room, a music room, a gymnasium, occupational therapy kitchens, an all-weather pitch, a stocked fishing pond, animal husbandry, a physical healthcare suite and an outdoor horticulture and woodwork area. The hospital had

off-ward facilities for patients to meet with visitors. Each ward had a secure garden area. The hospital also provided some patients with paid jobs. These included positions in: pond maintenance, shop assistant, laundry, library, gym assistant, coffee shop and fish tank maintenance.

Staff did not permit patients access into the clinic rooms on the wards. Staff completed examinations in the physical health suite or in patients' bedroom. Staff administered medication to patients through the clinic room door. The top part of the clinic room door opened which created a hatch. This meant that other patients and staff in the communal areas of the ward could see patients taking their medication. During our inspection, we did not see an alternative option offered to patients, which would enable patients to have privacy when taking their medication.

Almost all patients had access to telephones in private. All wards except the Isle Suite and the Wilton Unit had a telephone room where patients could make a phone call in private. Patients on the Wilton Unit had access to a cordless phone. Some wards had ward mobiles, which patients could use in bedrooms, and some patients in the hospital had access to their own mobile phones. During our inspection, we saw that in a ward round a patient requested access to their mobile phone, the multi-disciplinary team discussed and agreed this.

The Isle Suite did not promote recovery, comfort, dignity or confidentiality because the suite did not contain any

furniture with the exception of a mattress and bedding on the floor. The curtains in the suite were held up with duct tape in the bedroom and velcro in the lounge area. The suite was not personalised and did not contain any personal belongings except for stickers and curtains. Staff were present in the staff observation area at all times including when telephone calls were made. These calls were always on loud speaker as staff did not permit the mobile phone in the suite. This meant that there was no privacy when making or receiving telephone calls.

Nine of the patients we spoke with provided negative feedback about the food. The feedback included: it was terrible, disgusting and inedible, repetitive, lack of choice and it was not hot enough. One patient told us they felt they struggled to find an option to eat if they did not like what was on the menu. One patient we spoke with told us they thought the food was okay and one other told us that they were fed well. During our inspection, we looked at the food provided and this was as described on menus.

We reviewed the hospital menus. These rotated on a four weekly cycle with a change in menu each season of the year. Lunch menus provided options of jacket potatoes, sandwiches or salad dishes with fillings. Evening menus typically provided an option between two main meals one meat and one vegetarian. Staff and patients attended a catering meeting with the hospital chef on a monthly basis. During our inspection, we saw patients gave feedback on some of the issues raised about food provided and staff gave feedback. We saw that staff agreed to escalate some of the ideas in the meeting to the senior management team.

The hospital completed a patient care environment assessment in May 2016. The assessment rated different aspects of the food provided which included: menu, choice, quality, quantity, temperature and takeaway service availability. Staff rated all of the aspects as three for acceptable with the exception of takeaway service availability which they rated as four for good. The assessment contained no further information to show how this judgement was reached, any remedial actions identified or timescales.

We saw that some wards had open kitchens accessible to patients at any time to make hot drinks. Other wards allowed patients access under staff supervision, provided flasks in other communal areas for patients to make their own hot drinks or patients access hot drinks by asking staff to make them on their behalf. The Isle Suite did not have facilities to make hot drinks or store snacks. Staff made hot drinks and snacks from the Autism Spectrum Disorder Service office and provided these.

Almost all patients' bedrooms contained personal belongings and most patients had personalised their bedrooms according to their own preferences and interests. During our inspection, we observed that a patient decorating their own bedroom. However, the Isle Suite did not contain any personal belongings and was not personalised except for stickers on the walls and curtains. Each ward had a storage room where patients could store any possessions securely. Staff supervised access to this room.

Staff provided a range of activities that included educational, recreational, independent living skills and sport based. Activities ran on a 15 week timetable. Activities provided by the hospital included ward based and off-ward activities. They ran as part of an occupational therapy timetable and a dedicated recovery college. Activities based on wards included: coffee mornings, breakfast clubs and arts and crafts. Staff told us that sometimes other activities took place but these were dependent on the ward having enough staff to provide these. Activities provided as part of the activity timetable included education, recreational, sports and independent living skills based activities such as: basic educational skills, mathematics, computers, literacy, open university, library, cooking, reading, art, table tennis, badminton, animal care, health and well-being, horticulture, budgeting skills, wood work, creative writing and furniture restoration.

At the time of our inspection, the recovery college provided courses and sessions on: garden design, marketing, choir, level two food hygiene and how to present information effectively. During our inspection, the managing director taught a session at the recovery college for a group learning skills on being prepared for employment. However, one member of staff told us that they found difficulty in meeting the needs of individuals with autism spectrum disorders through the recovery college. They thought that the principles of the courses were aimed at recovery and these patients may have difficulty in understanding the concept of mental health recovery.

Staff completed an audit of 25 hours weekly meaningful activity in April 2016. Staff that we spoke with told us that wards had reported information differently or had not

recorded this activity. This meant the findings of the audit could not be analysed accurately. The audit showed that the wards reported the following: Aire 100%, Foss 100%, Hebble 90%, Gill 80%, and Brook 75% received 25 hours meaningful activity or more per week. The remaining wards had not recorded accurate information to audit. The action plan stated staff would complete a re-audit in September 2016. Staff had not completed this re-audit. We reviewed information recorded for December 2016; this showed that 0% of patients in the Wilton Unit and Isle Suite had accessed 25 hours meaningful activity.

Meeting the needs of all people who use the service

The hospital wards were all on the ground level of the hospital. Access through the main hospital entrance was elevated from the ground level. The hospital had a lift for access if required. The hospital had access to occupational therapy to assess for any equipment or adaptations required. We saw that for one patient they had recommended that the patient use a stool in the shower.

On Hebble ward, a board contained different facial expressions. These included happy, sad and angry. Patients could place their name next to the face they felt represented how they were feeling each day. In the staff observation, area of the Isle Suite a communication board was displayed which contained different picture symbols.

The hospital had information displayed to enable patients to understand their rights, advocacy services, how to contact the Care Quality Commission and how to complain should they need this. The hospital provided leaflets for information on different psychological therapies available in brief and easy to understand formats.

The hospital had access to interpreter services through an external organisation if required and some staff spoke different languages so could facilitate discussions with patients if needed. We did not see information leaflets in different languages. However, following the inspection, the provider told us that the hospital had leaflets in different languages and easy-read format for patients and staff.

Evening meal menus provided patients with a choice of two meals and patients could choose an option from the lunch menu. Two patients told us that all meat provided was halal regardless of patients' cultural needs and this meant that one of them had chosen not to eat any of the meat provided. However, we reviewed menus which showed that a selection of meals provided contained halal meat. We also saw an invoice which identified that the provider had purchased meat from a butcher which was non-halal. This included gammon and pork. Another patient that we spoke with told us that they had requested dishes to meet their cultural preference and staff had refused this request.

Patients had access to a multi-faith room. The hospital had a chaplain from the local parish who visited on a fortnightly basis to promote engagement and one to one sessions with patients. Every three months the rector of the local parish attended the hospital to lead a holy communion service.

The chaplain ran an introduction to Christian faith group for patients to attend. Patients also attended a local community parish church. For eight years, local parishioners had attended the hospital to perform a carol service at Christmas.

The hospital had visiting facilities off the wards. Patients and visitors booked in visits in advance. Where required the hospital social work team would ensure visits were appropriate with the relevant safeguards in place if required.

Listening to and learning from concerns and complaints

Information reported by the provider showed that between 11 November 2015 and 23 October 2016 the provider had received 59 complaints. Of these, 10 complaints were upheld, 10 complaints were partially upheld, 37 complaints were not upheld and the outcome of two complaints was not reported. One complaint was referred to the ombudsman. The outcome of this was not known at the time of our inspection.

During our inspection, we reviewed five complaints investigation files. These showed that staff followed the provider's policy in investigating complaints. Staff investigated each of these complaints thoroughly. It was not clear whether or not these complaints investigations had been concluded at that time. However, three patients that we spoke with told us that they had not received an outcome of complaints that they had submitted.

Patients we spoke with were aware that they could make a complaint. We saw that wards had displayed information

for patients relating to the hospital's complaints policy and procedure. Some of the patients we spoke with had submitted complaints to the provider using the complaints procedure.

None of the staff that we spoke with told us that they received information on the outcome of complaints and the findings, or knew of any changes to practice following complaints made.

Are forensic inpatient/secure wards well-led?

Inadequate

Vision and values

The provider had organisational values based on the six c's: care, commitment, compassion, competence, communication and courage. The provider had an additional value of candour.

The provider had objectives aimed to improve culture to support their strategy. These involved:

- Agreeing a model based on the organisational values
- Using the model of care to shape recruitment, staff training and performance
- Managing director to greet new staff and outline the organisational ethos and expectations
- Consultations and surveys with staff and patients
- Developing a recovery college
- Ward based cultural champions
- Registered manager reviews of safety and effectiveness

During our inspection, we saw examples displayed of staff quotes on how they thought they displayed the organisational values in their work. Most staff we spoke with could explain some of the organisational values. However, staff including senior staff within the organisation could not explain the full responsibilities of the duty of candour.

All staff we spoke with told us that the senior management team visited the wards regularly and staff felt they could speak to senior managers if or when needed.

Good governance

After our last inspection, we told the provider to take actions to improve. The provider produced an action plan to show how they planned to address issues and improve. This action plan recorded all actions completed with one amber action. Amber represented in progress not yet completed.

However, we found during this inspection that the provider had not made improvement to ensure:

- That the provider had appropriate timescales for how long it would take to improve the ability for staff to see patients in their bedrooms at night.
- Staff practiced safe and proper management of medication including monitoring physical health of patients and ensuring patients self-medicating had the correct documentation such as, support plans and risk assessments.
- That staff knew their responsibilities under the duty of candour.

A senior management team consisted of a: managing director, chief medical officer, medical director, quality and risk director, finance director and human resources and support services director. During our inspection, it was not clear which members of the senior management team were responsible for specific duties and differences between roles. For example, the difference between the chief medical officer and the medical director.

The delivery of care was not assured by governance systems. Governance committee meeting minutes did not provide assurance that systems and processes worked effectively to address issues identified. Policies continued to refer to previous roles and systems within the organisation such as, the director of nursing and a previous incident reporting system. The provider's Mental Capacity Act policy was not in line with the Act or the Code of Practice in relation to the role of lasting power of attorneys.

Ineffective systems led to failures of reporting statutory notifiable incidents to the Care Quality Commission. Policies on serious untoward incidents, safeguarding and duty of candour did not provide staff with clear information on who was responsible for the completion and submission of statutory notifications. Staff we spoke with could not explain who was responsible for this. Senior managers did not have oversight over this. On five occasions, the registered person did not inform us of

notifiable incidents and on two further occasions, staff submitted statutory notifications with a delay. There was no system in place to identify whether or not statutory notifications had been submitted where appropriate to us.

The provider did not have oversight of staff registrations to ensure that staff were fit and proper people suitable for the role they had been appointed. The provider had not ensured that staff files and monitoring systems were up to date with the information about their professional registrations and disclosure and barring service checks. During our inspection, when requested staff produced evidence to show that staff had the required registrations and all but one staff had a valid disclosure and barring service check. However, they were not aware that these systems were not up-to-date and this meant that staff may have worked within the hospital without the required registrations and checks.

The provider failed to ensure that the requirements of the fit and proper persons were met before appointing directors. Four of the directors' files did not contain the required checks to ensure that all directors had the correct registrations, qualifications, references, assessed health and disclosure and barring service checks. They also did not contain evidence that financial including bankruptcy checks had been completed.

Systems did not ensure that staff received all of the required training, supervision and appraisal. Information submitted showed that staff received mandatory training. However, the training matrix did not meet six out of 15 standards of the care certificate. The provider did not have a cleaning schedule in place for the Isle Suite. This meant that the provider did not ensure that staff had all of the recommended skills and training. Only two wards and the psychology department met the provider's target for clinical supervision and average rate for the appraisal of non-medical staff was 52%.

The provider ensured that there was enough staff on shift to meet the minimum safe staffing levels tool in place. The provider had implemented the role of an assistant practitioner. This was aimed at streamlining some of the duties of qualified nursing staff to support the nursing teams and enable staff to maximise their time providing direct care to patients.

At our last inspection, we found issues with the safe and proper management of medicines. At this inspection, we found that the provider did not ensure that all reasonable and practicable steps were taken for the proper and safe management of medication. The provider's action plan stated that a nurse competency assessment was in place. However, when requested, the provider did not submit information to show how many staff had completed this. Staff made errors in administering medication, prescription writing, recording incorrect details and invalid Mental Health Act documentation. We found that staff did not manage medicines safely with other items stored with medication, medication stored securely and observing staff not ensuring a patient had taken their medication. The provider had not taken sufficient action to address these issues.

Schedules in place to show work to reduce and remove ligature risks did not address improving the visibility of patients in their bedrooms and the schedule inaccurately recorded the replacement of taps in some communal bathrooms, which had not been replaced. The provider did not always ensure that standardised processes in place were working effectively. Examples of where staff had not consistently followed processes included the assessment and mitigation of the risk of ligature points and the records of team meeting minutes. The quality of these differed amongst wards with ligature audits inaccurate and team meeting minutes did not containing sufficient information to reflect meetings.

After our last inspection, we told the provider that it must improve the physical health monitoring of patients. At this inspection, we found that the provider did not have an effective system to ensure that patients' physical health was assessed and monitored. Physical health was not embedded into the care and treatment of patients. Staff did not meet the physical health needs of patients with long-term health conditions. The system in place did not identify issues in monitoring physical health. We saw examples of where blood monitoring had shown high levels of blood glucose levels and this had not been escalated to doctors. There was no assurance that the system could identify where physical health monitoring had not been completed. The provider had not completed an audit after making changes to guidance and tools to monitor physical health to assess effectiveness and performance.

Despite policies in place to provide guidance on the investigation of serious incidents, staff did not follow these

entirely, did not carry out the responsibilities of the duty of candour and there was no evidence of lessons learnt that could be shared with staff. Governance systems in place did not identify these issues.

The provider had a clinical audit programme that was not effective. Aspects of service delivery were not audited or re-audited including: physical health monitoring and 25 hours of meaningful activity. Some audits completed did not have associated action plans and this meant any learning or action to be taken was not recorded, monitored and shared with staff. The provider measured ward performance against designated monthly audits completed by ward managers for wards they did not have management responsibility. Weekly meetings took place to discuss the performance of wards called Ward to Board meetings. We reviewed minutes from these meetings and saw that performance was discussed with updates provided from staff from each ward. However, not all wards were represented at these meetings each time. Staff told us that they shared positive practice where they have been able to improve ward performance with their colleagues from other wards.

Staff who worked in management roles told us that they could escalate their concerns to senior management for consideration.

Following our inspection, we asked the provider to submit a copy of the hospital's risk register. The provider submitted a risk register that had not been completed since March 2016. This risk register stated that the new risk register would be in place from November 2016. Staff told us that they could not provide a copy of the risk register as it was integrated into their incident reporting system. At the factual accuracy stage, more than four months after the site visit, the provider told us they had a fully operational risk register and provided a screen shot extract of part of this. This did not demonstrate the system's full capabilities so we were unable to fully review this.

Leadership, morale and staff engagement

The average staff absence rate was 3%. The provider reported in the 12 months leading up to 06 March 2017 that there were no reported cases of bullying and harassment. The provider had an agreement with an external support service that staff could access for a number of counselling sessions. Staff we spoke with told us that they could raise concerns without fear of victimisation. However, minutes reviewed from a team meeting for Don ward contained statements that did not promote staff morale and engagement. This was in response to staff speaking to senior managers about the management of the ward.

Most of the staff told us that they felt positive about their role and had a sense of job satisfaction. Staff told us that they had opportunities for leadership development and progressing through accessing additional training, gaining funding for employment through studying nursing and progressing into different roles within the organisation. Staff told us that teams worked together and provided support to each other when needed. For, example when other wards required staff, they were told which ward to work on which was not necessarily their usual ward.

Staff told us that they would be open and transparent when something went wrong. However, we found that staff lacked an understanding of their responsibility of the duty of candour and we could not see examples of where this been demonstrated in practice.

Staff told us that they could give feedback by speaking to managers, sharing their views in meetings and attending employee management forum meetings.

Commitment to quality improvement and innovation

The provider was a member of the Quality Network for Forensic Mental Health. The last review took place in January 2017.

At the time of our inspection, the hospital took part in Commissioning for Quality and Innovation goals in reducing restrictive practice and improving physical health. Information submitted by the provider about reducing restrictive practice showed that staff had commenced work aimed at reducing the restrictive interventions used across low and medium secure services provided. An action plan was in place and staff had started a reducing restrictive practice group. Staff at the hospital were working on a number of actions that were rated as amber and red (which represented not completed) on the action plan. The provider was in the process of collating information as part of the physical health goal for submission in March 2017.

The provider had a recovery college. This ran a range of different courses and activities that patients could access. Dedicated recovery college teachers facilitated these sessions.

Inadequate

Forensic inpatient/secure wards

The hospital had a memorandum of understanding with the International Institute of Organisational Psychological Medicine and one of the hospital's doctors was an executive board director.

The provider participated in research into patients' experience of multi-disciplinary meetings. This looked at patient experience in relation to: feeling prepared, requesting leave, level of anxiety, amount of people present, physical environment, value of the meeting, decisions and communication.

At the time of our inspection, the provider was working with external researchers to explore the relationship between staff burnout and coping mechanisms for staff working in low and medium secure mental health services.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that timescales are in place to reduce and remove ligature risks in communal bathrooms.
- The provider must ensure that they increase staff ability to see patients in their bedrooms to check patients are safe and well.
- The provider must ensure that staff understand and are aware of ligature risks in the areas that they work.
- The provider must ensure that ligature audits and risk assessments are accurate, contain risk management plans and actions plans to show how ligature risks are managed and mitigated and any actions required to enable this to be achieved.
- The provider must ensure that all staff complete the observation of patients in their bedrooms consistently and that staff understand what is required of them when undertaking observations.
- The provider must ensure that seclusion suites are maintained and that items that could obscure staff observation are repaired or replaced.
- The provider must ensure that they carry out a risk assessment and staff accurately record emergency and practice drills. These must determine the practicality of emergency medicines reaching patients within the timescales set out in the provider's policy.
- The provider must ensure that all areas of the hospital are cleaned regularly and have an effective cleaning schedule in place.
- The provider must ensure that there is provision made to enable effective hand hygiene for staff working in the Isle Suite.
- The provider must ensure that electrical equipment is tested regularly to ensure that it is safe to use.
- The provider must ensure that regular checks are undertaken to ensure that equipment in first aid boxes is replenished and is fit for use.
- The provider must ensure that all patients' care and treatment records contain a current and regularly reviewed risk assessment and a risk management plan which is sufficient to manage and mitigate patient risk.
- The provider must ensure that the policy on searching provides clarity on what staff responsibility for searching is and the rationale for this and complies with the Mental Health Act Code of Practice.
- The provider must ensure that any restrictions on patients are in relation to clinical decisions based on individual patient risk and are the least restrictive on rights and freedoms.
- The provider must ensure that medication errors are reduced and action is taken appropriately to address medication errors and ensure staff are competent in the safe management and administration of medicines.
- The provider must ensure that there are effective systems in place for the safe and proper management of medicines.
- The provider must ensure that staff carry out a risk assessment and complete a care plan for patients that self-medicate and ensure this is regularly reviewed.
- The provider must ensure that staff follow the provider's policies in relation to the investigation of serious incidents.
- The provider must ensure that statutory notifications to the Care Quality Commission are submitted without delay for the specified occurrences in the Care Quality Commission Registration Regulations 2009.
- The provider must ensure that there is clear communication to staff at all levels about lessons learnt.
- The provider must ensure that an effective system is in place where patients can raise concerns about staff and that action is taken to address concerns raised appropriately by the provider.
- The provider must ensure that staff involve patients and record their views in plans about their care and treatment.
- The provider must ensure that the Isle Suite facilities promote recovery, comfort, dignity and confidentiality of any patient receiving care and treatment in this area.
- The provider must ensure that an effective system is in place that ensures that all staff have the qualifications,

Outstanding practice and areas for improvement

competence, skills and experience required to for the work they are employed. This must ensure that staff meet the requirements of the fit and proper persons test and information is sought about staff health.
- The provider must ensure that a robust system is in place to complete the assessment and ongoing monitoring of physical health of patients.
- The provider must ensure that patients' care and treatment records contain sufficient information to enable staff to meet their physical health needs.
- The provider must ensure that long-term segregation and the care and treatment of patients in long-term segregation follows the Mental Health Act and Mental Health Act code of practice.
- The provider must ensure that the Mental Capacity Act policy is in line with the Mental Capacity Act and its code of practice.
- The provider must ensure that information in patient care and treatment records can be accessed quickly when needed.
- The provider must ensure that a comprehensive audit programme is in place and that this is completed.
- The provider must ensure that records of meetings are accurate and contain sufficient information to reflect the meeting.
- The provider must ensure that robust and effective governance systems are place to provide assurance and clear responsibility for senior managers within the organisation.
- The provider must ensure that policies are updated in line with organisational change.

Action the provider SHOULD take to improve

- The provider should ensure that items that are controlled substances potentially hazardous to health are stored securely.
- The provider should ensure that furniture and fixtures are replaced or repaired when worn or damaged.
- The provider should take steps to reduce the amount of section 17 leave cancelled or postponed due to staffing issues.
- The provider should ensure that where fridge temperatures exceed the recommended range that staff take action to escalate and address this appropriately.
- The provider should ensure that the needs of patients are taken into account in the mix of male and female staff allocated on shift.
- The provider should ensure that with patient consent that staff involve carers and provide information promptly to both patients and carers to enable their participation and involvement.
- The provider should ensure that staff uphold a patient's privacy when taking medication.
- The provider should ensure that the privacy of any patient using the Isle Suite is upheld when making or receiving telephone calls.
- The provider should ensure that the food provision is reviewed and amended to ensure patients have access to food of good quality, a variety of choice and that food on offer is appropriate to meet all cultural and religious needs.
- The provider should ensure that care plans contain clear and concise information to provide consistent care and treatment to patients.
- The provider should ensure that all staff receive an appraisal of their performance every 12 months.
- The provider should ensure that clinical facilities are used for clinical tasks only.
- The provider should ensure that staff maintain professional boundaries by not allowing inappropriate physical contact including touching between staff and patients.
- The provider must ensure that all staff understand and carry out their responsibilities of the duty of candour.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care How the regulation was not being met: More than half of care plans reviewed did not contain the patients' views or show evidence of patient involvement. Regulation 9 (c)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent How the regulation was not being met: One patient's care and treatment records did not contained evidence of assessments of Mental Capacity for decisions that did not form part of their detention under the Mental Health Act 1983. Regulation 11 (1) (3)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment How the regulation was not being met:

This section is primarily information for the provider

Requirement notices

Staff did not follow procedures in place for the safe and proper medicines management. They had also not ensured that all electrical equipment was tested and first aid boxes were regularly checked.

Staff did not follow procedures to monitor the physical health of patients. The system in use did not identify shortfalls in physical health monitoring. Care plans did not contain sufficient information regarding identified physical health needs.

Patients' risk assessments did not contain information to show how staff managed and mitigated patient risk. Patients' self-medicating did not have a risk assessment in place.

The provider had not increased the ability for staff to see patients in their bedrooms at night. Staff did not always follow the provider's observation policy.

Regulation 12 (1) (2) (a) (b) (d) (f) (g)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment How the regulation was not being met: Brook and Don wards had set shaving times and punitive practice operated on Don ward. Staff exercised control and restraint, which was not always necessary, in response to or proportionate to the risk of harm posed by the patient. Regulation 13 (1) (4) (b) (c) (d)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment

This section is primarily information for the provider

Requirement notices

How the regulation was not being met:

Surfaces across the hospital contained debris and the Isle Suite was not regularly cleaned by staff. The Isle Suite was unclean and visibly dirty with stains and residue on the floors and ceilings and brown stains on the ceilings.

The Isle Suite was in poor condition with limited furnishings. The suite did not have an intercom system. Communication between staff and patient occurred through a hatch and the door.

Regulation 15 (1) (a) (c) (e)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance How the regulation was not being met: The governance structure was unclear. The provider's systems and processes were not established or effective and did not provide assurance that actions had or had not been completed. Systems and processes did not ensure that staff files had the required relevant qualifications, disclosure and barring service checks and registrations. Staff that investigated serious incidents did not follow the provider's policy. Files did not contain evidence of lessons learned. These documented general investigation findings. Many investigations did not contain any recommendations or action plans. Regulation 17 (1) (2) (a) (f)

Regulated activity	Regulation

This section is primarily information for the provider

Requirement notices

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

Treatment of disease, disorder or injury

Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed

How the regulation was not being met:

The provider failed to obtain information that satisfied the requirements of fit and proper persons test prior to the appointment of directors.

The provider's records were not up to date and did not show current registrations.

This meant that the provider was not aware whether staff had the correct

registrations to perform their roles.

Regulation 19 (1) (a) (b) (2) (3)

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 Treatment of disease, disorder or injury	Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents How the regulation was not being met: The registered person did not notify the Care Quality Commission of six allegations of abuse in relation to patients. On two occasions, the registered person notified the Care Quality Commission with delay. The registered person did not know who was supposed to submit statutory notifications to Care Quality Commission. The provider's policies provided a lack of clarity as to who should submit statutory notifications to the Care Quality Commission.