Partnerships in Care Limited

Stockton Hall

Quality Report

Stockton Hall, The Village,
Stockton-on-the-Forest,
York.
YO32 9UN
Tel:01904 400500
Website:
www.partnershipsincare.co.uk/hospitals/Stockton-hallStockton-hall

Date of inspection visit: To Be Confirmed
Date of publication: 17/01/2018

Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
1-129389306	Stockton Hall	Boston Ward Farndale ward Kirby ward Kyme ward Hambleton ward Dalby ward Fenton ward	YO32 9UN

This report describes our judgement of the quality of care provided within this core service by Partnerships in Care Ltd. Where relevant we provide detail of each location or area of service visited.

Our judgement is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from people who use services, the public and other organisations.

Where applicable, we have reported on each core service provided by Partnerships in Care Ltd and these are brought together to inform our overall judgement of Partnerships in Care Ltd.

Summary of findings

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

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

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

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

Summary of findings

Contents

Summary of findings

Overall summary

- On the day of our inspection, there was sufficient and adequately trained and experienced staff available across all wards. The hospital had experienced difficulties with staffing particularly at weekends that affected some wards; however, this had improved across all wards over the past three months.
- Incidents of low staffing had not affected patient safety. Managers and staff planned staffing to meet patients' needs and prioritised patient safety and access to Section 17 leave. Staff who were familiar with patients' needs were present across all wards. Most patients told us there was enough staff and felt safe and most staff said there was usually enough staff to maintain safe patient care.
- Staff completed patient records that demonstrated good practice and kept them up to date. The overall compliance rate for staff training, appraisal, and supervision was high and most staff told us they were able to take regular breaks when they needed them.
- Staff vacancies at the hospital remained high but managers had an active recruitment and retention programme to make improvements in staffing.

However,

- Boston ward had experienced more staffing difficulties than others and overall reported the highest number of serious incidents, seclusion, and restraint. Although staffing had improved and patients told us they felt safe, this was the only ward where all staff told us they felt unsafe.
- A number of staff left the hospital during organisational change at the beginning of the year. All wards had qualified nurse vacancies and six of the seven wards had support worker vacancies at the time of our inspection.
- We reviewed staff rotas from April to June 2017 that showed the hospital had experienced difficulties in staffing that occurred mainly at weekends. Shortfalls were due to short notice staff absence on all occasions. Staff said that staffing had experienced "peaks and troughs" but felt it was improving.

Summary of findings

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

Are services safe?

- Each ward had an up to date environmental ligature risk assessment and staff carried out individual patient risk assessments and observations to keep patients safe. A ligature point is a place where someone intent on self-harm might tie something to strangle themselves.
- Staff completed checks of equipment, cleaning and maintenance on every ward to ensure that the environment was safe and clean. This included fire checks and drills across the hospital. Staff took action to ensure that patients were not placed at risk when equipment or rooms were not safe. We saw that one ward had closed their seclusion room until maintenance staff completed repairs.
- Senior managers and staff regularly planned, implemented, and reviewed staffing levels and skill mix across the hospital so that patients received safe care. On the day of our inspection, we saw that staffing and skill mix of staff on duty compared with the planned levels. Staff told us that staffing was good. We observed there were sufficient numbers of adequately trained and experienced staff to support patients' needs such as observation levels and access to Section 17 leave. There was always enough adequately trained staff available across the hospital to respond in an emergency, including medical cover. A senior qualified nurse was always on site at evenings and weekends and was the point of contact for any staffing issues. Staff used an effective manager on call system to raise issues. Staff on five of the six wards told us they felt safe and 11 patients said they felt safe on the ward.
- All new staff received a period of induction and training and completed competencies to ensure they were adequately skilled. The hospital employed and trained their own bank staff who were familiar to wards. The use of agency staff was very low with only one qualified agency nurse who worked on one ward.
- All staff received mandatory training that helped to keep patients safe such as safeguarding adults and children, basic and immediate life support, conflict resolution and management of violence and aggression. The compliance rates across the hospital for mandatory training, supervision, and appraisal were overall high.

Summary of findings

- We reviewed incidents of seclusion, restraint and serious incidents across the hospital. The hospital rarely used prone restraint. We found that Boston ward was one of the highest reporters of seclusion restraint and serious incidents across the hospital. Dalby ward had the lowest incidents of seclusion, restraint and serious incidents across the hospital.
- Staff assessed and manged risks on a daily basis to keep patients safe. We reviewed 28 patient records and found that all had individual, comprehensive, and up to date risk assessments and management plans. This included plans for patients in seclusion. Staff received a daily handover when their shifts changed and staff we spoke with were knowledgeable about individual patients' needs and risks.
- The hospital had robust safety and security processes that are required for a safe medium secure hospital environment. Staff took action to help patients and staff feel safe. Staff reported incidents and held de-briefs sessions to reflect on and learn from incidents. There was good governance arrangements in place that meant managers shared information about incidents and lessons learned across the hospital.
- All wards had vacancies for qualified nurses and support workers. Senior managers identified the risks associated with staffing difficulties as high on the hospital risk register. Managers had an active recruitment and retention plan and staffing across all wards had improved over the past three months.

However

- A number of staff left the hospital during organisational change at the beginning of the year. All wards had qualified nurse vacancies and six of the seven wards had support worker vacancies at the time of our inspection. Senior managers identified the risk of failure to maintain appropriate staff numbers and skill mix due to recruitment difficulties as high on the hospital risk register. To mitigate the risk, the hospital had an ongoing recruitment and retention plan and staffing levels had improved over the past three months.
- We reviewed staff rotas from April to June 2017 that showed the hospital had experienced difficulties in staffing that occurred mainly at weekends. The rotas for September to November 2017, showed staffing difficulties remained mostly at weekends

Summary of findings

but the number of shifts not filled was low across all wards. Shortfalls were due to short notice staff absence on all occasions. Staff said that staffing had experienced “peaks and troughs” but felt it was improving.

- On Boston ward all staff told us they felt unsafe due to inadequate staffing. This was the only ward across the hospital where staff told us they felt unsafe.

Are services effective?
At the last comprehensive inspection in February 2016, we found areas of good practice. Since that inspection, we have received no information that would cause us to re-inspect this key question.

Are services caring?
At the last comprehensive inspection in February 2016, we found areas of good practice. Since that inspection, we have received no information that would cause us to re-inspect this key question.

Are services responsive to people's needs?
At the last comprehensive inspection in February 2016, we found areas of good practice. Since that inspection, we have received no information that would cause us to re-inspect this key question.

Are services well-led?
At the last comprehensive inspection in February 2016, we found areas of good practice. Since that inspection, we have received no information that would cause us to re-inspect this key question.

Summary of findings

Information about the service

Stockton Hall is a 112-bed medium secure hospital for people over the age of 18 with mental health problems, personality disorders, and learning disabilities. The hospital admits patients from the United Kingdom. All patients are detained under the Mental Health Act.

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

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

• diagnostic and screening procedures

• treatment of disease, disorder or injury.

The hospital is part of Partnerships in Care Limited and in November 2016, it merged with The Priory group. Both Partnerships in care Limited and The Priory group is also part of the Acadia Healthcare organisation.

The hospital has a registered manager and a controlled drug accountable officer. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered persons have legal responsibility for meeting the requirements of the Health and Social Care Act 2008 and associated regulations about how the service is run. An accountable officer is a senior person within the organisation with the responsibility of monitoring the management of controlled drugs to prevent mishandling or misuse as required by law.

Patient accommodation comprised:

- Boston Ward – 24-bed ward for men with mental illness.
- Kirby Ward – 24-bed ward for men with mental illness.
- Hambleton Ward – Eight-bed ward for older men with mental illness.
- Dalby Ward – 16-bed ward for men with mental illness and personality disorder.
- Farndale Ward – 16-bed ward for women with mental illness and personality disorder.
- Kyme Ward – 16-bed ward for men with learning disability.
- Fenton Ward – eight-bed ward for men with autism spectrum disorders and associated behaviours that challenge.

There have been six inspections carried out at Stockton Hall. The most recent inspection took place in November 2016. This was a focused and unannounced inspection to find out whether the hospital had made the required improvements since our comprehensive inspection in February 2016. At the comprehensive inspection in February 2016, we found the hospital did not meet Regulation 13 of the Health and Social Care Act (Regulated Activities) Regulations 2014 Safeguarding. This was because not all wards carried out reviews of seclusion according to the hospital policy and the Mental Health Act Code of Practice, or provided pillows for patients to use in seclusion, or document why they did not provide a pillow. Following our unannounced, focused inspection in November 2016, we found that the hospital had made the required improvements and the hospital was rated as good overall.

A Mental Health Act Review visit took place on all wards in the past two years;

- Kirby ward in January 2016 issues found: patient records were incomplete and there were no reviews following Section 17 leave. Review dates for revisiting patient rights was past three months and recording patients understanding or response was limited. Staff understanding of seclusion was limited and they did not understand why a patient was in seclusion.
- Boston Ward in July 2016 issues found: patients were not treated with dignity and respect and they were not involved in their care plans
- Kyme Ward in July 2016 issues found: staff shortages at weekends, patients were bored and a lack of activities at weekends.
- Farndale Ward in October 2016 issues found: patients had a lack of dignity and were not treated with respect, patients saying they were bored due to a lack

Summary of findings

of activities and they felt unsafe on the ward. Some restrictive practices were identified. The Mental Health Act Reviewer issued a letter to request the hospital provide further assurances.

- Dalby Ward in February 2017 issues found: restrictive practices, patients had a lack of dignity and respect and availability of staffing.
- Hambleton Ward in February 2016 August 2017 issues found: blanket restrictions with set bed times and set smoking times. Missing Section 17 leave form, no patients had an Independent Mental Health Advocate (IMHA) and patients were not aware of what an IMHA was. Evidence of legal detention on the ward missing.

Our inspection team

The team that inspected the service comprised three CQC inspectors one of who had a background in forensic services.

Why we carried out this inspection

Since our last focused inspection in November 2016, we received information of concern about low staffing levels across the hospital and the impact this may have on safety for patients and staff. As part of our regular engagement activity with the hospital, we carried out a planned visit to Stockton Hall in August 2017 and spoke with 20 patients from across the hospital. We asked commissioners and other stakeholders for their feedback and senior managers provided supporting information about how the hospital maintained safe staffing levels. This included information about staffing rotas, incidents, and staff training. The feedback we received from the patients and stakeholders was mostly positive. Most patients said they felt safe on the wards and stakeholders did not have concerns about patients' safety. The hospital provided timely information about how managers maintained safe staffing levels and patient safety across the hospital.

In November 2017, we received further information of concern for Boston ward about low staffing, lack of adequately trained staff over the weekend and the impact on patient and staff safety. In response, we carried out this unannounced focused inspection during the weekend and across all wards to look at the safe domain, specifically the staffing on the wards. Following the inspection, we asked the hospital to provide further supporting information.

How we carried out this inspection

To fully understand the experience of people who use services, we always ask the following questions:

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

Before this inspection, we reviewed information we held about Stockton Hall and spoke with local commissioners and other stakeholders. We carried out regular meetings with the senior managers and spoke with patients and staff from across the hospital as part of our ongoing engagement.

During the inspection visit, the inspection team:

- visited all seven wards at the hospital, looked at the quality of the ward environment and observed how staff were caring for patients;
- spoke with 12 patients who were using the service
- spoke with the Director of Nursing for the hospital
- spoke with 17other staff members; including qualified nurses and health care support workers

Summary of findings

- looked at 28 care and treatment records of patients
- looked at a range of documents relating to the running of the service.

What people who use the provider's services say

We spoke with 12 patients from five wards during our visit. Patients commented that most staff were caring and respectful and that there was enough staff available when they needed them. They told us they were able to access their Section 17 leave when required. Patients said that sometimes staff re-arranged their Section 17 leave because of other priorities but staff rarely cancelled planned leaves and activities. Patients who are detained for treatment under the Mental Health Act are only legally allowed to leave the hospital under the terms of Section 17. Most patients liked the more relaxed atmosphere of their wards at weekends and 11 patients told us they felt safe on the ward. Some patients expressed concern about recent changes at the hospital and staff leaving. Patients were also concerned about how proposals to develop the hospital building might affect their current access to facilities such as the therapy centre and hospital shop. The swimming pool is currently unavailable to patients.

Areas for improvement

Action the provider SHOULD take to improve

- The service should ensure that all required staff are compliant with their mandatory training for management of violence and aggression.
- The service should ensure that all staff can access the electronic system for reporting incidents
- The service should review and address staff concerns about their safety.
- The service should ensure that patients and staff are involved in decisions about the service and that managers consider their concerns.
- The service should ensure their recruitment and retention plan is implemented fully so that the number of vacancies can be reduced.

Partnerships in Care Limited

Stockton Hall

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Boston ward Kirby ward Hambleton ward Dalby ward Farndale ward Kyme ward Fenton ward	Stockton Hall

Mental Health Act responsibilities

This was a focused inspection looking primarily at the staffing levels at the hospital so we did not look at their Mental Health Act responsibilities.

Mental Capacity Act and Deprivation of Liberty Safeguards

This was a focused inspection looking primarily at the staffing levels at the hospital so we did not look at their Mental Capacity Act and Deprivation of Liberty Safeguard responsibilities.

Are services safe?

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

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

Our findings

Safe and clean environment

There were good arrangements to keep people safe in their environment. The audit lead and ward managers completed environmental audits together and senior staff agreed action plans at the hospital clinical governance meetings. This included how each ward mitigated the risk from ligature points. (A ligature point is a place where people might tie something to strangle themselves). Ward staff carried out individual patient risk assessments and carried out environmental and individual patient observations to mitigate the risks and keep people safe.

All wards met the guidance on same sex accommodation because all wards accommodated only male or female patients.

Ward staff accessed fully equipped clinical rooms with equipment that they checked regularly to ensure it was safe to use. This included defibrillators and electrocardiograph machines that external staff checked and calibrated to ensure equipment was in good working order.

Staff carried out regular checks that ensured wards were secure and completed records that demonstrated that staff kept wards clean and well maintained. This included checks on seclusion rooms to ensure seclusion rooms were safe to use. We observed that staff closed one seclusion room whilst waiting for maintenance repairs.

There were robust arrangements for fire safety across the hospital to keep people safe. When patients were secluded, staff completed personal evacuation plans to ensure patients in seclusion were safe in the event of a fire. The compliance rate for fire training was high across all wards and all wards had completed fire drills in the past 12 months. The hospital always had an identified fire lead on duty and worked closely with the local fire department who visited and provided advice on local practice.

We observed that all staff carried personal alarms and radios and all wards had rooms with nurse call systems to call staff in an emergency. Staff checked all alarm systems on a regular basis to ensure they were safe to use.

Safe staffing

The whole time equivalent establishment levels and vacancies for each ward were;

Boston ward - 11 qualified nurses, with five vacancies (45%)

21 nursing assistants with no vacancies

Dalby ward - 13 qualified nurses with five vacancies (38%)

13 nursing assistants with three vacancies (23%)

Farndale ward - 11 qualified nurses with five vacancies (45%)

18 health care assistants with one vacancy (5%)

Fenton ward – six qualified nurses with five vacancies (83%)

10 health care assistants with one vacancy (10%)

Hambleton ward – six qualified nurses with two vacancies (25%)

15 health care assistants with two vacancies (13%)

Kirby ward - 11 qualified nurses with five vacancies (45%)

21 health care assistants with two vacancies. (9%)

Kyme ward - 9 qualified nurses with five vacancies (55%)

18 health care assistants with two vacancies (11%)

The overall sickness rate across the hospital from April 2017-November 2017 was low with sickness rates ranging from 0.03%-0.13%

Over the past eight months, the staff turnover rate was 25%

All seven wards had vacancies for qualified nurses and six of the seven wards had vacancies for support workers. The hospital had a total of 32 qualified nurse vacancies and 11 support worker vacancies.

We spoke with 12 patients across the hospital and 11 told us they felt safe and there was enough staff available when they needed them. When we spoke with staff, most did not have concerns about safety of patients or staff. However, staff on Boston ward told us they felt unsafe. They felt the ward was often understaffed with insufficient, adequately trained, and experienced staff available to provide safe patient care.

Are services safe?

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

However, on the day of our inspection, we saw there was sufficient experienced staff on duty and staff were always present in communal areas on all wards. When we reviewed the rotas, we saw evidence that most staffing shortfalls occurred at weekends. From March to June 2017, four wards experienced staffing shortfalls that occurred mostly at weekends. Boston had the highest number of shortfalls and 18 of the 34 shifts occurred at weekends. From September to November 2017, staffing had significantly improved for all wards although most shortfalls still occurred at weekends. Boston and Kirby ward had four shifts where the ward was one member of staff below the agreed establishment. This was the highest number of shortfalls across all seven wards. However, there was always at least one qualified and experienced nurse on duty on each ward and all shortfalls were due to short notice absence. Staff told us they received appraisals and opportunity for training and supervision. We saw evidence that supervision and appraisal levels ranged between 75% and 100% across the wards.Compliance across all wards for mandatory training, supervision, and appraisal was over 80%. This meant that there were enough adequately trained staff on duty who received the support they needed to carry out their roles.

Senior managers had agreed the establishment levels and skill mix of nurses and support workers for every ward. The hospital employed and trained bank staff and used only one agency staff member. Managers allocated bank and agency staff to specific wards that meant bank and agency staff were very familiar with the ward and patients' care needs. In addition, all staff worked flexibly and moved to other wards or worked additional hours to fill gaps in staffing and cover staff breaks.

Ward staff worked a combination of shifts. The morning shift commenced at 7.30am and the night shift commenced at 7.30pm. Within those hours, some staff worked long days until 7.30pm, day shift from 9.00am - 5.00pm and twilight shifts from 11.00am until 11.00pm. Each ward had a charge nurse who worked shifts and a ward manager who worked weekdays. In addition to ward staff, senior managers, and members of the multi-disciplinary team such as medical and therapy staff worked during the week. However, these staff did not generally work shifts at weekends and evenings which meant there was less staff available across the hospital during these times.

When staff required additional support or advice "out of hours", they escalated through an effective senior manager on call system. On the day of our inspection, we saw the "bronze" manager on site. The "silver" manager who was on call attended the hospital to support staff during our inspection. We saw there was adequate medical cover, with a doctor available and present on one ward to conduct a seclusion review.

Senior managers and ward staff worked proactively to plan safe staffing levels across the hospital on a daily basis. Every weekday morning managers held a joint meeting where ward and senior managers discussed staff cover. We reviewed the last meeting minutes that discussed issues relating to sickness and planned ahead to fill predicted gaps in staffing.

Ward staff planned and adjusted rosters that took patient care needs into account as well as staff training and planned absences. We saw that staff planned patient needs into ward diaries and the planned rota reflected adequate staff to support those needs. Ward staff held regular meetings with patients to discuss and plan adequate staffing to support Section 17 leaves, activities, and appointments outside the hospital. This meant that there should be enough staff available to support these sessions in addition to patient observations, individual sessions, and planned meetings. Patients told us that staff never cancelled their Section 17 leave but sometimes re-arranged it if staff were busy. Patients said there was always someone available for them to talk to if needed. During our inspection, we saw a number of patients access activities, ad-hoc and Section 17 leave and visits. We saw staff carried out specific tasks such physical health observations in addition to carrying out individual observations and interacting with patients.

Staff received mandatory training and the overall compliance rate across the hospital was high. This included basic and immediate life support, safeguarding adults and children and fire safety. The exception was management of violence and aggression training. This was because when Stockton Hall merged with the Priory group the training requirements changed which meant all staff had to update. In order to improve compliance, the hospital had commenced a "train the trainer" initiative and provided additional training slots for staff training. All staff received conflict resolution training at induction. These staff could not carry out restraint with patients but the rotas for each

ward identified key staff that could. Each ward allocated one member of staff to the emergency response team .Response staff received management of violence and aggression training that meant there was always enough adequately trained staff on duty to respond in an emergency. We saw that all rotas identified response staff and all staff carried personal alarms and radios that they checked on a regular basis.

Assessing and managing risk to patients and staff

We reviewed the number of incidents of seclusion in the past six months between June -November 2017.

All wards except Hambleton ward had seclusion facilities. Boston, Kirby and Farndale wards had two seclusion rooms and Dalby, Fenton and Kyme ward had one seclusion room. At the time of our inspection, three patients were in seclusion. All three patients were from Boston ward but two patients were secluded on Kirby ward .This was because one seclusion room on Boston ward was not safe and was awaiting maintenance repairs. Staff prepared for one patient's re-integration back to Boston ward. We saw that there was sufficient staff to observe patients safely in seclusion and that nursing and medical reviews occurred in accordance with the Mental Health Act Code of Practice.

Overall, there were 141 incidents of seclusion. Boston ward used seclusion on 41 occasions and was the highest across the hospital. Dalby ward reported the lowest use of seclusion with three episodes of seclusion. Farndale ward reported 39 episodes of seclusion, which was also one of the highest across the hospital. Farndale ward had increased the seclusion facility from one room to two. This was because the ward had experienced a period when up to five patients required seclusion at the same time. This meant that staff secluded patients in their bedrooms or quiet rooms. These environments did not meet the recommendations of the Mental Health Act Code of Practice. In response, the hospital refurbished the seclusion facilities on Farndale and provided a seclusion suite suitable to accommodate two patients in an improved environment. Because of the level of seclusions used, the concerns raised about the suitability of the facilities used and quality of the records kept the Commission held a management review meeting. This meeting specifically looked at the issues raised around the use of seclusion and the outcome was that a mental health act reviewer would carry out a separate review on the use of seclusion. Staff told us they had felt unsafe at times but the situation had now improved over the past few weeks. This was because patients who required an alternative placement had been transferred. However, staff remained concerned about their safety should a similar situation occur again. This was because staff felt that the stools they used to sit on whilst they observed patients in seclusion could be used as weapons by patients or patients might push staff off the stools. We saw that the management had carried out risk assessments on the use of the stools when they were provided.

Hambleton ward reported four episodes of seclusion and staff secluded patients on other wards on these four occasions.

Fenton ward was the only ward that reported four incidents of long-term segregation that involved one patient.

We reviewed the number of incidents of restraint in past six months between June - November 2017. Overall, there were 222 episodes of restraint. This is a reduction in figures that from the last inspection, which, showed 340 incidents between 9 April 2015 and 9 October 2015. Farndale ward reported 84 incidents of restraint which was the highest across the hospital and Dalby ward reported one incident which was the lowest. Farndale ward reported one episode of prone restraint. This was the only ward across the hospital that used prone restraint.

We reviewed 28 patient care records across all six wards and found that all 28 records demonstrated good practice in record keeping. Staff used a recognised risk assessment tool and completed comprehensive risk assessments following admission and updated following any incidents. Staff kept good records for all three patients in seclusion that demonstrated good practice recommendations in keeping with the Mental Health Act Code of Practice. We saw that staff used the Lester tool to screen and provide interventions for patients' physical health. This is a tool used to monitor physical health for patients prescribed certain medications. It is recommended good practice in the National Institute for Health and Care Excellence guidelines for adults with schizophrenia and psychosis and minimises the risk of patients experiencing problems associated with their prescribed medication and how that may affect their physical health.

All wards were involved in the hospital restrictive practice reduction strategy and regularly reviewed the use of restrictive practices with patients. For example, all wards

Are services safe?

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

had reduced restrictive practices at mealtimes and staff no longer locked the dining room door during meal times. Patients could leave the dining room individually after handing in their own cutlery. Before this, all patients had to remain in the dining room and could not leave until staff checked all cutleries as present. All wards, with the exception of Farndale introduced metal cutlery based on individual patient risk assessments. Prior to this all patients used plastic cutlery that was not individually risk assessed and therefore regarded as a blanket restriction.

Staff followed the hospital policy and procedures for patient observations that kept patients safe in their environments. We saw that across all wards there was sufficient staff to carry out patient observations that included one to one whilst in seclusion, 15 minute, and hourly observations. Staff used a combination of random and regular searches to ensure that patients did not have possession of banned articles such as sharp objects.

Staff used restraint as a last resort with patients. All staff received mandatory training in manging aggression and staff told us they used restraint only after other techniques such as de-escalation had failed. Fenton ward had a sensory room that patients used as a de-escalation area and other wards had quiet areas.

We reviewed 28 patient care records across all wards. All records were up to date and contained detailed positive behaviour support plans, risk formulations and management plans. These plans informed staff how to recognise triggers and behaviours and how best to support individual patients. Staff also attended handovers at the beginning of their shifts when staff handed over relevant information about patient risks. All staff we spoke with were aware of patient observation levels and risks.

All staff received mandatory training that helped to keep patients safe such as safeguarding adults and children. Staff were aware of safeguarding issues such as neglect, physical, verbal, and sexual abuse and raised their concerns through an electronic system. Senior staff investigated safeguarding concerns and ward staff held safety meetings with patients to help them feel safe. Only one patient said they felt unsafe. Staff held a patient safety meeting and continued to address the patient's safety concerns.

The wards followed safe procedures for children visiting. Staff planned child-visiting arrangements in advance to ensure enough staff were available to support visits that always took place away from the ward. During our visit, we saw that adequate and appropriate staff were available to support one child visit that took place in the identified child visiting area within the hospital.

Track record on safety

We reviewed the number of serious incidents reported by the hospital over the past 12 months from December 2016 to October 2017.

Six of the seven wards reported a total of 12 serious incidents during this period. Boston and Farndale ward both reported four incidents. Dalby ward reported the lowest with zero reports of serious incidents.

Senior staff at the hospital or external investigators investigated serious incidents. The hospital had made improvements in their security arrangements after two incidents that involved security breaches.

Reporting incidents and learning from when things go wrong

All staff knew how to report incidents although some staff said they had experienced difficulty accessing the electronic system to report incidents. Staff understood about their duty of candour and apologised to patients when things went wrong. Staff reported incidents such as patient and staff assaults, police involvement, and allegations of abuse. The hospital notified the Care Quality Commission and Commissioners about incidents in a timely way and provided the outcome of investigations and any learning. The hospital had good governance arrangements that ensured staff shared learning from incidents across all wards. The hospital had investigated and taken action to make improvements following incidents such as improving security checks. Ward staff discussed feedback from incidents at ward meetings and handovers and staff told us they had opportunity to receive de-briefs following incidents.

Are services effective?

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

Our findings

At the last comprehensive inspection in February 2016, we found areas of good practice. Since that inspection, we have received no information that would cause us to re-inspect this key question.

Are services caring?

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

Our findings

At the last comprehensive inspection in February 2016, we found areas of good practice. Since that inspection, we have received no information that would cause us to re-inspect this key question.

Are services responsive to people's needs?

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

Our findings

At the last comprehensive inspection in February 2016, we found areas of good practice. Since that inspection, we have received no information that would cause us to re-inspect this key question.

Are services well-led?

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

Our findings

At the last comprehensive inspection in February 2016, we found areas of good practice. Since that inspection, we have received no information that would cause us to re-inspect this key question.