CareQuality Commission

Cygnet Hospital Beckton

Quality Report

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

Ratings

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

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

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

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

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

Summary of findings

Overall summary

We rated Cygnet Beckton as good because:

The hospital provides mental health services for females across four wards for psychiatric intensive care, personality disorders, forensic and learning disabilities and autism.

- Staff worked hard to provide safe care in most areas across the hospital. The ward environments were safe and clean. Hooper (psychiatric intensive care unit), New Dawn (specialist personality disorders) and Hansa (learning disabilities and autism) wards had enough nurses and doctors to meet the needs of patients in their care. Staff across the hospital assessed and managed risk well. Staff participated in the providers reducing restrictive practice initiative that championed the use of anticipating, de-escalating and managing challenging behaviour. Staff followed good practice in protecting patients from abuse after the provider improved the service's safeguarding system. Staff on Hansa Ward knew about and worked towards achieving the aims of the stop over-medicating people with a learning disability programme.
- Staff across the hospital developed holistic, recovery-oriented care plans informed by a comprehensive assessment. They provided a range of treatments suitable to the needs of the patients and in line with national guidance about best practice. Staff engaged in clinical audit to evaluate the quality of care they provided.
- The ward teams included or had access to the full range of specialists required to meet the needs of patients on the wards. This included consultant psychiatrists, occupational therapists and psychologists. Staff worked well together as a multidisciplinary team to provide effective care and treatment to patients.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, and understood the individual needs of patients. Staff participated in patient involvement programmes such as the Peoples Council and 'Safewards' to empower patients and staff to collaborate in their care and treatment.

- Staff involved patients in decisions about the service. Patients co-produced the hospital newsletter, outlining what activities and projects the hospital was hosting.
- Staff ensured that patients had good access to physical healthcare and supported patients to live healthier lives. Staff supported patients with their social and educational wellbeing. The service had a gym onsite that all patients could access. In addition, patients used the hospital's recovery college to enrol on courses about mental health and wellbeing.
- Staff supported patients to make decisions on their care for themselves. Staff understood the principles of the Mental Capacity Act 2005, assessed and supported patients who might have impaired mental capacity. Staff made sure they could explain patients' rights to them under the Mental Health Act 1983.
- The service was well-led and the governance processes ensured that ward procedures ran smoothly. Staff engaged actively in local and national quality improvement activities. There was a great commitment towards continual improvement and innovation. The service had been proactive in capturing and responding to patients' concerns and complaints. There were creative attempts to involve patients in all aspects of the service.

However:

- Although medicines were stored and administered safely, improvements were required on Hooper Ward to oversee the administration of medicines and the implementation of action to prevent medicines errors. We found staff had made two similar errors in the dispensing of the same patient's 'as required' medicine and given over the prescribed amount in a 24-hour period. This meant the patient had been overmedicated and could lead to physical health complications.
- Staff did not always ensure that physical health monitoring of patients' vital signs was undertaken after every use of rapid tranquilisation, record physical health observations accurately for patients, and seek medical advice when indicated.
- Not all patients had access to an alarm to call for help should they need it in an emergency. The provider had

Summary of findings

installed some on each ward and patients who were deemed at risk of needing to call for help more than others were given these bedrooms. However, staff did assess the risk for patients on most wards and said they would give alarms to patients if they needed one. Not all patients knew about this.

- Staff on Hooper Ward imposed a blanket restriction on patients. Staff locked away snacks from patients and this was not based on individual patient risk.
- Staff did not always respond to complaints in a timely manner. This meant complainants may not know what stage their complaint was at.

Summary of findings

Contents

Cygnet Hospital Beckton

Good 🟢

Services we looked at

Acute wards for adults of working age and psychiatric intensive care units; Forensic inpatient or secure wards; Wards for people with learning disabilities or autism; Specialist eating disorders services

Summary of this inspection

Background to Cygnet Hospital Beckton

Cygnet Hospital Beckton is an independent hospital for 61 women with complex mental health needs. The hospital is provided by Cygnet Healthcare. At the time of the inspection, 56 patients were receiving care and treatment at the service.

The service 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
- treatment of disease, disorder or injury

The service has a registered manager.

There are four wards at Cygnet Hospital Beckton:

New Dawn Ward is an 18-bed personality disorder ward offering dialectic behaviour therapy interventions. The ward is split into two sections. New Dawn comprises of 12 patients who were newer admissions (pre-engagement). New Dawn 2 is a step down for six patients that have moved along with their recovery (engagement).

Bewick Ward is a 15-bed low-secure unit for complex care and recovery. At the time of the inspection, the provider informed us that the service model would soon be changing to an acute ward for women.

Hooper Ward is a 15-bed psychiatric intensive care unit (PICU). At the time of the inspection, only 10 patients were receiving care and treatment on the ward because the provider did not operate at full capacity when four patients were on one-to-one observations.

Hansa Ward is a 13-bed learning disability ward that provides care and treatment to detained and informal patients.

At the time of the inspection most patients were from outside of London.

We have inspected this service six times previously. At the last inspection in March 2017, the service was rated good overall.

Our inspection team

The team that inspected the service comprised four CQC inspectors, an inspection manager, an assistant inspector, four specialist nurse advisors who had experiencing working in personality disorders, psychiatric intensive care units, learning disabilities and forensic wards and an expert by experience. An expert by experience is someone who has previously used services.

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 and asked other organisations for information

Summary of this inspection

During the inspection visit, the inspection team:

- visited all four wards at the hospital, looked at the quality of the ward environment and observed how staff were caring for patients;
- spoke with 18 patients who were using the service;
- spoke with the managers and acting managers for each of the wards;
- spoke with four members from the senior leadership team;
- spoke with 28 other staff members; including doctors, nurses, occupational therapist, psychologist and social worker;

- received feedback about the service from one commissioner;
- spoke with an independent advocate;
- attended and observed two hand-over meetings, two multi-disciplinary meetings and two ward round meetings;
- looked at 17 care and treatment records of patients:
- carried out a specific check of the medication management on all wards; and
- looked at a range of policies, procedures and other documents relating to the running of the service

What people who use the service say

We spoke to 18 patients across the hospital and most fed back positively about staff and how they were treated. The majority said that what they liked most about the service was that there had been improvements to the activities and group work. Most patients said that staff supported them and treated them with dignity and respect. Patients enjoyed the sensory group and really liked the occupational therapists. Patients said staff treated them well and behaved kindly. Patients told us staff were busy but made an effort to spend time with them.

However, most patients across the hospital said what they would like to improve was the staffing levels to meet their needs.

Staff attitudes and behaviours when interacting with patients showed that they were discreet, respectful and responsive, providing patients with help, emotional support and advice at the time they needed it. Positive and caring relationships were developed between patients and staff. We observed that staff were kind, warm and friendly with people and were genuinely concerned for their wellbeing.

Patients and carers had opportunities to give feedback on the service. For example, the service conducted an annual patient survey. The most recent results showed that 11% of patients felt that their overall care at the service was excellent and 33% felt that is was good. Most patients (56%) felt safe at the service sometimes and 56% felt they were sometimes involved in their care and treatment with 44% saying they always felt involved. Staff listened to patients and used their feedback to improve the service. For example, patients said they wanted the wards redecorated and refreshed. In response, staff redecorated the wards and put plans in place to create new sensory rooms.

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?

We rated safe as requires improvement because:

Requires improvement ●

- Staff did not always monitor and record patients' vital signs appropriately. On Bewick and New Dawn Wards we found that when staff decided not to escalate concerns about patients with elevated scores on the modified early warning score charts, they did not always record why this decision was taken and the decision was not reflected in the patient's care plan. Information on physical health monitoring scores was stored in two different parts of the patient records, which could lead to errors in transferring data or in finding accurate information when needed.

- On Hooper Ward, patients did not always receive their medicines as prescribed. We found staff had made two similar errors in the dispensing of the same patient's 'as required' medicine and given over the prescribed amount in a 24-hour period. This meant the patient had been overmedicated and could lead to physical health complications.

- Staff did not always ensure that physical health monitoring of patients' vital signs was undertaken after every use of rapid tranquilisation.

- Staff on Hooper Ward imposed a blanket restriction on patients. Staff locked away snacks from patient and this was not based on individual patient risk.

- Not all patients had access to an alarm to call for help should they need it in an emergency. The provider had installed some on each ward and patients who were deemed at risk of needing to call for help more than others were given these bedrooms. However, staff did assess the risk for patients on most wards and said they would give alarms to patients if they needed one. Not all patients knew about this.

However,

- Staff kept the ward environments safe and clean. This included monthly infection control audits and cleaning medical equipment.
- Hooper, New Dawn and Hansa wards had enough nurses and doctors to keep patients safe.

Summary of this inspection

- Staff assessed and managed risk well. Risk assessments and management plans were reviewed and updated regularly. Staff knew about potential ligature anchor points and mitigated the risks to keep patients safe.
- Staff had the skills required to develop and implement good positive behaviour support plans and followed best practice in anticipating, de-escalating and managing challenging behaviour.
- Staff minimised the use of restrictive practices by participating in the provider's reducing restrictive practices initiative. This included assigning staff leads on each ward to implement reducing restrictive practices.
- Staff and patients took part in the 'Safewards' model, which emphasises better relationships between staff and patients and increases patient safety. Staff used tools like the 'calm down' box, mutual expectations and staff personal profiles. On Hansa Ward patients had a calm card attached to their medicine's administration records. The information on these cards were generated by patients and used before staff and patients considered using 'when required' medication.
- Staff on Hansa Ward regularly reviewed the effects of medicines on each patient's physical health. They knew about and worked towards achieving the aims of the stop over-medicating people with a learning disability.
- Staff followed good practice with respect to safeguarding. The service had recently made improvements to their safeguarding practice to ensure better reporting. The safeguarding team promoted improved practice through regular training and workshops for staff and patients.
- The wards had a good track record on safety. The service managed patient safety incidents well. Staff ensured they de-briefed after an incident to gather information which could be useful in reducing the risk of future restrictive interventions. When things went wrong, staff apologised and gave patients honest information and suitable support.

Are services effective?

We rated effective as **good** because:

- Staff assessed the physical and mental health of all patients on admission. They developed individual care plans, which they reviewed regularly through multidisciplinary discussion and updated as needed. Care plans reflected the assessed needs, were personalised, holistic and recovery oriented.
- Staff from different disciplines worked together as a team to benefit patients. This included consultant psychiatrists, nurses,

Good ●

occupational therapists and psychologists. They supported each other to make sure patients had no gaps in their care. Managers made sure they had staff with a range of skills needed to provide high quality care. For example, the majority of staff across the hospital were trained in dialectic behavioural therapy to support women with personality disorders.

- Staff provided a range of care and treatment interventions suitable for patients receiving support for intensive psychiatric support, personality disorders, learning disabilities and low secure rehabilitation that was consistent with national institute for health and care excellence guidance.
- Staff ensured that patients had good access to physical healthcare and supported patients to live healthier lives. The service had gym facilities onsite and provided patients with support to quit smoking.
- Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice and discharged these well. Managers made sure that staff could explain patients' rights to them.
- Staff supported patients to make decisions on their care for themselves. Staff understood the provider's policy on the Mental Capacity Act 2005, assessed and supported patients who might have impaired mental capacity.

Are services caring?

We rated caring as **good** because:

Good ●

- Staff treated patients with compassion and kindness. They respected patients' privacy and dignity. They understood the individual needs of patients and supported patients to understand and manage their care and treatment.
- Staff involved patients in care planning and risk assessment and actively sought their feedback on the quality of care provided. Staff participated in patient involvement programmes such as the Peoples Council and 'Safewards' to empower patients to be involved in their care and treatment.
- Staff on Hansa ward developed social stories with patients prior to activities to aid in the communication and delivery of care and support. Social stories help patients understand difficult situations and activities with simple visual representation of a conservation, situation, event, or activity.
- Staff involved patients in decisions about the service. Patients co-produced the hospital newsletter, outlining what activities and projects the hospital was hosting. Patients also had the opportunity to take part in ward-based jobs, such as gardening.

Summary of this inspection

- Patients had access to dedicated advocates on the wards to ensure they had their voices heard.

However,

- Whilst staff involved carers and families appropriately, patient care plans did not always show this.

Are services responsive?

We rated responsive as **good** because:

- Staff planned and managed discharge well. Staff worked collaboratively with other professionals to ensure that patients moved on to suitable placements. Staff worked hard to engage patients who had stayed at the service for a significant amount of time and were not yet ready for discharge.
- The design, layout, and furnishings of the ward supported patients' treatment, privacy and dignity. Each patient had their own bedroom and could keep their personal belongings safe. There were quiet areas for privacy.
- The service met the diverse needs of all patients who used the service, including patients with a protected characteristic. Staff helped patients with communication, advocacy and cultural and spiritual support.
- Staff supported patients with their social and educational wellbeing. Patients used the hospital's recovery college to enrol on courses about mental health and their wellbeing.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results.

However,

- Staff did not always respond to complaints in a timely manner or keep complainants up to date with what was happening with their complaint.

Good ●

Are services well-led?

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

- Our findings from the other key questions generally demonstrated that governance processes operated effectively at ward level and that performance and risk were managed well.

- The service was generally well-led at ward level and by the hospital director. Staff engaged actively in local and national quality improvement activities. There was a great commitment towards continual improvement and innovation.

Good ●

Summary of this inspection

- The service had been proactive in capturing and responding to patients concerns and complaints. There were creative attempts to involve patients in all aspects of the service. The lead occupational therapist had recently launched a Working Together group to involve families and carers in their loved one's care.

- Leaders had the skills, knowledge and experience to perform their roles, had a good understanding of the services they managed, and were visible in the service and approachable for patients and staff.

- Staff felt respected, supported and valued. They reported that the provider promoted equality and diversity in its day-to-day work and in providing opportunities for career progression. They felt able to raise concerns without fear of retribution.

- Ward teams had access to the information they needed to provide safe and effective care and used that information to good effect.

However,

- We found some issues that the provider needed to improve to ensure they provided safe care and treatment for patients. For example, on two wards, staff did not always monitor and record patients' vital signs appropriately. On Hooper Ward, we found staff had made two similar errors in the dispensing of the same patient's 'as required' medicine and given over the prescribed amount in a 24-hour period.

Detailed findings from this inspection

Mental Health Act responsibilities

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

Staff understood their roles and responsibilities under the Mental Health Act 1983, the code of practice and its guiding principles.

Staff authorised and administered medicines for detained patients in line with the Mental Health Act Code of Practice. Staff explained to patients their rights under the Mental Health Act in a way they could understand.

Mental Capacity Act and Deprivation of Liberty Safeguards

Most staff had a good understanding of the Mental Capacity Act and the five statutory principles. Staff knew how to support patients who lacked capacity to make decisions about their care.

Staff completed capacity assessments for patients that might have impaired capacity. These were time and decision specific. Staff understood the need to seek consent from patients before providing care and treatment.

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Acute wards for adults of working age and psychiatric intensive care units	Requires improvement	Good	Good	Good	Good	Good
Forensic inpatient or secure wards	Requires improvement	Good	Good	Good	Good	Good
Wards for people with learning disabilities or autism	Good	Good	Good	Good	Good	Good
Personality disorder services	Requires improvement	Good	Good	Good	Good	Good
Overall	Requires improvement	Good	Good	Good	Good	Good

Acute wards for adults of working age and psychiatric intensive care units

Good 🟢

Safe	**Requires improvement**	🟠
Effective	**Good**	🟢
Caring	**Good**	🟢
Responsive	**Good**	🟢
Well-led	**Good**	🟢

Are acute wards for adults of working age and psychiatric intensive care unit services safe?

Requires improvement 🟠

Safe and clean environment

Safety of the ward layout

Hooper Ward was safe, clean, well equipped, well furnished, well maintained and fit for purpose. Staff carried out a health and safety check of the ward environment on each shift. The ward manager and clinical quality manager made an environmental risk assessment of the ward each week to ensure any outstanding maintenance issues were followed up. In addition, the fire alarm was tested each week. Fire safety equipment had been checked and maintained. There were fire drills every six months with a full evacuation of the hospital.

Staff observed the safety of patients as they moved around the ward. Staff were aware of those parts of the ward, which were hard to observe and may pose a risk to patients. Staff followed procedures to check all parts of the ward. Convex mirrors were installed in the corridors, which assisted staff to observe patients.

Staff completed and regularly updated thorough risk assessments of all areas and removed or reduced any risks they identified. The provider had carried out an assessment of all ligature risks and staff were aware of the identified risks and how to mitigate them through observation. Some areas such as the therapy rooms and air lock entrance to the ward had ligature risks but staff were aware that patients should not be in these areas without a member of staff. In addition, all staff who were new to the ward were taken on a ward tour by a more experienced team member and shown blind spots, ligature risks and other potential risks.

Staff had easy access to alarms and patients had easy access to nurse call systems. Staff and people visiting the ward carried security alarms. Patients could use a nurse call alarm when in their bedroom. We tested a bedroom alarm during the inspection and staff attended immediately. However, not all patients had access to an alarm to call for help should they need it in an emergency. The provider had installed some on each ward and patients who were deemed at risk of needing to call for help more than others were given these bedrooms. However, staff did assess the risk for patients on most wards and said they would give alarms to patients if they needed one. Not all patients knew about this.

Staff had training on responding to medical emergencies, which included simulations of emergencies to help prepare them to effectively respond to such incidents.

Maintenance, cleanliness and infection control

All ward areas were visibly clean. Cleaning records were up to date and showed that all parts of the ward were cleaned regularly.

We observed that staff followed infection control procedures including hand washing. The ward conducted an infection control audit monthly.

Seclusion room

The service did not have a seclusion room, it did not use seclusion to manage behaviours. The service had a

de-escalation room. During the inspection we confirmed that staff acted in accordance with the Mental Health Act code of practice and did not confine patients to their bedrooms or in the de-escalation room.

Clinic room and equipment

Clinic rooms were fully equipped, with accessible resuscitation equipment and emergency drugs that staff checked regularly. Resuscitation equipment and emergency medicines were readily available for staff to use if there was a medical emergency. Staff checked equipment and medicines to ensure they were fit for purpose. Staff knew the location of the ligature cutters.

Staff checked, maintained, and cleaned equipment. The equipment staff used to monitor patients' health was clean and there were stickers to show that the equipment was maintained and kept clean.

Safe staffing

Nursing staff

The service had enough nursing and support staff to keep patients safe. Patients told us that there were enough staff on the ward. Managers calculated the staffing level required for the ward according to the number of patients and their level of need. On the day of the inspection, there were two registered nurses and nine health care assistants on duty. This staffing level was increased because four of the ten patients required continuous one to one observation by a member of staff.

The staffing establishment for the service was ten whole-time equivalent registered nurses. At the time of the inspection, there were three whole-time equivalent vacancies. The establishment for healthcare assistants was 20, with seven vacancies. Five support workers had recently been recruited to work on the ward. Bank and agency staff covered for vacancies, sickness and leave.

On the second day of the inspection both the registered nurses on duty were permanent staff and of the 12 support workers, four were permanent, four were bank staff and four were agency. All the bank staff and agency staff working on the ward had worked there previously and the service retained some agency staff on contract to provide continuity of care. Staff said that usually bank and agency staff who knew the ward were used.

The sickness rate for the ward averaged less than 2% (provider's target) in the period January to October 2019.

Staff told us that managers adjusted staffing levels to ensure patients and staff were safe. The ward manager told us that the provider had agreed in October 2019 that there should be no more than four, or exceptionally five, patients on the ward at any one time requiring one to one observation. Therefore, the provider would halt new admissions to the ward if necessary.

Staff said there had been a recent period when there had been a high level of patients requiring one to one observation with a high volume of incidents of violence and aggression, which had a negative impact on staff morale.

Medical staff

Doctors were readily available to meet patients' medical needs. During the day a ward doctor and a consultant psychiatrist were available. Staff told us that, out of hours, they were able to ask a duty doctor to assess and treat a patient if necessary.

Mandatory training

Staff had received and kept up-to-date with mandatory training. Overall, staff on the ward had undertaken 95% of the required training. This included training on managing physical health conditions, safeguarding, equality and diversity and managing violence and aggression.

Assessing and managing risk to patients and staff

Assessment of patient risk

Staff used a recognised risk assessment tool to assess risks to patients and themselves well. We reviewed three patient care records. The service received risk information about the patient on referral. A nurse and a doctor then completed standardised risk assessments when the patient was admitted to the ward. These risk assessments included relevant information on risks of self-harm, harm to others, and mental health and physical health risks. The service relied on referring agencies to provide relevant information about the patient's risk history.

Management of patient risk

Staff managed risks to patients and themselves well. Staff had a good awareness of the risks for each patient and how to manage them. For example, in the case of a patient who

Acute wards for adults of working age and psychiatric intensive care units

Good ●

was at risk of self-harm, there were detailed plans about how staff should support the patient to verbalise any distress they felt and to support them with techniques to prevent self-harm. In addition, there were details of how staff should interact with the patient and details of groupwork and one to one psychosocial interventions. The risk management plan detailed the steps staff should take to minimise injury if the patient actively tried to self-harm.

We observed that staff responded to changing risks. For example, by attempting to talk with patients when they became distressed. In one case, a staff member suggested the patient go out into the courtyard garden for some fresh air, which had the effect of calming the patient.

The multidisciplinary team reviewed risks at the hospital's twice daily safety huddles, at twice daily shift handover meetings and at weekly ward rounds. Staff reviewed any new incidents, clarified the level of risk and decided how the patient should be observed whilst on the ward.

Staff monitored deterioration in patients' physical health. The multidisciplinary team decided how often they should monitor each patient's vital signs based on the level of risk of them becoming unwell. Staff completed the modified early warning score to identify deteriorating patients. Patient records showed that nursing staff escalated any concerns to the ward doctor. The multi-disciplinary team reviewed information on the patient's physical health at the weekly ward round and decided whether any further follow up was required.

Staff followed trust policies and procedures when they needed to search patients or their bedrooms to keep them safe from harm. Staff received training in safely and effectively searching patients.

The ward was smoke-free and occupational therapy staff led on activities to support patients with smoking cessation.

Use of restrictive interventions

Staff made every attempt to avoid using restraint by using de-escalation techniques and restrained patients only when these failed and when necessary to keep the patient or others safe. The service had 119 incidences of physical restraint, two of which were in the prone position between 1 February 2019 and 31 July 2019. However, in August 2019 there were four episodes of prone restraint. Three of the four incidents were for prevention of self-harm and

administration of rapid tranquilisation. Two of these restraints were carried out prone because the patient positioned them self on the floor prior to restraint. The other prone restraint was due to patient refusal of medication. In September 2019, there were four prone restraints for the prevention of self-harm and administration of intramuscular medication. The provider told us there were two particularly challenging admissions during the August to September 2019 period, which had an impact on or otherwise low use of prone restraint.

We reviewed incident reports and care and treatment records about recent incidents of restraint. It was clear that staff had followed the provider's procedures in relation to the use and documentation of restraint. Staff had carried out the appropriate physical health observations after an incidence of rapid tranquilisation.

Patient records included information on the actions taken by staff to de-escalate situations and calm patients before restraint was used. The provider had a strategy in place to reduce restrictive interventions. Staff used the 'Safewards' model to reduce the risk of the use of restrictive interventions. Staff told us how they tried to establish rapport with patients and talked to them when they were distressed with the aim of reducing the need for restraint. The ward also had a 'calm down box', which contained items selected by patients to help manage their distress.

The provider told us that emphasis was placed on de-briefs with both staff and patients to ensure lessons were learnt about using the least restrictive intervention. The provider checked whether ward staff were carrying out these de-briefs through means of a key performance indicator. Records of these de-briefs showed that both patients and staff gave information, which could be useful in reducing the risk of future restrictive interventions. For example, patients gave suggestions about what staff could do to help them to manage their anxiety.

Staff were working to reduce blanket restrictions on the ward. Staff participated in the provider's reducing restrictive practices initiative. This included implementing a reducing restrictive practice champion on the ward. The staff team had worked actively to reduce restrictive interventions and to not apply restrictions in a blanket manner. Where, the ward had blanket restrictions in place, these were mostly restrictions that were in line with a psychiatric intensive care unit. However, staff locked

Acute wards for adults of working age and psychiatric intensive care units

Good ●

patients' snacks in the kitchen. Although patients told us staff responded when they asked for a snack; this meant staff did not support patients in a manner that reflected their needs and preferences.

At the time of the inspection, patients were unable to retain their mobile phone if it had a camera on it. We were told this policy was under review. Patients told us there were phones on the ward which they could use to contact their friends and family in private. Patients could also use a computer with internet access under supervision.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff were trained in safeguarding and knew how to identify and report any concerns about abuse or neglect. The provider's social work team maintained a database of safeguarding concerns and had an effective system to maintain links with the police and the local authority. This ensured that incidents were investigated in line with multi-agency procedures and patients were protected from harm. All staff teams had a safeguarding champion.

The social work team clarified any safeguarding risks in relation to the patient's family or children and ensured that these were considered by the multidisciplinary team when planning home leave or the patient's discharge from the ward. Patients' contact with children was planned in in advance and subject to a risk assessment. If necessary, a room could be used off the ward for patients to meet with children.

The social work team collected information on lessons learnt from safeguarding incidents and had improvement targets for the service. These included, ensuring safeguarding information was obtained during the referral process, that body maps were completed to record any injuries, that safeguarding incidents were fully documented and that there was thorough documentation of debriefs with patients and staff. The safeguarding team were monitoring progress with these aims and promoting improved practice through regular training and workshops for staff.

Staff access to essential information

Staff had good access to essential information. At the time of the inspection, staff were using both paper and electronic patient records. Staff knew where to find key information. Staff told us that the current paper-based systems for incident reporting were quite time consuming.

Staff told us the provider was intending to move to a fully electronic patient record system soon, but they had not yet been given an implementation date.

Medicines management

Although staff generally followed good practice in the storage, dispensing and prescribing of medicines, improvements were required in the monitoring of the administration of medicines. This included the implementation of action to follow up after errors were identified. During the inspection on 12 November 2019, we found that staff had made two similar errors in the dispensing of the same patient's 'as required' medicine, on 3 November 2019 and 8 November 2019. In both instances, the patient was given over the prescribed amount in a 24-hour period and given the medicine more frequently than the prescribed interval between doses. This meant the patient had been overmedicated and could lead to physical health complications.

On 4 November 2019, the visiting pharmacist identified the error that had been made on 3 November 2019. However, the service was not able to respond effectively to prevent the similar error on 8 November 2019. This meant staff did not act to minimise the risk of medicines errors happening again.

The external visiting pharmacist visited the ward once a week on a Friday. They informed the ward manager of any errors by email for follow up. The National Association of Psychiatric Intensive Care Units standards state that, 'many medicines will need to be reviewed daily, and the pharmacist needs to visit the PICU frequently enough to do this with prescribing colleagues, focusing on their therapeutic as well as adverse effects.'

Medicines were stored at the correct temperature and staff completed medicines charts in line with best practice. Staff spoke with patients about their medicines and any side effects at the ward round. The appropriate physical health checks were made in line with the National Institute for Health and Care Excellence (NICE) guidance.

Track record on safety

Acute wards for adults of working age and psychiatric intensive care units

Good ●

The service had a good track record on safety. From 1 August 2018 - 31 July 2019 the provider reported 18 incidents as serious. These included security breaches and allegations of abuse.

Reporting incidents and learning from when things go wrong

Staff recognised incidents and reported them appropriately. From 1 August 2018 - 31 July 2019 staff reported 541 incidents on Hooper Ward. Staff understood their responsibilities in relation to the provider's incident reporting procedures. For example, staff reported any incidents of self-harm.

Managers debriefed and supported staff after any serious incident. Records showed that incidents had been appropriately followed-up and there had been de-briefs with patients and staff.

The ward manager had detailed information on all incidents that had occurred on the ward and reviewed incidents and their follow-up each week. They ensured there was discussion about incidents at team meeting. A member of staff told us about the learning from an incident where a patient was found to be dehydrated. This led to changes in the way staff documented food and fluid intake and monitored vital signs.

Are acute wards for adults of working age and psychiatric intensive care unit services effective?
(for example, treatment is effective)

Good ●

Assessment of needs and planning of care

Staff assessed the physical and mental health of all patients on admission. We reviewed four patient care and treatment records. A doctor and a registered nurse assessed the mental health and physical health of each patient on admission to the service. These assessments were in line with best practice guidance on the planning of care and treatment for patients admitted to a psychiatric intensive care unit.

Care plans were personalised, holistic and recovery orientated. The multi-disciplinary team then developed the patient's individual care plan to meet their specific needs and with the aim of stabilising the patient's mental health. The service aimed to discharge patients within four to six weeks. There was a target discharge date in the patient's care plan.

Care plans stated in plain English how staff would support the patient to stabilise their mental health through a range of interventions. These included treatment with medicines and psychosocial interventions. Care plans included information on the arrangements for the patient's leave from the ward. Care plans were completed by the patient's key nurse and reviewed and updated at ward rounds or more frequently if the patient's needs changed.

Staff developed care plans to address patients' physical health needs. For one patient there was a care plan which explained what staff should do if they had a seizure. In the case of another patient, there was a diabetes care plan, which explained how staff should support the patient to manage their health condition.

Best practice in treatment and care

The multi-disciplinary team provided care and treatment to meet patients' physical, psychological, social, mental and spiritual care needs. These interventions were in line with National Institute for Health and Care Excellence guidance on the care and treatment of patients with acute mental health needs and on the management of violence and aggression.

Staff provided a range of care and treatment suitable for patients needing a psychiatric intensive care unit. The consultant psychiatrist for the service and the ward doctor had appropriate expertise in the assessment and treatment of mental health patients with a high level of need. They were readily available to advise the staff team on the management of disturbed or aggressive behaviour. A clinical psychologist provided assessment of psychological need and provided a range of therapeutic interventions. An occupational therapist contributed to care and treatment plans and organised a rota of activities for patients.

Staff helped patients live healthier lives by supporting them to take part in programmes or giving advice. Staff offered smoking cessation support and worked with patients to reduce their smoking. The service had a dedicated gym onsite with support staff to educate and support patients to exercise.

Acute wards for adults of working age and psychiatric intensive care units

Good ●

Staff used Health of the Nation Outcome Scales to record the severity of each patient's needs and their outcomes as their treatment progressed.

Skilled staff to deliver care

The multidisciplinary team included the full range of specialists required to meet the needs of patients using a psychiatric intensive care unit. As well as nurses and doctors, there was an occupational therapist, a social worker, and a clinical psychologist. These staff had the appropriate qualifications, experience and knowledge to work with the patients using the service.

Staff who were new to the service had an induction to the service, which included ward procedures and some specialist training on the care and treatment of patients using the ward. For example, staff received training on supporting patients with personality disorders.

Managers provided staff with clinical supervision and an annual appraisal to support staff to develop their skills and ensure the quality of care and treatment. Rates of compliance for supervision and appraisals were both over 90%. We reviewed three clinical supervision records. It was clear that staff were given the opportunity to talk about any difficulties with their work role and were supported to develop their skills. Staff told us their managers gave them personal support when needed. They said that their colleagues in the multidisciplinary team shared their knowledge.

Staff had appropriate professional supervision, support and training. For example, the occupational therapy team had specific arrangements to ensure they discussed best practice and met with occupational therapists from other services to improve the quality of the service they provided.

Multidisciplinary and interagency team work

Staff from different disciplines worked together as a team to benefit patients. Multidisciplinary ward rounds were well-organised. We observed that staff from different disciplines collaborated to report on the patient's progress with their care and treatment plan. During the ward round staff could see a projected copy of the ward round template, which included all relevant information about the patient. The template was updated during the meeting and any changes in, for example, levels of risk or leave arrangements were recorded during the meeting.

Staff attempted to have effective working relationships with external teams and organisations. Staff sent a copy of the ward round template to the patient's care coordinator to ensure they had up to date information about the patient's progress to assist with discharge planning. Most care coordinators were at some distance from the service and contact with them was mainly by email or telephone.

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

Staff adhered to the Mental Health Act and the Mental Health Act Code of Practice. All the patients using the service were detained under the Mental Health Act. Patient records showed staff had informed these patients of their rights and there were appropriate arrangements for their leave from the ward.

There was a Mental Health Act administrator who assisted staff in checking Mental Health Act paperwork to ensure that legal requirements were met. The multidisciplinary team kept track of each patient's period of detention and their legal status. Patients had access to an independent Mental Health Act advocate.

Good practice in applying the Mental Capacity Act

Staff followed good practice in the application of the Mental Capacity Act. On admission, a doctor recorded information on the patient's mental capacity to understand their mental health needs and the proposed plan of care and treatment. Assessments included details of discussions with the patient and the patient's abilities to retain information, weigh up decisions and understand their mental health needs.

Staff took practical steps to enable patients to make their own decisions when they had the mental capacity to do so. We observed that staff explained options to patients in a way they could understand, for example when discussing leave arrangements.

Acute wards for adults of working age and psychiatric intensive care units

Good 🟢

Are acute wards for adults of working age and psychiatric intensive care unit services caring?

Good 🟢

Kindness, privacy, dignity, respect, compassion and support

Patients told us that staff treated them kindly and respected their privacy. We observed that staff were polite and friendly. Staff had a good understanding of each patient's needs and were able to explain to us what was important to the patient and how they communicated with them. We observed staff to be friendly and supportive when talking with patients. The service celebrated patients' birthdays with a cake and a birthday tea.

Staff gave patients help, emotional support and advice when they needed it. Staff ensured they greeted and communicated with each patient on each shift. The provider's policy was that on each shift the patient's key nurse should greet the patient, introduce themselves to the patient and plan with the patient their care and treatment during the shift. On some patient records it was clear that this policy had been carried out, but in the majority of shift records it was not clear whether the key nurse had attempted to have a one to one with the patient or not.

Staff supported patients to understand and manage their mental health needs. At the ward round, the multi-disciplinary team had a discussion with the patient about the advice the psychologist had given them on managing their self-harming behaviour and gave the patient praise for the way they were managing it.

Involvement in care

Involvement of patients

Staff involved patients in care planning and risk assessment and actively sought their feedback on the quality of care provided. Staff welcomed new patients to the ward, explained the service to them and gave them an information pack.

The multidisciplinary team encouraged patients to participate in ward rounds, even when they had a high level of mental health needs. All team members ensured that they communicated well with patients and listened to what they had to say. The team made it clear to the patient what action they would be taking in response to any questions or queries they had. For example, the consultant psychiatrist explained to one patient how they would be making changes to their leave arrangements in response to points made by the patient.

Staff involved patients in decisions about the service, when appropriate. The service held monthly people's council meetings. These meetings consisted of patients from across the hospital coming together to discuss ward activities, projects and patient involvement. In addition, the service involved patients on recruitment panels to support interviews of potential staff. Patients could also join the clinical governance meetings as a service user representative.

Involvement of families and carers

Staff informed and involved families and carers appropriately. The consultant psychiatrist said they were aiming to improve partnership working with the patient's family and carers. For many patients, their families were at some considerable distance away and they could not easily visit. At the ward round, the multidisciplinary team used teleconferencing to involve a family member in the patient's care and treatment and discharge planning. The consultant psychiatrist explained to the family member how they would liaise with community mental health services to ensure they received appropriate support when the patient was discharged.

Patients could use a lap top with video to contact their families.

Are acute wards for adults of working age and psychiatric intensive care unit services responsive to people's needs? (for example, to feedback?)

Good 🟢

Access and discharge

Bed management

Acute wards for adults of working age and psychiatric intensive care units

Good ●

The service planned all admissions and discharges. Admissions and discharges took place at an appropriate time of the day.

Staff managed beds well. The service admitted patients from across the UK. At the time of the inspection Hooper Ward only had 10 patients admitted. This was because the manager did not want more than four patients on one-to-one observations due to risk. The average length of stay was four to six weeks.

Discharge and transfers of care

Patient discharge was rarely delayed for other than clinical reasons. The service did not have any delayed transfers of care. Discharge planning was included in the standard template used at the ward round. The template was emailed to the patient's care coordinator to ensure that transfers of care could be planned.

Facilities that promote comfort, dignity and privacy

The design, layout, and furnishings of the service supported patients' treatment, privacy and dignity. Patients had their own bedrooms which they could personalise and keep locked so that their possessions were safe.

The service had a suitable range of rooms, for example, a clinic room, and a multidisciplinary room. There was a secure and pleasant courtyard garden, which patients could use. Therapy rooms and visitor rooms were located close to the ward. The provider had a schedule of improvements to the ward, which was in progress.

At the time of the inspection there was only one working shower. The other shower was out of commission and staff were unsure when it would be in use again. However, at the time of the inspection the ward was not full and the managers assured us they would get the shower fixed as soon as possible.

Patients were able to use phones loaned by the service to make calls in private.

Patients told us that food was of a good quality.

There was a rota of activities for patients that covered the whole week. A whiteboard was used to publicise the day's activities. Patients told us they enjoyed the activities which included arts and crafts, cookery and pampering sessions.

Patients' engagement with the wider community

Staff made sure patients had access to opportunities for education and work, and supported patients. The on-site recovery college offered educational courses about mental health and recovery, which were designed to increase knowledge and skills to promote self-management.

Meeting the needs of all people who use the service

The service met the needs of all patients who used the service, including those with a protected characteristic. The service was ground level-access and subject to risk assessment could accommodate the needs of patients with physical disabilities.

Staff could access interpreters if required. Patients had a choice of food which meet their diverse dietary requirements.

Staff made sure that patients had access to appropriate spiritual support. The hospital arranged for a chaplain to visit. Staff supported patients to attend churches and religious groups in the community.

Listening to and learning from concerns and complaints

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team and wider service. Patients knew how to complain and felt able to do so. When patients were admitted to the service, they signed to say they knew and understood the complaints process. Staff displayed this information on the noticeboards.

Staff told us that information from complaints was used to improve the service. For example, some complaints were about lost property. Consequently, managers reminded staff to make an inventory of the patient's property. In addition, the ward now had a designated property room with lockers for patients to use.

Managers handled complaints appropriately, but improvements needed to be made to their timeliness. The general manager kept a log of all formal and informal complaints. Records showed the managers discussed complaints with staff at their monthly team meetings and shared any learning that had resulted. The service knew they had further work to do on improving their response times. For example, the hospital clinical governance meeting reported that 19 of the 29 complaints about the service received I July 2019 to 30 September 2019 had not

Acute wards for adults of working age and psychiatric intensive care units

Good ●

been responded to within the provider's 20-day target. This meant complaints were not responded to promptly, so the complainant can proceed with their complaint in a timely way.

Are acute wards for adults of working age and psychiatric intensive care unit services well-led?

Good ●

Leadership

The service was well-led. The ward manager post was vacant. At the time of the inspection, a senior manager with appropriate skills, experience and qualifications was acting as the ward manager. A new ward manager with experience of working in a psychiatric intensive care unit had been recruited. They were due to start work at the service the week after the inspection.

The service had recently invested in strengthening their senior leadership team. This included permanent consultant psychiatrists (for each ward), leads for psychology, safeguarding and occupational therapy as well as a new medical director.

Staff told us that the new consultant psychiatrist for the ward, who had been in post for a month, had made positive changes in terms of the way the ward round operated. Staff said managers were present in the service, talked with patients and staff and were fully aware of what was happening in the service. Patients said knew the managers and told us they could easily speak with them to raise any concerns.

Vision and strategy

Staff understood and implemented the provider's vision and values and put these into practice. The provider's vision is 'to provide high quality care for all who use our services'.

Staff were able to explain how they put into practice the provider's values of compassionate care, respect, empowerment and trust. The service had recently implemented a value–based recruitment programme, which centred the recruitment application and assessment on the service's new collaborative objectives.

Culture

Staff felt respected, supported and valued by their team and the provider. They said they were proud to work in the service and working relationships were friendly and positive. Staff said they would have no hesitation in raising any concerns about the service.

Staff completed an annual survey in 2018. The results showed that 22% of staff felt that the Pay and Reward system was not transparent, and they were disadvantaged. For example, they should be paid be paid London weighting. Most staff (92%) felt that there should be more opportunities for specialist training to develop in their role. Managers listened to staff and completed an action plan from their feedback to improve their experience.

Staff told us they considered there was equality of opportunity and they were supported with their career progression. The provider celebrated staff success and operated a staff awards scheme.

Managers told us that they could access support from the provider to manage any areas of poor staff performance.

The service's sickness rate was similar to the provider target.

Governance

Our findings from the other key questions demonstrated that governance processes were effective at ward level and that performance and risk were managed well. For example, managers checked incident reports to ensure that, when appropriate, there had been a de-brief with the patient and staff involved. The data collected was used as a key performance indicator, which was monitored at a monthly hospital-wide clinical governance meeting and at board meetings.

However, during the inspection we identified that the provider's governance processes for medicines management needed further work. We found a medicines error, that could have had serious consequences for a patient, that should have been picked sooner so that staff could identify actions and make improvements, to prevent it being repeated.

The service had a monthly staff meeting and a monthly business meeting. These meetings were well-organised and with standard agendas. Records were kept of issues raised and planned actions. Learning from incidents,

safeguarding alerts and complaints was routinely discussed at staff meetings. Staff told us that meetings were well-run and informative, and they were emailed a copy of the minutes, so they were kept informed if they were unable to attend the meeting.

The hospital-wide clinical governance meeting reviewed performance across key aspects of care and treatment. For example, the meeting reviewed compliance with the provider's schedule of audits and checked that audit findings were actioned at ward-level to improve the quality of the service.

Staff had implemented recommendations from reviews of deaths, incidents, complaints and safeguarding alerts at the service level. Staff across the service had reported an increase in safeguarding incidents between June – September 2019 relating to patients alleging that staff had physically or verbally assaulted them. Eight safeguarding incidents of this kind were reported during this period. Each allegation was raised by either staff members on the ward or by the patient. The senior team attributed this to several varying factors, including lack of management oversight on Hooper Ward over the summer. The ward now has a permanent ward manager in post. Managers investigated these allegations and reported them to the police. Across the hospital two of these incidents were substantiated and as a result the staff members involved were dismissed. The service had improved their safeguarding systems by strengthening the safeguarding leadership and empowering staff and patients to speak up if they had concerns. In addition, each ward has a permanent consultant psychiatrist in post to provide clinical leadership and oversight to staff.

Management of risk, issues and performance

The managers used systems to identify, understand, monitor, and reduce or eliminate risks that were mostly effective. They ensured risks were dealt with at the appropriate level. The service had a local risk register, which the manager added to when needed. Risks included the management of ligature points and illicit substances entering the service. The hospital manager said the top challenge for the service was staff recruitment and retention.

The service had a recruitment initiative in place to support with the recruitment of new staff. For example, one of the biggest challenges to recruitment was staff salaries and the comparison to other services.

The provider ensured they carried out the necessary checks on staff prior to employment. We checked the personnel files of ten staff across the service and found that each had appropriate checks in place. This included two references from a previous employer to check an employee's experience and skills to carry out their job role. The service had systems in place to check that all staff received a criminal record check. This ensured new staff were suitable to work with patients in the service.

The service had plans for emergencies. Business continuity plans covered a range of scenarios such as a terrorism bomb threat or a no deal Brexit.

Information management

Staff said they had access to up to date information from the provider. Staff had received training on data security and confidentiality. The service collected reliable information and analysed it to understand performance and to enable staff to make decisions and improvements. The service had a dashboard that held pertinent data about the service, for example, discharges and length of patient admissions.

The information systems were integrated and secure. Information was recorded in a combination of an electronic record system and paper records. Staff completed serious incident records on paper, the ward clerk then copied out the completed incident report into the electronic system.

The service notified the Care Quality Commission of notifiable incidents, including incidents involving the police.

Engagement

Staff asked patients and carers to give feedback on the service at ward rounds, community meetings and through surveys and questionnaires. The managers used the feedback from surveys to make improvements. Patients completed a satisfaction survey each quarter. The most recent results showed that 11% of patients felt that their overall care at the service was excellent and 33% felt that is was good. Most patients (56%) felt safe at the service

Acute wards for adults of working age and psychiatric intensive care units

Good ●

sometimes and 56% felt they were sometimes involved in their care and treatment with 44% saying they always felt involved. Staff listened to patients and used their feedback to improve the service.

Patients and carers were involved in decision-making about changes to the service. For example, patients had been involved in recruitment panels to interview prospective new staff. In addition, the service produced a quarterly newsletter co-produced with patients for patients. This included what projects were going on within the service and individual patient stories. Staff and patients attended the provider's National Service User Awards 2019 in the summer.

The lead occupational therapist had recently launched a Working Together group to involve families and carers in their loved one's care. Part of the group was holding regular carers forums and producing a newsletter with families. However, this was relatively new and still needed to embed across the hospital.

The service collaborated with partner organisations to help improve services for patients. Staff worked hard to improve effective communication with other professionals involved in the patients care such as, community mental health teams and social workers. This would ensure that staff worked with others to provide consistent care and treatment for patients.

Staff said the provider kept them well-informed through various forms of communication and senior managers visited the service to talk with staff and patients.

Learning, continuous improvement and innovation

The service has achieved accreditation from the National Association of Psychiatric Intensive Care Units and the Royal College of Psychiatrists.

Forensic inpatient or secure wards

Good 🟢

Safe	**Requires improvement** 🟠
Effective	**Good** 🟢
Caring	**Good** 🟢
Responsive	**Good** 🟢
Well-led	**Good** 🟢

Are forensic inpatient or secure wards safe?

Requires improvement 🟠

Safe and clean care environments

Safety of the ward layout

Bewick Ward environment was safe. Staff carried out regular risk assessments of the environment. This included an annual review of fire safety. The service used an external health and safety company to carry out checks on fire safety and produce an action plan. The service last had an inspection in September 2019 and was working on the actions set out from the assessment. In addition, the local fire brigade carried out an unannounced inspection in May 2019. Patients who needed them (low mobility), had a personal emergency evacuation plan to follow in the event of a fire or other emergency.

Staff could observe patients in all parts of the wards. The ward had installed convex mirrors and closed-circuit television (CCTV) cameras throughout the communal areas on the ward to allow better observation by staff.

Staff knew about potential ligature anchor points and mitigated the risks to keep patients safe. A ligature anchor point is an environmental feature or structure, which patients may use to fix a ligature with the intention of harming themselves. A ligature risk map was on display in the nursing office. The ligature risk assessment was in date and staff were knowledgeable about ligature risks present on the ward. During a tour of the ward we identified two ligature risks that were present in a bedroom, although the bedroom was not in use at the time of the inspection. The ward manager was made aware of this and the room was repaired immediately.

Staff had easy access to alarms. Alarms were allocated at the beginning of each shift. An emergency nurse call system was in place to summon support from other wards when this was required. When activated, the alarms sounded throughout the wards. The ward had an electronic panel, which alerted staff to where the alarm had been activated. There were no call buttons in patients' bedrooms. This meant that it might be difficult for patients to seek assistance if they were unable to leave their bedroom. Staff mitigated this for one patient who had low mobility by placing an alarm call bell in their bedroom and would do so for other patients that needed it.

Maintenance, cleanliness and infection control

The ward environment was clean overall, and the standard of decoration was good throughout.

Cleaning records were up to date and demonstrated that the ward areas were cleaned regularly. Cleaning records included a list of tasks to be completed each shift. Housekeeping staff signed the form to confirm that these tasks had been completed.

Staff adhered to infection control principles, including handwashing. Guidance and information about handwashing was displayed for staff and visitors to follow. The ward conducted an infection control audit on a monthly basis.

Seclusion room

Forensic inpatient or secure wards

The ward did not contain a seclusion room but did have a de-escalation room. Staff said that the de-escalation room was rarely used, and its primary use was as a room for searching patients returning from leave.

Clinic room and equipment

The clinic room was fully equipped, with accessible resuscitation equipment and emergency drugs that staff checked regularly. Staff completed records to check the emergency bags on a weekly basis.

Staff checked, maintained and cleaned equipment. Medical equipment appeared to be clean although staff did not consistently label medical equipment with the date of the last clean. Equipment such as weighing scales, an oximeter and a digital thermometer were missing labels to indicate they were clean at the time of inspection.

Safe staffing

Nursing staff

Although the ward had several vacancies for registered nurses, there was enough staff who knew the patients and received suitable training to keep patients safe from avoidable harm. The ward had multiple nursing vacancies, there were five nursing vacancies at the time of inspection out of an establishment of nine nurses. These vacancies were filled by agency nurses, the agency nurses were familiar with the service. The manager completed a block booking of agency staff to ensure continuity on the ward. Long term agency staff received bi-monthly supervision from managers on the ward.

Managers had calculated the number and grade of nurses and healthcare assistants required to keep patients safe. The ward operated two nursing shifts each day. During the day there were two registered nurses and two health care assistants working on the ward. There was also a security nurse present on each shift who was responsible for monitoring and carrying out security procedures. We reviewed the staffing rotas for October 2019 and found there were enough staff to meet requirements.

Managers made sure all bank and agency staff had a full induction and understood the service before starting their shift. New agency staff were required to complete an induction checklist before starting on the ward. The induction checklist required staff to be familiar with the medical emergency procedure, location of fire alarms, security procedures and the clinic room.

During the inspection we always observed a qualified nurse was present in the communal areas of the ward.

Managers supported staff who needed time off for ill health. Between 1 August 2018 and 31 July 2019, the ward had a sickness rate of 3%.

Staffing levels allowed patients to have regular one-to-one time with their named nurse. Patients that we spoke with said that they regularly met their named nurse.

Staff shortages rarely resulted in staff cancelling escorted leave. However, one patient that we spoke to said nurse-led activities would sometimes be cancelled due to staff shortages.

The ward had enough staff on each shift to carry out any physical interventions safely. Staff could call colleagues from other wards to assist with physical interventions if necessary.

Staff shared key information to keep patients safe when handing over their care to others. Staff held nursing handovers at the start and end of each shift. The multidisciplinary team reviewed patients at a meeting each morning.

Medical staff

The service had enough daytime and night time medical cover and a doctor available to go to the ward quickly in an emergency.

Mandatory training

The compliance for mandatory and statutory training courses at July 2019 was 95%.

All relevant staff had completed training in preventing and managing violence and aggression, relational security, basic and intermediate life support, and safeguarding.

Assessing and managing risk to patients and staff

Assessment of patient risk

Staff used a recognised risk assessment tool to assist their evaluations of patients' individual risks. We reviewed the records of four patients and found that detailed risk assessments had been carried out on admission by a registered nurse or the ward doctor. These assessments were frequently updated and included clear information about current risks. A wide range of actual and potential risks were recorded including those relating to self-harm,

Forensic inpatient or secure wards

suicidal thoughts and violence towards staff. Risk management plans included details of how these risks were to be managed in a way that was specific to the individual needs and preferences of the patient. In addition, the service completed, or updated a historical clinical risk management assessment, known as an HCR-20, in the first three months of admission. The HCR-20 form documented the patient's forensic history in detail.

Management of patient risk

Staff knew about any risks to each patient and acted to prevent or reduce risks. They recorded the risks for each patient in the initial risk assessment and reviewed these at the daily multidisciplinary team meeting.

The ward had a security nurse on duty for each shift. The security nurse was responsible for monitoring and carrying out security procedures. This included checking the security of the ward environment and searching

Staff displayed excellent relational security; they took full account of individual patient need when they compiled risk management plans. Relational security was reviewed in monthly team meetings. Relational security is the knowledge and understanding staff have of a patient and of the environment, and the translation of that information into appropriate responses and care.

Staff identified and responded to any changes in risks to, or posed by, patients. Staff identified triggers to heightened risk through observations and discussions with patients. Staff reviewed each patient's presentation daily. If the patient presented an increasing risk staff would review the patient's treatment. Staff could also increase the frequency of observations and restrict leave from the ward.

Staff used a nationally recognised tool to identify deteriorating patients but did not always escalate or score them appropriately. Staff on the unit used a modified early warning score (MEWS) to identify deteriorating patients. MEWS is a simple scoring system based on regular observations of patients' blood pressure, respiratory rate, oxygen saturation, temperature and pulse rate, which are then used to calculate a score indicating the severity of a patient's physical health concern. We reviewed eight MEWS charts; two out of eight charts showed that staff had not recorded whether they had escalated high scores that indicated emergency services should be called. Staff explained that these patients were reviewed by the ward doctor but there was no documentation indicating that this

had happened. For one patient, their prescription chart indicated that they should have daily checks of their vital signs, but these were not always happening. The MEWS chart indicated there should be weekly physical health checks for this patient, which contradicted the daily observations required in the prescription chart. There was a risk that this could impact the clinical team's ability to identify deteriorating patients.

Staff followed the provider's policies and procedures when they needed to search patients or their bedrooms to keep them safe from harm. The security nurse was responsible for searching patients when they returned from unescorted leave. All staff had received security training to conduct searches safely and effectively. A search room was located off the ward and had recently been created due to issues with contraband coming onto the ward.

Staff applied blanket restrictions on patients' freedom only when justified. Patients who had been risk assessed as safe to access a mobile phone on the ward could have one.

Staff adhered to best practice in implementing a smoke-free policy. Patients could purchase e-cigarettes on the ward.

Use of restrictive interventions

Staff achieved the right balance between maintaining safety and providing the least restrictive environment possible in order to facilitate patients' recovery. This service had eight incidences of restraint between 1 February 2019 and 31 July 2019. Episodes of restraint were recorded in detail in incident reporting forms. Details included the duration of each position of restraint, the type of restraint and which staff members were present during the restraint. There were no incidences of prone restraint, between 1 February 2019 and 31 July 2019.

Staff participated in the provider's restrictive interventions reduction programme, which met best practice standards. The service was a member of the restraint reduction network and had locally introduced reducing restrictive practice champions on each ward.

Staff made every attempt to avoid using restraint by using de-escalation techniques and restrained patients only when these failed and when necessary to keep the patient or others safe. Staff across the service received training in

Forensic inpatient or secure wards

de-escalation techniques. Staff also received training in the use of restraint and had a good understanding of ensuring that restraint was used as a last resort after verbal de-escalation had been tried.

Staff understood the Mental Capacity Act definition of restraint and worked within it. Records showed that staff restrained a patient because it was necessary to prevent harm to the patient. Records also showed that this was a proportionate response to the likelihood and seriousness of that harm.

Staff did not always follow National Institute for Health and Care Excellence (NICE) guidance when using rapid tranquilisation. We reviewed four incidents of intramuscular rapid tranquilisation on Bewick Ward. Two out of four records showed that staff did not record the physical health observations after administering rapid tranquilisation. This meant that staff may not have been able to intervene quickly if the patient was experiencing adverse effects of the medicine. However, two records showed that staff recorded physical observations when the injection was administered. Staff made further attempts to take the patients pulse, blood pressure, temperature and oxygen saturation in line with national guidance.

Staff did not use seclusion to manage patients behaviours. There was no seclusion room at the hospital.

Safeguarding

Staff were trained in safeguarding, knew how to make a safeguarding alert, and did that when appropriate. Overall, 94% of staff had completed training in safeguarding individuals at risk. We spoke with five members of staff about safeguarding. All of the staff said they felt confident in managing safeguarding situations.

The ward had two safeguarding leads on the ward, staff had recently received training about how to document safeguarding referrals. The safeguarding team were improving their practice in safeguarding awareness through regular training and workshops for staff. Potential safeguarding alerts were discussed at team meetings, handovers and in clinical supervision. Staff said that they would contact the safeguarding leads or the social worker within the service if they required safeguarding advice. The lead social worker for the service had recently led a discussion about a recent safeguarding case with the ward staff at a team away day.

Staff could give clear examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act.

Staff knew how to recognise adults and children at risk of or suffering harm and worked with other agencies to protect them. Staff discussed safeguarding daily as part of their handovers and daily multidisciplinary meetings. Staff worked closely with external agencies to ensure patients were appropriately protected from harm or abuse.

Staff followed clear procedures to keep children visiting the hospital safe. When children visited patients, they met in a specifically designated room in the hospital that was not on the ward.

Staff access to essential information

Patient notes were comprehensive, and all staff could access them easily. Although the service used a combination of electronic and paper records, staff made sure they were up-to-date and complete. However, the incident reporting system required information to be recorded on several documents. There was a separate paper-based document to be used for incidents, restraint, rapid tranquilisation and physical observations could also be recorded on separate physical health charts.This meant staff could not easily access all patient information in a timely manner.

Records were stored securely. Staff could only access the electronic record system using a personal log-in and password.

Medicines management

Staff followed systems and processes when safely prescribing, administering, recording and storing medicines. Staff recorded the temperatures at which medicines were stored. Records showed that these temperatures were within the required range. Staff disposed of medicines in a designated bin. Needles and other sharp items were disposed of in a sharps bin.

Staff reviewed patients' medicines regularly and provided specific advice to patients and carers about their medicines. Patients were able to meet with a pharmacist if they had questions about their medication.

Track record on safety

The service had a good track record on safety.

Forensic inpatient or secure wards

Between 1 August 2018 and 31 July 2019, there had been 11 serious incidents on Bewick Ward categorised as serious incidents using the providers guidance.The most common type of incidents was patients going absent without leave, incidents of self-harm and incidents of contraband being brought onto the ward.

Reporting incidents and learning from when things go wrong

All staff knew what incidents to report and how to report them. All staff said they were familiar with incident reporting. Staff said they would report anything that was harmful, potentially harmful or unsafe. Guidance on reporting incidents was displayed in the nurses' office.

Staff reported serious incidents clearly and in line with provider policy. Staff on the ward reported incidents such as self-harm, an information breach, patients going absent without leave and allegations of abuse.

Staff understood the duty of candour. They were open, transparent and gave patients and families a full explanation if and when things went wrong. All staff we spoke with had a good understanding of the duty of candour. This duty of candour requires staff to provide people who use services with reasonable support, truthful information and an apology when things go wrong.

Managers debriefed and supported staff after any serious incident. A psychologist facilitated reflective practice sessions with staff. During these sessions staff reflected on incidents that had happened on the ward. Following a serious incident on the ward staff said they had been sent a fruit hamper from the senior leadership team. The ward manager would call staff regularly to have a wellbeing check in following serious incidents

Staff met to discuss the feedback and look at improvements to patient care. Feedback and possible improvements would be discussed at monthly team meetings and during monthly supervision.

There was evidence that changes had been made as a result of feedback. The introduction of a search room off the ward had been introduced due to issues with contraband coming onto the ward. Staff told us that they felt this was working well and had helped reduce issues with contraband coming onto the ward.

Managers shared learning with their staff about never events that happened elsewhere. A lessons learnt folder was located in the nurses' office. This folder contained information about lessons learnt within the service and from NHS organisations. For example, following an incident at an NHS organisation changes had been made to the showers on the ward.

Are forensic inpatient or secure wards effective?
(for example, treatment is effective)

Good ●

Assessment of needs and planning of care

Staff completed a comprehensive mental health assessment of patients in a timely manner at, or soon after, admission. We reviewed the records of four patients. All the patient records we reviewed showed that staff had completed a comprehensive assessment of the patient's mental health on the day of admission. Assessments included details of the reason for admission, past medical history and details of the patient's social circumstances.

Staff assessed and supported patients with their physical health needs and worked collaboratively with specialists when needed. Comprehensive physical assessments were completed and plans for on-going monitoring of health conditions and healthcare investigations were developed. This included close and regular monitoring of blood samples, heart rate, pulse, urine tests, temperature, weight monitoring and electrocardiogram (ECG).

Staff developed a comprehensive care plan for each patient that met their mental and physical health needs. The provider separated care plans into specific domains, for example, "staying healthy", "moving on" and "life skills". Staff worked collaboratively with patients to review warning signs and triggers for distressed behaviour. Care plans contained goals for the patient and multidisciplinary team members. Patients were clear about their care plans and goals for recovery when we spoke with them.

Staff updated care plans when necessary. All care records we reviewed had been updated in the last three months.

Forensic inpatient or secure wards

Care plans were personalised, holistic and recovery orientated. We saw examples of care plans that clearly recorded the patients' views and showed consideration of their strengths and preferences.

Best practice in treatment and care

Staff provided a range of care and treatment interventions suitable for the patient group. The interventions were those recommended by, and were delivered in line with, guidance from the National Institute for Health and Care Excellence (NICE).

Care plans showed that the service provided psychological therapies in accordance with NICE guidance. These therapies included cognitive behaviour therapy, dialectical behaviour therapy, speech-language therapy and cognitive analytic therapy.

Patients had access to a variety of treatment groups. These groups included violence reduction, enhanced thinking skills, emotion regulation and reasoning and rehabilitation. Patients also had access to inter-ward groups. These groups included fortnightly walking football, social club and yoga. Patients that we spoke with were positive about the groups and activities provided on the ward.

Staff identified patients' physical health needs and recorded them in their care plans. Doctors carried out a full medical examination of each patient when they were admitted to the ward. A ward doctor, or an on-call doctor based on-site, could see patients at any time. Staff supported patients to attend the general hospital if they required specialist care and treatment. Patients were registered at a local GP and were supported to access local opticians and dentists.

Staff met patients' dietary needs and assessed those needing specialist care for nutrition and hydration. The ward could refer patients to a dietitian when appropriate.

Staff helped patients live healthier lives by supporting them to take part in programmes or giving advice. The service facilitated walks, yoga and exercise groups at the service's onsite gym for patients. Patients could attend fortnightly walking football and fortnightly swimming groups. Patients could also participate in a weekly smoothie making group.

Staff used recognised rating scales to assess and record the severity of patients' conditions and care and treatment outcomes. The ward used health of the nation outcome scales to measure patient outcomes. The ward psychologist also used patient reported outcome measures (PROMs) and clinician reported outcome measures (CROMs) to measure treatment outcomes.

Staff participated in a range of clinical audits. These included an audit of record keeping, one to one contact and checking section 17 leave forms.

Skilled staff to deliver care

The ward team included or had access to the full range of specialists required to meet the needs of patients on the ward. The staff team on Bewick Ward included nurses, nursing assistants, a consultant psychiatrist, a specialist doctor, psychologist, occupational therapist and a social worker. A dietitian worked across all four wards at the hospital.

Managers ensured staff had the right skills, qualifications and experience to meet the needs of the patients in their care, including bank and agency staff. Some of the staff we interviewed had worked within the service for several years, whereas others were newly appointed.

Managers gave each new member of staff a full induction to the service before they started work. Staff completed an induction checklist covering policies and procedures, health and safety and performance management. We spoke to two new staff members who told us their inductions had been supportive and thorough.

Managers supported staff through regular, constructive appraisals of their work. At the end of last year (1 August 2018 and 31 July 2019), the overall appraisal rate for non-medical staff on the ward was 90%.

Managers provided staff with supervision. These meetings covered safeguarding, wellbeing check in, incidents and discussions about career development. All staff had received clinical supervision between 1 August 2018 and 31 July 2019. Staff that we spoke to said they felt well supported by their managers.

Managers facilitated regular team meetings and gave information to staff that could not attend. At each meeting they discussed incidents, lessons learned from investigations and staff received reminders about compliance with policies such as searches and the dress policy.

Forensic inpatient or secure wards

Staff had undertaken additional specialist training. Ward staff had received training in dialectical behaviour therapy, positive behaviour support, understanding personality disorders and motivational interviewing.

Managers dealt with poor staff performance promptly and effectively. If there were concerns about a member of staff, or the member of staff was not complying with policy and procedure, the manager would discuss this with them.

Multi-disciplinary and interagency team work

Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care. The ward teams had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation.

Staff shared information about patients at effective handover meetings within the team. Nursing staff held handover meetings at the start of each shift. A multidisciplinary team (MDT) handover would also take place every morning. During the inspection we attended an MDT handover, during the handover staff shared information about each patient's mental and physical health and whether additional care and support was needed. During the handover there was input from all members of the MDT.

Ward teams had effective working relationships with external teams and organisations. The forensic service worked with colleagues in the North London Consortium. Patients were registered at a local GP practice and staff would assist patients with booking and attending appointments.

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

Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice and discharged these well. As of 31 July 2019, 95% of staff had received training in the Mental Health Act.

Staff had access to support and advice on implementing the Mental Health Act and its Code of Practice. Staff knew who their Mental Health Act administrator was and when to ask them for support. The Mental Health Act administrator would inform the ward if a patient's section was due to expire or they needed their rights to be explained.

The service had clear, accessible, relevant and up-to-date policies and procedures that reflected all relevant legislation and the Mental Health Act Code of Practice.

Patients had easy access to information about independent mental health advocacy and patients who lacked capacity were automatically referred to the service. An independent mental health advocate regularly visited the ward and contact details were displayed on the ward notice boards.

Staff explained to each patient their rights under the Mental Health Act in a way that they could understand, repeated as necessary and recorded it clearly in the patient's notes each time. Staff attempted to explain patients their rights on a monthly basis. In one record we reviewed it was not clear that a patients' rights had been explained on admission to the ward.

Staff made sure patients could take section 17 leave (permission to leave the hospital) when this was agreed with the Responsible Clinician and with the Ministry of Justice (for those on a Ministry of Justice restriction). Patients told us that leave was rarely cancelled.

Staff stored copies of patients' detention papers and associated records correctly and staff could access them when needed. We reviewed four records on inspection and all copies of detention papers were stored correctly and were accessible.

Staff completed regular audits to ensure that the MHA was being applied correctly and there was evidence of learning from those audits. The MHA administrator carried out a weekly audit to ensure all patients were legally detained under the MHA. Based on the findings of the audit the service manager would implement an action plan for areas that required improvement. The audit was also discussed in the audit committee and clinical governance meeting.

Good practice in applying the Mental Capacity Act

Staff supported patients to make decisions on their care for themselves. Staff received, and were up-to-date with, training in the Mental Capacity Act and had a good understanding of the five principles. As of 31 July 2019, 95% of staff had received training in the Mental Capacity Act.

There were no deprivation of liberty safeguards applications made in the last six months.

Forensic inpatient or secure wards

There was a clear policy on Mental Capacity Act and deprivation of liberty safeguards, which staff could describe and knew how to access.

Staff knew where to get accurate advice on the Mental Capacity Act (MCA) and deprivation of liberty safeguards. The Mental Health Act administrator provided advice to staff on the MCA when required.

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

A doctor and nurse assessed each patient's capacity to consent to admission and treatment when patients were admitted. Staff updated these assessments when it was appropriate. Staff recorded assessments of patients' capacity to consent to treatment and stored these in the patient's records.

The service had arrangements to monitor adherence to the MCA. Staff discussed issues relating to patients' capacity during clinical meetings and handover meetings, where relevant.

Are forensic inpatient or secure wards caring?

Good ⬤

Kindness, privacy, dignity, respect, compassion and support

Staff attitudes and behaviours when interacting with patients showed that they were discreet, respectful and responsive, providing patients with help, emotional support and advice at the time they needed it. Positive and caring relationships were developed between patients and staff. We observed that staff were kind, warm and friendly with patients and were genuinely concerned for their wellbeing.

Staff supported patients to understand and manage their own care treatment or condition. For example, the multidisciplinary teams talked to patients about their conditions at regular meetings.

Staff directed patients to other services and supported them to access those services if they needed help. Staff signposted patients to other services and supported them in accessing those services if necessary.

Patients said staff treated them well and behaved kindly. Patients we spoke to were generally positive about the staff on the ward and felt they were caring and supportive. Patients told us staff were busy but did make an effort to spend time with them. Patients told us that staff treated them with respect and dignity.

Staff had a good understanding of patients' individual needs. We saw staff talking with patients throughout the day. During these conversations, staff showed that they knew about patients' interests, their families, their care and treatment plans and the activities they enjoyed.

Staff told us there was an open culture within the staff teams and they were confident in raising any concerns about disrespectful, discriminatory or abusive behaviour without fear of the consequences.

Staff helped families to give feedback on the service. Staff encouraged families and carers to complete feedback questionnaires.

Involvement in care

Involvement of patients

Staff involved patients in care planning and risk assessment and actively sought their feedback on the quality of care provided. Staff introduced patients to the ward and the services as part of their admission. Staff gave patients information about the activities and routines on the ward during the admission process.

Staff involved patients and gave them access to their care planning and risk assessments. Patients reported that they contributed to discussions about their care plan during 1:1 time with their named nurse and ward rounds.

A daily planning meeting took place on each ward to discuss the programme for the day which included activities, visits, medical appointments and attending various therapies. This daily planning meeting was chaired by a patient.

Staff supported patients to understand their mental health issues and to take responsibility for managing their health

as far as possible. For example, one patient was provided with easy read labels for their medication.Another patient had been supported to develop their independence and administer their own medication.

Staff involved patients in decisions about the service, when appropriate. Patients had been involved in recruitment panels to interview prospective new staff.

Patients could give feedback on the service and their treatment and staff supported them to do this. Community meetings were held on a fortnightly basis, patients told us that they felt listened to and changes were made following the meetings. For example, patients complained about staff handovers taking place in the dining room because they would like 24-hour access to the dining room. Handovers were moved in response to this feedback to either the nursing office or a room off the ward. Patients were supported to complete a service user satisfaction survey.

The service had a patient council, there was a patient representative from each ward on the patient council. Meetings were held monthly and feedback from these meeting were shared at community meetings on each of the wards. Patients discussed hospital projects such as 'Dragons Den', social activities and reducing restrictions on the wards. The patient council acted as a link between the patient group and senior leaders within the service.

Patient involvement in activity and therapy groups was encouraged by ward staff. The ward had a wall of fame chart, that mapped out each patients' monthly group attendance. Patients would receive rewards, such as shopping vouchers, for achieving high levels of group attendance.

Staff made sure patients could access advocacy services. Details of how to contact the advocate was displayed throughout the ward. In the latest patient satisfaction survey 100% of respondents reported that they knew how to make a complaint and were aware of the advocacy service.

Involvement of families and carers

Staff informed and involved families and carers appropriately and provided then with support when needed. Family and carers were invited to ward rounds and CPAs with the patient's permission. Patients' relationships with family members were discussed at daily

meetings.Care records showed there was a high level of family and carer involvement. However, for one patient the level of family involvement was not documented in detail. The care plan only briefly mentioned the patient's family and friends. However, during discussions with staff, they showed that the patient's family were heavily involved.

Staff helped families to give feedback on the service. Family and friends were able to complete a friends and family survey. In the latest survey 77% of carers reported feeling satisfied that the hospital catered to their specific needs as a carer and 87% reported feeling satisfied that staff were polite and approachable when phoning and when visiting patients. A carers forum was also available for friends and family to attend.

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

Good 🟢

Access and discharge

Bed management

The service planned all admissions and discharges. Admissions and discharges took place at an appropriate time of the day.Referrals came from the North London Consortium. The North London Consortium is made up of five local NHS trusts.

Staff planned and managed discharge, and the flow of patients through the ward, well. Bed occupancy on the ward was 74% between 1 February 2019 and 31 July 2019.

The average length of stay of patients discharged between 1 February 2019 and 31 July 2019 was 416 days.

Facilities that promote comfort, dignity and privacy

The design, layout, and furnishings of the ward/service supported patients' treatment. Patients had their own bedrooms and were not expected to sleep in bed bays or dormitories. Bedrooms were large, fitted with good quality furniture and had ensuite facilities. Patients could personalise bedrooms.Many patients chose to display personal belongings and family photographs.

Forensic inpatient or secure wards

Patients had somewhere secure to store their possessions. Patients could lock their bedroom doors to ensure their possessions were secure,

The ward was clean and well maintained. The service provided a full range of rooms for patients to use including a lounge, dining room and quiet room. Patients had access to a computer that was in the therapy room.

There were quiet areas on the ward and a room where patients could meet visitors.

Patients could make a phone call in private. Patients had access to their own mobile phones and could also use the ward phone. Patients could make phone calls in their bedrooms if they required privacy.

Patients had access to outside space. The walk and talk group occurred twice a week. This group was facilitated by the ward staff and ward doctor. The group would walk around the local area and informal discussions could take place between staff and patients.

The food was of a good quality. The dietitian had recently attended a community meeting as there had been negative feedback about the food. Patients were asked to complete regular surveys about the quality of food. In the latest patient satisfaction survey 92% of respondents reported satisfaction with the food.

Patients had access to hot drinks and snacks 24 hours a day.

Patients' engagement with the wider community

Staff made sure patients had access to opportunities for education and work, and supported patients. One patient was paid for chairing the daily planning meeting and another was responsible for collecting magazines from the local shop for the ward. Patients could access the recovery college. The recovery college offered educational courses about mental health and recovery, which were designed to increase knowledge and skills to promote self-management. Patients were also supported on trips off the ward such as visiting a local farm or the local library.

Staff supported patients to maintain contact with their families and carers. Most patients maintained contact with their families throughout their admission through visits or telephone conversations.

Meeting the needs of all people who use the service

The service could support and make adjustments for disabled people and those with communication needs or other specific needs. The ward was situated on the first floor of the hospital. A lift from the ground floor allowed step free access for patients and visitors who had limited mobility. Easy read signs were present throughout the ward. Easy read is a way of presenting written information to make it easier to understand for people with difficulty reading.

Staff made sure patients could access information on treatment, local service, their rights and how to complain. Staff displayed information about treatments, patients' rights and advice on how to complain on notice boards on the ward. The hospital displayed information about its performance on a large notice board near the entrance.

The service could provide interpreters for patients whose first language was not English.

Patients had a choice of food to meet the dietary requirements of religious and ethnic groups. All food was prepared and cooked on-site and could be made according to specific needs and preferences.

Staff made sure that patients had access to appropriate spiritual support. The hospital arranged for a chaplain to visit. Staff supported patients to attend churches and religious groups in the community.

Staff considered patients' cultural, equality and diverse needs to support their recovery. For example, staff supported patients with their spiritual needs. Staff were supportive of patients who were LGBT+.

Listening to and learning from concerns and complaints

The service treated concerns and complaints seriously, investigated them and learned lessons from the outcomes. Between July – September 2019, the service overall received 29 complaints. Eight of these complaints we upheld and four were partially upheld. Patients complained about their care and treatment or staff attitudes.

Patients knew how to complain and felt able to do so. When patients were admitted to the service, they signed to say they knew and understood the complaints process. Staff displayed this information on the noticeboards.

Forensic inpatient or secure wards

Good ●

When patients complained, staff provided them with feedback from investigations. We looked at four complaint investigations across the service. The manager wrote to the patient and verbally discussed the outcome with them. Records showed that patients received support from staff in a timely way after they complained. The service had recently implemented a complaint outcome satisfaction survey, which was sent out to all complainants following the outcome of their complaint to monitor how satisfied they were with how their complaint was handled and resolved.

Managers handled complaints appropriately, but improvements needed to be made to their timeliness. The general manager kept a log of all formal and informal complaints. Records showed the managers discussed complaints with staff at their monthly team meetings and shared any learning that had resulted. The service knew they had further work to do on improving their response times. For example, the hospital clinical governance meeting reported that 19 of the 29 complaints about the service received I July 2019 to 30 September 2019 had not been responded to within the provider's 20-day target. This meant complaints were not responded to promptly, so the complainant can proceed with their complaint in a timely way.

The service collected compliments. The service had received five compliments in the same period.

Are forensic inpatient or secure wards well-led?

Good ●

Leadership

Leaders had the skills, knowledge and experience to perform their roles and had a good understanding of the services they managed. The ward manager and team leaders had a good understanding of their responsibilities and knew their teams well. They were aware of the key risks and challenges and were open in sharing them.

The service had recently invested in strengthening their senior leadership team. This included permanent consultant psychiatrists, leads for psychology, safeguarding and occupational therapy as well as a new medical director.

Staff said that the senior managers in the service were visible and approachable. The hospital manager had worked at the service for several years and knew the patients and staff well.

Leadership development opportunities were available, including opportunities for staff below team manager level. Staff could apply to participate in training courses through the provider's academy. Four members of the ward staff had completed an introduction to leadership training module. Registered and non-registered nurses had lead roles for key areas on the ward and developed their expertise in areas such as physical health and safeguarding.

Vision and Strategy

The provider's senior leadership team had successfully communicated the provider's vision and values to the frontline staff in this service. Staff spoke positively about the organisations vision and said this helped to provide focus and serve to remind them that patients were at the centre of their work.

Staff understood the vision and values of the service. They tried to deliver care in accordance with these values. The service had recently implemented a value–based recruitment programme, which based the recruitment application and assessment on the service's new collaborative objectives. The provider aimed to help people rebuild their living and vocational skills, ready to regain their place in the community. Staff emphasised optimism in patient's recovery and treated them with dignity and respect.

Culture

Staff felt respected, supported and valued. We spoke with five members of the ward team. They all said they felt respected and valued. They were all very positive about their work. We spoke to two new staff members. They said they had found the ward welcoming and they quickly felt part of the established staff team. The service had an open culture where patients, their families and staff could raise concerns without fear. Staff knew how to use the whistle-blowing processes.

Forensic inpatient or secure wards

Teams worked well together and where there were difficulties managers dealt with them appropriately. Staff that we interviewed acknowledged that their work could be stressful at times. However, they said they felt supported by colleagues and their manager in these circumstances.

Staff appraisals included conversations about career development and how it could be supported.

Staff completed an annual survey in 2018. The results showed that 21% of staff felt that the Pay and Reward system was not transparent, and they were disadvantaged. For example, they should be paid be paid London weighting. Most staff (92%) felt that there should be more opportunities for specialist training to develop in their role. Managers listened to staff and completed an action plan from their feedback to improve their experience.

Governance

Our findings from the other key questions demonstrated that governance processes were effective at ward level and that performance and risk were managed well. For example, managers checked incident reports to ensure that, when appropriate, there had been a de-brief with the patient and staff involved. The data collected was used as a key performance indicator, which was monitored at a monthly hospital-wide clinical governance meeting and at board meetings.

However, during the inspection we identified that the provider's governance processes for monitoring patient physical observations and escalating physical health deterioration promptly had not been effective. For example, clinical governance meetings had highlighted this as an area for improvement, but we found this was still an issue.

The service had a monthly staff meeting and a monthly business meeting. These meetings were well-organised and with standard agendas. Records were kept of issues raised and planned actions. Learning from incidents, safeguarding alerts and complaints was routinely discussed at staff meetings. Staff told us that meetings were well-run and informative, and they were emailed a copy of the minutes, so they were kept informed if they were unable to attend the meeting.

The hospital-wide clinical governance meeting reviewed performance across key aspects of care and treatment. For example, the meeting reviewed compliance with the provider's schedule of audits and checked that audit findings were actioned at ward-level to improve the quality of the service.

Staff had implemented recommendations from reviews of deaths, incidents, complaints and safeguarding alerts at the service level. Staff across the service had reported an increase in safeguarding incidents between June – September 2019 relating to patients alleging that staff had physically or verbally assaulted them. Eight safeguarding incidents of this kind were reported during this period. Each allegation was raised by either staff members on the ward or by the patient. The senior team attributed this to several factors, including the current patient cohort on the ward over the summer. Managers investigated these allegations and reported them to the police. Across the hospital two of these incidents were substantiated and as a result the staff members involved were dismissed. The service had improved their safeguarding systems by strengthening the safeguarding leadership and empowering staff and patients to speak up if they had concerns. In addition, each ward had a permanent consultant psychiatrist in post to provide clinical leadership and oversight to staff.

Management of risk, issues and performance

The managers used systems to identify, understand, monitor, and reduce or eliminate risks that were mostly effective. They ensured risks were dealt with at the appropriate level. The service had a local risk register which the manager added to. Risks included the management of ligature points and illicit substances coming into the service. The hospital manager said the top challenge for the service was staff recruitment and retention.

The service had a recruitment initiative in place to support with the recruitment of new staff. For example, one of the biggest challenges to recruitment was staff salaries and the comparison to other services.

The provider ensured they carried out the necessary checks on staff prior to employment. We checked the personnel files of ten staff across the service and found that each had appropriate checks in place. This included two references from a previous employer to check an employee's

Forensic inpatient or secure wards

experience and skills to carry out their job role. The service had systems in place to check that all staff received a criminal record check. This meant managers knew that staff were suitable to work with patients

The service had plans for emergencies. Business continuity plans covered a range of scenarios such as a terrorism bomb threat or a no deal Brexit.

Information Management

The service collected reliable information and analysed it to understand performance and to enable staff to make decisions and improvements. The service had a dashboard that held pertinent data about the service, for example, discharges and length of patient admissions.

The information systems were integrated and secure. The managers had access to information to support them with their management role. This included information on the performance of the service, staffing and patient care. Administrative staff supported managers to record key performance indicators.

Information was recorded in a combination of an electronic record system and paper records. Staff completed serious incident records on paper, the ward clerk then copied out the completed incident report into the electronic system. However, we found that staff recorded patients' physical health observations in three different places. Therefore, staff missed some recordings of physical health observations. This meant that patient notes were not always comprehensive, and staff could not easily access them.

The service notified the Care Quality Commission of notifiable incidents, including incidents involving the police.

Engagement

The service engaged well with patients and staff to plan and manage appropriate services. Staff could attend the organisation's quarterly staff representative group. In addition, the service produced a quarterly newsletter co-produced with patients for patients. This included what projects were going on within the service and individual patient stories. Staff and patients attended the provider's National Service User Awards 2019 in the summer.

Patients and carers had opportunities to give feedback about the service. For example, the service conducted an annual patient survey. In addition, patients gave staff feedback in weekly community meetings and on the service's 'you said, we did' boards.

The managers used the feedback from surveys to make improvements. The patients completed a satisfaction survey each quarter. The most recent results showed that 11% of patients felt that their overall care at the service was excellent and 33% felt that is was good. Most patients (56%) felt safe at the service sometimes and 56% felt they were sometimes involved in their care and treatment with 44% saying they always felt involved. Staff listened to patients and used their feedback to improve the service.

Patients and carers were involved in decision-making about changes to the service. For example, patients had been involved in recruitment panels to interview prospective new staff.

The service collaborated with partner organisations to help improve services for patients. However, there was more work the provider could do to improve effective communication with other health professionals working with patients. This included community mental health teams and social workers. This would ensure that staff always worked with others to ensure consistent care and treatment for patients.

The lead occupational therapist had recently launched a Working Together group to involve families and carers in their loved one's care. Part of the group was holding regular carers forums and producing a newsletter with families. However, this was relatively new and still needed to embed across the hospital.

Learning, continuous improvement and innovation

Bewick Ward was a member of the Quality Forensic Mental Health Network and was last reviewed on 15 May 2019. During the review the ward achieved 84% compliance with the required standards.

Wards for people with learning disabilities or autism

Good 🟢

Safe	**Good**	🟢
Effective	**Good**	🟢
Caring	**Good**	🟢
Responsive	**Good**	🟢
Well-led	**Good**	🟢

Are wards for people with learning disabilities or autism safe?

Good 🟢

Safe and clean care environments

Safety of the ward layout

Hansa ward was safe, clean, well furnished, well maintained and fit for purpose. Staff did regular risk assessments of the ward environment and recorded these. Staff took action to address any concerns identified. For example, where a fire door was not closing properly staff raised this with the maintenance team who promptly attended and resolved the issue. This was all logged in the ward's maintenance book. The service had a review of fire safety annually. The service used an external health and safety company to carry out checks on fire safety and produced an action plan to address areas for improvement. The service last had an inspection in September 2019 and was working on the actions set out in the assessment. Patients who needed them (low mobility), had a personal emergency evacuation plan to follow in the event of a fire or other emergencies.

Hansa Ward had some blind spots where staff could not always view patients in communal areas. The service had taken appropriate steps to mitigate the risks associated with blind spots by installing CCTV in communal areas. Staff could access recordings when needed. Patients had signed a form to confirm they were aware that CCTV recordings were being made.

Staff knew about any potential ligature anchor points and mitigated the risks to keep patients safe. The service completed an annual ligature audit highlighting the ligature risks on the ward. The service had plans in place to mitigate these. The ward had a map of the ward with the risk areas highlighted in the staff office. This included pictures of the ligature risks. This made staff aware of the risks. Staff were required to read the ligature risk assessment and sign that they had reviewed it. Ligature risks were including in the new staff induction checklist.

Staff had easy access to alarms. The service issued personal alarms to all staff. Staff tested their alarms when they received them at the start of each shift. There was only a call alarm in one patient's bedroom. This had been put in place to ensure the patient, who had specific mobility needs could call staff for assistance. No other patients' bedrooms had alarms. Staffing levels were adequate to appropriately respond to alarms.

Maintenance, cleanliness and infection control

Ward areas were clean and well maintained. Domestic staff cleaned the ward each day. This included cleaning patients' bedrooms. Cleaning records were up-to-date.

Staff followed the service's infection control policy, including handwashing. Guidance and information about handwashing was available for staff and visitors to follow. Staff used appropriate personal protective equipment such as gloves and aprons when needed.

Seclusion room

Hansa Ward did not have a seclusion room but had a de-escalation room. The de-escalation room was not used for seclusion. If patients were supported in the de-escalation room they could leave when they chose to.

Clinic room and equipment

Wards for people with learning disabilities or autism

The ward's clinic room was fully equipped, with accessible resuscitation equipment and emergency drugs that staff checked regularly. Staff checked, maintained, and cleaned equipment to ensure it was fit for purpose and kept records to confirm this.

Safe staffing

Nursing staff

The ward had enough nursing and medical staff, who knew the patients and received basic training to keep people safe from avoidable harm.

Staff felt safe working on the ward and that staffing levels were adequate. Patients told us that staff were always available. The staffing establishment for the service was nine whole-time equivalent registered nurses. The establishment for support workers (including social therapists) was 16. The service had low vacancy rates. The ward reported an overall vacancy rate of 7% for non-medical staff at 31 July 2019, representing two whole time equivalent posts. At the time of this inspection the ward had filled one of these posts and had one vacancy for a social therapist. One member of staff had left in the previous 12 months.

The day shift had a minimum of two registered nurses and four support workers. The night shift had a minimum of two registered nurses and two support workers. The manager was able to adjust staffing levels daily to take account of patients' needs. The ward used a matrix for planning shifts to ensure the correct number of staff were available on the rota according to patient numbers and needs.

The sickness rate for the ward was 3.3% between 1 August 2018 and 31 July 2019. Staff told us managers supported them if they needed time off for ill health.

The ward made use of bank and agency staff when required. The ward had a pool of regular bank and agency staff who were familiar with the service. Staff had the autonomy to book bank or agency staff when required. The manager made sure all bank and agency staff had a full induction and understood the service before starting their shift.

The manager could adjust staffing levels according to the needs of the patients. The ward made arrangements in advance by booking any additional staff needed to escort patients for external activities or meetings.

Staff were always present on the ward. Patients said that staff were always available. Patients told us that they rarely had their escorted leave, or activities cancelled, even when the service was short staffed. Patient said that they had regular one to one sessions with staff. The service had enough staff on each shift to carry out any physical support or interventions safely. A staff member was present in communal areas of the ward at all times. Staff were always available at all meal times.

Medical staff

There were two part time consultant psychiatrists that covered the ward. One was on the ward three days a week and the other was on the ward two days a week. A doctor was present on the ward from Monday to Friday. An on-call consultant psychiatrist and on-call doctor were available at weekends and out of hours.

Mandatory Training

Staff had completed and kept up-to-date with their mandatory training. Ninty five per cent of staff had completed mandatory and statutory training courses at 31 July 2019. All relevant staff had completed training in preventing and managing violence and aggression, relational security, basic and intermediate life support, safeguarding, and learning disabilities.

Assessing and managing risk to patients and staff

Assessment of patient risk

Staff assessed risks to patients and themselves well. Staff completed risk assessments using recognised tools; the short-term assessment of risk and treatability tool and the historical clinical risk management assessment (HCR-20). We reviewed the care records of three patients and found detailed risk assessments had been carried out following admission. Their assessments included a risk history and assessment of risks associated with patients' mental and physical health and social history. Following admission patients' were also assessed by a speech and language therapist to identity any risk of difficulty or discomfort in swallowing and any communication needs. Risk assessments had been updated regularly, including after any incident, and contained clear information of current risks.

Management of patient risk

Wards for people with learning disabilities or autism

Staff managed risks to patients and themselves well. Staff we spoke to were aware of the risks identified for each patient and knew what to do to prevent and/or reduce risks. Staff put management plans in place to mitigate individual patient risks and these included both mental and physical health risks. Staff reviewed patients' risks regularly in multi-disciplinary meetings, ward rounds, daily handovers and safety huddles.

Staff identified and responded to any changes in risks to, or posed by, patients. We observed staff responding to an increase in patient risk. We saw staff support the patient who became extremely distressed through direct engagement and discussion about the event that lead to the patient distress. This approach de-escalated the situation and had a calming effect on the patient. The patient later told us that they found the staff intervention very helpful and addressed their immediate distress.

Staff implemented good positive behaviour support plans. Each patient had an individualised positive behaviour support care plan. The use of positive behaviour support plans is a proactive approach staff use to support challenging behaviour. These are used to develop more effective behaviours and as these progress challenging behaviours reduce.

Staff monitored patients' physical health using the Modified Early Warning Score (MEWS). Staff we spoke to were aware of the need and procedures to escalate any concerns to the ward doctor when the MEWS identified deteriorating patients. The multi-disciplinary team reviewed information on the patients' physical health at every weekly ward round and put in place further action if required.

Staff followed good procedures for observing patients and completed records of observations for all patients.

Staff followed trust policies and procedures when they needed to search patients or their bedrooms to keep them safe from harm.

Use of restrictive interventions

The service had 13 incidences of restraint with one of those incidents being prone restraint between 1 February 2019 and 31 July 2019. During this period one of these incidents result in the patient receiving oral rapid tranquilisation.

Staff made every attempt to avoid using restraint by using de-escalation techniques. Staff applied practices from the 'Safewards' model to reduce the need for restraint. Staff stated that they tried to talk to patients and use their rapport to address patient concerns when patients were distressed. Staff restrained patients only when all attempts to de-escalate failed and when it was necessary to keep the patient or others safe. Staff had been trained in the use of correct techniques when using physical interventions.

Staff understood the Mental Capacity Act definition of restraint and worked within it. Records showed that staff only restrained a patient because it was necessary to prevent harm to the patient. Patients we spoke to said staff used restraint appropriately and as a proportionate response to prevent harm.

Staff followed the National Institute for Health and Care Excellence guidance and the service's policy when using rapid tranquilisation. We reviewed four incidents of oral rapid tranquilisation. The service had no incidences of intramuscular rapid tranquilisation. Records showed that staff recorded patients' physical health observations after rapid tranquilisation. When patients refused physical health observations after rapid tranquilisation staff recorded the patients' respiratory rate and sedation levels from visually observations.

Staff participated in the provider's restrictive interventions reduction programme. The ward had a 'calm down box' to help patient regulate emotions. This box contained objects which had a calming effect. This included items that stimulated the senses such as stress balls, tactile fabrics and toys, perfumes and face masks, and small puzzles. Staff said this was a useful toolkit for supporting patients and reported that patients used the 'calm down box' both when they were agitated and also when they were calm.

Staff on the ward worked to reduce blanket restrictions. The ward had two least restrictive champions, one staff member and one patient. These champions raised issues and provided feedback on restrictive interventions and restrictive practices to the ward team and senior hospital management. For example, staff used to routinely lock the TV lounge during the night. The champions challenged this and the TV lounge was left open resulting in an improved environment for patients who were active during night. Staff reported that feedback from these champions helped them to reflect on their practice and patient experiences.

Safeguarding

Wards for people with learning disabilities or autism

Staff had training on how to recognise and report abuse and they knew how to apply it. Staff kept up-to-date with their safeguarding training with all relevant staff having completed the provider's safeguarding individuals at risk training.

Staff understood how to protect patients from abuse. The safeguarding team were improving their practice in safeguarding awareness through regular training and workshops for staff. Staff felt confident in reporting safeguarding alerts and could give clear examples of how to protect patients from harm. For example, staff told us about a safeguarding alert that was raised regarding a patient's self harm. Staff recorded the initial incident, discussed it with the patient, discussed it with the multi-disciplinary team and the ward's social worker, raised it with the provider's safeguarding lead and notified the local authority safeguarding team. Staff worked with the patient to update the patient's risk assessment and care plan and built in discussions to try to understand what lead to the incident. Staff also discussed and recorded interventions that might help the patient in the future manage self harm behaviours. Staff further discussed these actions in nursing handovers, safety huddles, staff meetings and individual supervision.

Staff knew how to recognise adults and children at risk of or suffering harm and worked with other agencies to protect them. Staff worked in partnership with external agencies such local authority teams to ensure patients and any members of the public were protected from harm.

Staff followed clear procedures to keep children visiting the ward safe. Staff were able to arrange a private room for children and families when visiting patients.

Staff access to essential information

Staff had easy access to clinical information and it was easy for them to maintain and update clinical records. Patients' notes were comprehensive and all staff could access them easily. Although the service used a combination of electronic and paper records, staff made sure they were up-to-date and complete.

Records were stored securely. Staff used individual logins and passwords to access electronic records.

Medicines management

Staff followed systems and processes when safely prescribing, administering, recording and storing medicines. We checked medicines administration records for six patients. Patient's told us that they reviewed their medicines regularly with staff, and staff provided specific advice to patients about their medicines.

Staff stored and managed medicines and prescribing documents in line with the provider's policy. Review of stock medicines showed that medicines held on the premises were within their expiry dates. The service's pharmacist supported staff to ensure that medicines were stored safely and audited.

Decision-making processes were in place to ensure people's behaviour was not controlled by excessive and inappropriate use of medicines. As part of the ward's quality improvement process, since August 2019, staff had started working towards achieving the aims of Stop Over-Medicating People (STOMP) with a learning disability programme. STOMP is a national improvement programme to help people to stay well and have a good quality of life. It focuses on ensuring patients work with staff and the people who support them to get the right care and treatment, have regular medicine reviews, make sure they are taking the right medication for the right reasons, and find other ways for patients to stay well. Staff knew about and applied STOMP procedures to help reduce the use of 'when required' medication. In addition to STOMP practices, staff also used 'Safewards' tools to reduce the risk of restricting behaviour through medicines. All patients had a calm card attached to their medicines administration records. The information on these cards were generated by patients and were used before staff and patients considered using 'when required' medication. The calm cards we saw included things like 'offer a cup of tea', 'call nan for a chat' and 'go for a walk in the fresh air'. Initial data from the provider's October 2019 clinical governance meeting showed a reduction of PRN and the use of rapid tranquilisation between August 2019 and September 2019 from seven incidents to two. Patients and staff both felt this was having a positive impact on the reduction of when required medication.

Track record on safety

The service had a good track record on safety. Between 1 August 2018 and 31 July 2019 there were seven serious incidents reported by this service. Of the total number of incidents reported, the most common type of incident was alleged abuse with six.

Wards for people with learning disabilities or autism

Reporting incidents and learning from when things go wrong

The service managed patient safety incidents well. Staff knew what incidents to report and how to report them. Staff raised concerns and reported incidents in line with the provider's policy. Staff told us that they would report any incident of harm, potential harm and/or risks to safety. An incident flow chart was available in the staff office.

Staff knew how to report serious incidents. Staff were aware of serious incidents that occurred on other wards and discussed learning from serious incidents in team meetings and handover.

Staff understood the duty of candour. Patients felt that staff were open and transparent, and said that staff gave them clear explanations if and when things went wrong.

Staff were debriefed and supported by the service managers and ward manager after any serious incident. Staff reported that they were given the opportunity to reflect and learn from serious incidents as a team and openly discussed learning with patients. In one example, staff discussed as a team how to ensure a patient was protected from harm and reviewed this with the patient. The patient and staff implemented the actions that they felt would help to keep this individual safe.

Staff received feedback from investigations of incidents. We saw evidence of feedback and improvements to patient care being discussed in team meetings.

Are wards for people with learning disabilities or autism effective?
(for example, treatment is effective)

Good 🟢

Assessment of needs and planning of care

Staff completed a comprehensive mental health assessment of each patient on admission or soon after. We reviewed the care records for five patients. All the records we reviewed showed that patients' mental health had been fully assessed and recorded in the first few days of their admission. Assessments were comprehensive and covered the reason for the patient's admission, mental and physical health history, current presentation, a mental state examination, a medicines review, family history, and personal and social details.

All patients had their physical health assessed soon after admission and this was regularly reviewed during their time on the ward. Each patient had a comprehensive physical health action plan, which detailed all of their physical health concerns and related history. These included information of weight related issues, dietary needs, sleep problems, pain control, mobility problems, breathing problems, blood pressure and circulation problems, physical disability, and sensory and communication problems and needs.

Staff and patients collaborated to developed comprehensive care plans that reflected patients' mental and physical health needs. These included areas such as mental state and mood, medicine administration, physical health monitoring, risk and safety, challenging behaviour, activities, and interventions. Staff and patients regularly reviewed and updated care plans and positive behaviour support plans. Care plans were personalised, holistic and recovery-oriented. Positive behaviour support plans were present and supported by a comprehensive assessment.

Best practice in treatment and care

Staff provided a range of care and treatment suitable for the patients in the service. Staff delivered care in line with best practice and national guidance from the National Institute for Health and Care Excellence. All five of the patient care records we reviewed demonstrated evidence of good practice in relation to the range of treatment available. Therapeutic group sessions were a large component of the treatment offered by the ward. Patients attendance at suitable groups was part of patients' care plans. Group sessions were made up of recovery focused and recreational groups. These included mindfulness, interpersonal effectiveness, music therapy, art therapy, healthy living, education and skill development, cooking, smoking cessation, getting active, gym sessions and relaxation sessions. Patients told us that they attended groups sessions daily and there was always a lot of group activities each day including weekends. Patients said that staff were very good at helping people open up in group activities and enjoy what was on offer.

Wards for people with learning disabilities or autism

Staff understood patients positive behavioural support plans and provided care that supported the development of positive behaviours.

Staff identified patients' physical health needs and recorded them in their care plans. Staff monitored patients' physical health regularly recording vital signs and reported any changes to the multi-disciplinary team or escalated it to the ward or on-call doctor.

Staff made sure patients had access to physical health care, including specialists, when required. Patients told us that the staff addressed any physical health concerns they had. Patients could also access the ward doctor for any concerns or questions the nursing team could not address.

Staff met patients' dietary needs. Nutrition and hydration needs were assessed when the patients were admitted.

Staff helped patients live healthier lives by supporting them to take part in health focused activities or giving advice. Patients also told us that they discussed their physical health regularly with staff where staff would encourage them to stay active, eat healthy and try to avoid or reduce unhealthy activities such as smoking. Patients also had use of the gym within the service.

Staff used recognised rating scales including the health of the nation outcome scales for people with learning disabilities to assess and record the severity of patients' conditions and care and treatment outcomes.

Staff used technology to support patients. The ward had a sensory room, which was designed to help patients engage their senses as this had a calming or alerting effect. This room was designed to stimulate the senses and included different colour lighting effects, a range of sound and music options and padded wall sections that were nice to touch and interact with. Patients reported that they enjoyed using this room. They said they found the interactions in this room helpful in managing emotions and helped with motivation and engagement.

Staff took part in clinical audits, benchmarking and quality improvement initiatives. Staff audited care plans and record keeping and discussed the content and quality of records with their peers. The ward applied Stop Over-Medicating People (STOMP) with a learning disability practices to help reduce the use of 'when required' medicines.

Skilled staff to deliver care

The service had access to a full range of specialists to meet the needs of the patients on the ward. This included consultant psychiatrists, a doctor, nurses, support workers, social therapists, a social worker and occupational therapist.

The manager made sure staff had the right skills, qualifications and experience to meet the needs of the patients in their care, including bank and agency staff. The manager ensured staff received specialist training for their roles. This included learning disability, positive behaviour support, and dialectical behaviour therapy training.

The manager gave each new member of staff a full induction to the service before they started work. New staff and bank and agency staff working on the ward for the first time were provided with an induction. New staff went through an induction checklist covering area such as ligature risks, the ward environment policies, guidelines and expectations.

The manager ensured staff received regular, constructive appraisals of their work. The manager ensured all staff were provided with supervision and appraisal of their work performance. We saw evidence of both appraisal and supervision records and all staff had received an annual appraisal and monthly supervision. Staff reported to us that they found their supervision and appraisals as useful tools in reflecting and developing their practice.

Multi-disciplinary and interagency team work

Staff from different disciplines worked together as a team to benefit patients. Staff held regular multi-disciplinary meetings to discuss patients and improve their care. External professionals from other teams that were involved in patient care were invited to ward rounds and care programme approach meetings. This included care coordinators, social workers and community team managers.

Staff made sure they shared information about patients and any changes in their care. The ward's handover meetings occurred at the beginning of each shift. Staff discussed patients current presentation and any changes in risk levels, incidents and safeguarding concerns, and planned activities.

The team had effective working relationships with other teams in the organisation. The manager attended a

Wards for people with learning disabilities or autism

monthly meeting with the other ward manager and senior services managers. Learning from significant incidents and best practice was discussed, with the manager feeding this back to the team in team meetings.

The team had effective working relationships with external teams and organisations. We saw evidence of communication updates between the ward team and external care coordinators and service providers recorded in patients' records.

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

Staff understood their roles and responsibilities under the Mental Health Act (MHA) 1983 and the MHA Code of Practice and discharged these well. As of 31 July 2019, all relevant staff had received training in the MHA.

Staff had access to support and advice on implementing the MHA and its Code of Practice. Staff knew who their MHA administrators were and when to ask them for support. The MHA administration team would alert the ward if a patient's section was due to expire or their rights needed to be explained.

Patients had easy access to information about independent mental health advocacy. The ward displayed posters with the details of the local advocacy service. Patients said that a mental health advocate regularly visited the ward.

Staff explained to each patient their rights under the MHA in a way that they could understand and repeat if required. Staff documented in the patient's notes each time patients' rights were explained. Staff explained patients' rights at least once month or with any change in a patients' MHA status.

Staff made sure patients could take section 17 leave (permission to leave the hospital) when this was agreed with the Responsible Clinician and with the Ministry of Justice (when appropriate).

Staff stored copies of patients' detention papers and associated records correctly and staff could access them when needed. For the three patient records we reviewed all copies of detention papers were stored correctly and were accessible.

Patients' consent to treatment forms were completed in line with the MHA code of practice and recorded in each patients' records.

Good practice in applying the Mental Capacity Act

Staff supported patients to make decisions on their care for themselves. Staff received and kept up-to-date with training in the Mental Capacity Act (MCA) and staff we spoke to, had a good understanding of the five principles. As of 31 July 2019, 100% of relevant staff had received training in the MCA.

There were no deprivation of liberty safeguards applications made in the last six months. There was a clear policy on MCA and deprivation of liberty safeguards, which staff could describe and knew how to access.

Staff knew where to get accurate advice on the MCA and deprivation of liberty safeguards. The Mental Health Act administration team provided advice to staff on the MCA when required.

Staff conducted capacity assessments for each patient at the time of admission. This assessment focused on the patient's understanding around being admitted to the ward and their capacity to consent to treatment. The capacity of individual patients was discussed on a decision specific basis at multi-disciplinary meetings and ward round meetings. Patients were supported to make their own decisions.

Are wards for people with learning disabilities or autism caring?

Good ●

Kindness, privacy, dignity, respect, compassion and support

Staff treated patients with compassion, kindness and dignity. We spoke with five patients and they were all positive about the ward and highlighted that how supportive and caring the staff were. Patients said that staff treated them with respect and were very responsive to their needs. Patients told us the choice and quality of ward activities was excellent and there was always something enjoyable to do.

Wards for people with learning disabilities or autism

Staff gave patients help, emotional support and advice when they needed it. They understood the individual needs of patients. We observed staff demonstrating genuine warmth and concern when caring for patients who were upset and frustrated. We saw staff show affection and kindness in their interactions with patients.

Staff used appropriate communication methods to support patients to understand and manage their own care, treatment and/or condition. We observed staff listening to patients' concerns and using positive body language to help reassure and support them.

Patients told us staff understood and respected their individual needs. Patients said staff were always available to talk and gave patients time to discuss their needs and concerns.

Staff reported that they felt comfortable in raising any concerns about disrespectful, discriminatory or abusive behaviour without fear of the consequences.

Staff were aware of confidentiality issues when talking with patients and discussing patients within the team. They ensured conversations of this nature took place in appropriate settings.

Involvement in care

Involvement of patients

Staff introduced patients to the ward and the services as part of their admission. The ward provided a welcome pack to all patients and carers on admission. The welcome pack was in an easy read picture format and included pictures of the ward and an activity timetable to help orientate patients. Staff worked with a speech and language therapist to create the welcome pack.

Staff involved patients and gave them access to their care planning and risk assessments. Patients told us that they were involved in updating their care plans and risk assessments on a regular basis. One patient stated that their family members were able to help and input into their care planning.

Staff made sure patients understood their care and treatment and found ways to communicate with patients who had communication difficulties. Staff created social stories to communicate and help patients understand difficult situations and activities. Social stories provide a simple visual representation of a situation, event, activity or

conversation. One example we saw depicted the activities and events for a placement visit. This was used to help the patient build the right impression about leaving and returning to the ward, comprehend the unfamiliar processes and manage the anxiety of the situation. This was created as part of the patient's discharge planning. Staff felt social stories were a very effective tool in supporting patients.

Most patient information on display around the ward was supported with pictures to aid communication and comprehension.

Patients were valued as individuals and empowered as partners in their care. Staff encouraged patients to take an active part in ward rounds. We observed staff creating a relaxed atmosphere in ward round meetings and recognising each patient as unique. We saw staff in these meetings encouraged patients to voice their views and actively listen to patient experiences and concerns. Staff took patient's views into account when reviewing care and treatment. Patients could submit a written document completed with the help of staff or a relative prior to the ward round outlining what they wanted to discuss. The team went through this document in the meeting to ensure all points were covered. Where a patient had not completed this prior to their ward round meeting, the psychiatric consultant offered to support the patient to do so during the meeting if they wanted.

Patients could give feedback on the service and their treatment and staff supported them to do this. Patients told us that they felt comfortable in raising feedback with staff individually, to the manager or via the ward community meeting. The service had a 'you said we did' board in a communal area, which highlighted suggestions, requests and comments that patients had made and how the ward had addressed those.

Staff and patients facilitated a daily planning meeting on the ward to discuss the programme for the day, which included activities and any visits, appointments or meetings. Staff encouraged patients to identify activities that they wanted to join in with.

Staff made sure patients could access advocacy services. Patients we spoke to said they had met the mental health advocate and that they were regularly available on the ward.

Involvement of families and carers

Wards for people with learning disabilities or autism

Staff informed and involved families and carers appropriately. Family members and carers were invited to ward round meetings and care programme approach meetings. Patients we spoke with said their family members were involved in their care if their wanted. Patient records showed that staff contacted families and carers to provide updates and included details of family visits and input. Care plans included maintaining family, carer and friend networks.

Staff helped families to give feedback on the service. The service had a carers' forum people could attend. Staff encouraged family members and carers to complete the service's family and friends survey. The latest survey results showed that 77% of respondents felt satisfied that the hospital catered to their needs as a carer, 87% felt satisfied that staff were polite and approachable when phoning and when visiting patients, and 80% reported that they would recommend the service.

Are wards for people with learning disabilities or autism responsive to people's needs?
(for example, to feedback?)

Good ●

Access and discharge

Bed management

The service planned all admissions and discharges. Admissions and discharges took place at an appropriate time of the day. The service had clear admission and exclusion criteria for referrers.

Staff planned and managed the use of beds well. At the time of the inspection the ward was at capacity with 13 patients. Bed occupancy on the ward was 100% between 1 February 2019 and 31 July 2019. Staff felt that this was due to the lack of suitable provisions in the boroughs that referred to the service. Referrals were made and funded by the clinical commissioning groups from the patients' home boroughs. Six patients were from London boroughs and seven patients were from outside of London.

The average length of stay of patients discharged between 1 February 2019 and 31 July 2019 was 477 days.

Discharge and transfers of care

At the time of the inspection the service had one delayed discharge in the past year. This was due to a lack of supported housing services that could support the patient's needs in the patient's home borough. To address this delay, the ward had held a best interest meeting and was working with the patient's care coordinator and clinical commissioning group to identify a suitable residential placement, including exploring options within the provider's own pathway. The multi-disciplinary team put in measures to support the patient through this period and had updated their care plan, discharge plan and support documents to reflect this.

Staff carefully planned patients' discharge and worked with care managers and coordinators to make sure this went well. Staff created tailored discharge plans for each patient. Goals that supported patients' discharge were included in patients' care plans.

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

Facilities that promote comfort, dignity and privacy

The design, layout, and furnishings of the ward supported patients' treatment, privacy and dignity. Each patient had their own bedroom, which they could personalise. We saw that many patients had personalised their rooms with pictures and other keepsakes.

Patients had a secure place to store personal possessions. Patients were able to lock their bedrooms from inside and could ask staff to lock their bedrooms when they were in communal areas. Patients said that staff were always available to lock or unlock their rooms when they wanted.

Staff used a full range of rooms and equipment to support treatment and care. This included a clinic room to examine patients, activity and therapy rooms, and a sensory room.

There were quiet areas for privacy. The ward had quiet areas for patients to use and a room where patients could meet with visitors in private.

Patients could make phone calls in private. Patients were permitted unrestricted access to their own mobile telephones once this was risk assessed.

The service had an outside garden that patients could easily access.

Wards for people with learning disabilities or autism

Patients reported that hot drinks and snacks were always available and the variety and quality of the food was good.

Patients' engagement with the wider community

Staff supported patients with activities outside the service, such as visiting family members and shopping. Staff encouraged patients to stay in contact with the people that mattered to them. Patients told us that they were in regular contact with family and friends through telephone contact, visits to the ward and visits in the community.

Staff supported patients to access the wider community. For example, staff supported patients with shopping for halal and kosher foods in specialist shops.

Meeting the needs of all people who use the service

The ward met the needs of all patients including those with a protected characteristic. Staff helped patients with communication and cultural and spiritual support.

The ward could support and make adjustments for people with disabilities and those with communication needs or other specific needs. The ward was located on the ground floor and was accessible to people with disabilities. We saw that a call alarm was installed in one patient's room to alert staff if the patient needed assistance with transferring from their wheelchair to their bed. Staff had been trained to support with lifting and transferring safely in advance of this individual being admitted on to the ward.

There were pictures on doors to communicate information. For example, there was a picture of a shower to indicate it was the shower room.

Staff made sure patients could access information on treatment, local services, their rights and how to complain. The ward could provide information leaflets in different languages. Staff could request interpreters or signers if needed.

Patients had a choice of meals to meet their dietary requirements, including religious and/or cultural requirements. Menus reflected patients' cultural and ethnic backgrounds.

Patients had access to spiritual, religious and cultural support. The service arranged for a chaplain to visit the ward regularly and could arrange for other faith leaders to attend on request. Staff were aware of patients' protected characteristics and were supportive of patients who were LGBT+.

Listening to and learning from concerns and complaints

The service treated concerns and complaints seriously, investigated them and learned lessons from the outcomes. Between July 2019 and September 2019, the service overall received 29 complaints. Eight of these complaints were upheld and four were partially upheld. Patients complained about their care and treatment or staff attitudes.

Patients knew how to complain and felt able to do so. When patients were admitted to the service, they signed to say they knew and understood the complaints process. Staff displayed the complaints process on the noticeboards around the ward.

When patients complained, staff provided them with feedback from investigations. We looked at four complaint investigations across the service. For example, a ward manager wrote to the patient and verbally discussed the outcome with them. Records showed that patients received support from staff in a timely way after they complained.

Managers handled complaints appropriately. The general manager kept a log of all formal and informal complaints. Records showed the managers discussed complaints with staff at their monthly team meetings and shared any learning that had resulted.

The service collected compliments. The service had received five compliments between July 2019 and September 2019.

Are wards for people with learning disabilities or autism well-led?

Good ●

Leadership

The ward was well led. Leaders had the integrity, skills and abilities to run the service. The ward manager and clinical leaders understood the issues, priorities and challenges the service faced and managed them well. Staff said that managers were visible in the service and supported staff to develop their skills and take on more senior roles and

Wards for people with learning disabilities or autism

responsibilities. Staff felt that the managers supported them to develop in their roles and work towards building their careers. Leadership development was available and was supported for those who wanted to pursue it.

Staff said that the senior managers in the service were visible and approachable. The hospital manager had worked at the service for several years and knew the patients and staff well.

Vision and Strategy

The service's senior management team had successfully communicated the vision and values of the organisation to the frontline staff. Staff felt positive about the organisation's vision and values and found it easy to apply them in their work with patients.

Managers made sure staff understood the service's values and knew how to apply them. Staff said that they discussed the organisation's values of integrity, trust, empower, respect and care often in supervision and team meetings. Staff delivered care in accordance with these values. We observed staff empowering patients and treating them with respect and care in different settings and situations such as ward round meetings, supporting with lunch, group activities and general interactions.

Culture

Staff felt respected, supported and valued. Staff we spoke to said they felt happy at work. They told us they felt supported and valued as part of the team.

Staff told us that the culture on the ward was friendly and open with team members happy and willing to support each other. Staff stated that the team worked well together with managers and leaders providing effective support through busy periods. Staff felt confident in raising issues and that any concerns were addressed and taken seriously. Staff knew how to use the whistle-blowing process.

Staff felt that the ward culture was supportive of career development.

Staff across the service completed an annual survey in 2018. The results showed that 21.5% of staff felt that the Pay and Reward system was not transparent, and they were disadvantaged. For example, they should be paid be paid

London weighting. Most staff (91.6%) felt that there should be more opportunities for specialist training to develop in their role. Managers listened to staff and completed an action plan from their feedback to improve the service.

Governance

Our findings from the other key questions demonstrated that governance processes were effective and that performance and risk were managed well. There were systems and procedures to ensure that the premises were safe and clean; there were enough staff; staff were trained and supervised; clients were assessed and treated well; referrals were managed well; incidents were reported, investigated and learned from.

The provider ensured there were structures, processes and systems of accountability for the performance of the service. For example, managers checked incident reports to ensure that, when appropriate, there had been a de-brief with the patients and staff involved. The data collected was used as a key performance indicator, which was monitored at a monthly hospital-wide clinical governance meeting and at board meetings. For August 2019 data showed that on Hansa Ward staff debriefing after incidents had dropped to 14%. The ward manager and staff team then prioritised staff debriefing and built in protected time and support to ensure this happened. By September 2019 staff debriefing after incidents had risen to 100%.

Senior clinical managers discussed pertinent issues such as incidents, staffing, feedback from patients and performance at monthly clinical governance meetings. This system ensured key messages and learning were communicated from service level to the provider and vice versa. In addition, managers attended monthly head of department meetings to check the clinical performance of the wards. Staff discussed best practice, medicines management and physical health. This supported the delivery of safe and effective care.

The service held regular staff meetings where key information about the service was shared. There was a clear framework of what must be discussed to ensure that essential information, such as learning from incidents, safeguarding, staff training and complaints, was shared and discussed. In addition, members of the multi-disciplinary team met regularly on the ward to discuss best practice and complex cases.

Wards for people with learning disabilities or autism

Staff had implemented recommendations from reviews of deaths, incidents, complaints and safeguarding alerts at the service level. Staff across the service had reported an increase in safeguarding incidents between June 2019 to September 2019 relating to patients alleging that staff had physically or verbally assaulted them. Eight safeguarding incidents of this kind were reported during this period. Each allegation was raised by either staff members on the ward or by the patient. The senior team attributed this to several factors, including the current patient cohort on the ward over the summer. Managers investigated these allegations and reported them to the police. Across the hospital two of these incidents were substantiated and as a result the staff members involved were dismissed. The service had improved their safeguarding systems by strengthening the safeguarding leadership and empowering staff and patients to speak up if they had concerns. In addition, each ward had a permanent consultant psychiatrist in post to provide clinical leadership and oversight to staff.

Staff on the ward conducted clinical audits. The audits were sufficient to provide assurance and staff acted on the results when needed. The results of these audits were shared with staff during ward team meetings, supervision sessions and one to one discussions between staff.

Staff we spoke to understood the arrangements for working with other teams, both within the organisation and externally, to meet the needs of the patients. For example, the ward tried to maintain strong relationships with patients' community mental health teams and referring clinical commissioning groups.

Management of risk, issues and performance

The managers used systems to identify, understand, monitor, and reduce or eliminate risks that were mostly effective. They ensured risks were dealt with at the appropriate level. The service had a local risk register, which the manager added to. Risks included the management of ligature points and illicit substances. The hospital manager said the top challenge for the service was staff recruitment and retention. For example, one of the biggest challenges to recruitment was staff salaries and the comparison to other services. The service had a recruitment initiative in place to support with the recruitment of new staff. However, the organisation had not yet produced any particular initiatives to support with retaining staff.

The provider ensured they carried out the necessary checks on staff prior to employment. We checked the personnel files of ten staff across the service and found that each had appropriate checks in place. This included two references from a previous employer to check an employee's experience and skills to carry out their job role. The service had systems in place to check that all staff received a criminal record check. This meant managers could be confident that staff were suitable to work with vulnerable adults.

The service had a business contingency plan for emergencies. The plan detailed processes and procedures for staff to carry out in the event of a major staff absences, loss of electricity, a loss of information technology systems, severe travel disruption, adverse weather and a terrorism threat.

Information Management

The service collected reliable information and analysed it to understand performance and to enable staff to make decisions and improvements. The service had a dashboard that held pertinent data about the service, for example, discharges and length of patient admissions. The information systems were integrated and secure. The managers had access to information to support them with their management role. This included information on the performance of the service, staffing and patient care. Administrative staff supported managers to record key performance indicators.

Information was recorded in a combination of an electronic record system and paper records. Staff completed serious incident records on paper, the ward clerk then copied the completed incident report into the electronic system.

The service notified the Care Quality Commission of notifiable incidents, including incidents involving the police.

Engagement

The service engaged well with patients and staff to plan and manage appropriate services. Staff could attend the organisation's quarterly staff representative group. In addition, the service produced a quarterly newsletter co-produced with patients for patients. This included what projects were going on within the service and individual patient stories. Staff and patients attended the provider's National Service User Awards 2019 in the summer.

Wards for people with learning disabilities or autism

Patients and carers had opportunities to give feedback about the service. For example, the service conducted an annual patient survey. In addition, patients gave staff feedback in weekly community meetings and on the service's 'you said, we did' boards.

The managers used the feedback from surveys to make improvements. The patients completed a satisfaction survey each quarter. The most recent results showed that 11% of patients felt that their overall care at the service was excellent and 33% felt that is was good. Most patients, 56%, felt safe at the service sometimes and 56% felt they were sometimes involved in their care and treatment with 44% saying they always felt involved. Staff listened to patients and used their feedback to improve the service.

Patients and carers were involved in decision-making about changes to the service. For example, patients had been involved in recruitment panels to interview prospective new staff. The service collaborated with partner organisations to help improve services for patients. However, across the service there was more work the provider could do to improve effective communication with other health professionals working with patients. This included community mental health teams and social workers. This would ensure that staff always worked with others to ensure consistent care and treatment for patients.

The lead occupational therapist had recently launched a Working Together group to involve families and carers in their loved one's care. Part of the group was holding regular carers forums and producing a newsletter with families. However, this was relatively new and still needed to embed across the hospital.

Learning, continuous improvement and innovation

Staff on Hansa Ward were involved in a quality improvement process in relation to Stop Over-Medicating People with a learning disability and were applying this knowledge to their care and support practices.

Hansa Ward was accredited by the Quality Network for Inpatient Learning Disability Services for inpatient learning disability mental health services at the time of the inspection.

Personality disorder services

Good ●

Safe	**Requires improvement** ●
Effective	**Good** ●
Caring	**Good** ●
Responsive	**Good** ●
Well-led	**Good** ●

Are personality disorder services safe?

Requires improvement ●

Safe and clean environment

New Dawn Ward environment was safe. Staff knew about the risks and managed them well. Staff carried out regular risk assessments of the environment. This included an annual review of fire safety. The service used an external health and safety company to carry out checks on fire safety and produce an action plan. The service last had an inspection in September 2019 and was working on the actions set out from the assessment. In addition, London Fire Brigade carried out an unannounced inspection in May 2019. Patients who needed them (those with low mobility), had a personal emergency evacuation plan to follow in the event of a fire or other emergency.

Staff managed ligature risks in the environment appropriately and safely. The service had potential ligature anchor points on the ward. Staff reduced the risk to patients by carrying out observations, when needed, and two-hourly walkarounds as a minimum. In addition, staff knew the patients well.

Staff were aware of the ligature risks on the ward and how these were mitigated. Staff had updated ligature risk assessments and added photographs of key ligature points to help staff identify them.

There were some blind spots throughout the ward where staff could not always view patients in communal areas.

The service had taken appropriate steps to manage and mitigate the risks associated with blind spots by installing closed circuit television in communal areas as well as convex mirrors on the walls.

Staff had easy access to personal alarms, which meant they could summon assistance if there was an emergency. Staff knew how to use them. Staff also had two-way radios so that they could communicate with colleagues in other parts of the hospital. However, patient bedrooms did not have call alarms installed. This meant that patients may not be able to summon assistance in an emergency when they were on their own. Staff mitigated this for one patient who had low mobility by placing an alarm call bell in their bedroom and would do so for other patients that needed it.

Maintenance, cleanliness and infection control

Staff controlled infection risk well. Staff completed quarterly infection control audits. We looked at the most recent one completed in September 2019. The audit identified, a cluttered nurses' station, dusty shelves and a dirty water fountain in the communal area. The action plan showed that staff had completed these actions by 31 October 2019.

Clinic room and equipment

The service had appropriate premises and equipment and staff looked after them well. The clinic room contained the necessary equipment to carry out physical health examinations and emergency procedures. Staff checked the medicines fridge and room temperature readings each day. The daily records for the fridge temperatures showed these were within the correct range.

Personality disorder services

Clinic rooms were fully equipped, with accessible resuscitation equipment and emergency drugs that staff checked regularly. This included an emergency grab bag, blood pressure machines, thermometers, weighing scales, blood sugar level machines and pulse oximeters. Staff checked the equipment each week to ensure they worked. In addition, staff checked the emergency drug stock to ensure they were in date.

Safe staffing

The ward had enough nursing staff of all grades to keep patients safe. The manager calculated the number and grade of registered and non-registered nurses required on each shift using a recognised tool. The establishment levels were 12 whole time equivalent (WTE) registered nurses and 19 WTE non-registered nurses working across the service. Staff worked long day shifts. The day shift consisted of three registered nurses and eight non-registered nurses. At night it was three registered nurses and three non-registered nurses. The service had a ward manager working weekdays to oversee the running of the ward, including a hospital director that covered the overall hospital.

The ward had four vacancies for registered nurses and one vacancy for non-registered nurses at the time of the inspection. The manager block booked three agency nurses to cover these vacancies and ensure continuity of care for patients.

The manager limited their use of bank and agency staff and requested staff familiar with the service. The manager used extra bank and agency to cover staff sickness, enhanced observation levels and staff vacancies. The manager made sure all bank and agency staff had a full induction and understood the service before starting their shift. This included training in the use of ligature cutters, reading security policies and training in management of violence and aggression.

A registered nurse was always present in communal areas. The service had enough staff for patients to receive regular one-to-one time with their named nurse and to carry out physical interventions. The manager rarely cancelled patients' leave due to staff shortages.

Medical staff

The service had enough daytime and night time medical cover and a doctor available to go to the ward quickly in an emergency. A permanent consultant psychiatrist was based three days a week on the ward. In addition, the consultant was supported by a ward doctor working Monday-Friday on the ward.

Mandatory training

Staff had completed and kept up to date with their mandatory training. Mandatory training included immediate life support, prevent, prevention and management of violence and aggression and health and safety. Staff also participated in emergency scenario training. We looked at the emergency scenario training carried out in September 2019 with six members of staff across the hospital participating in it. The service reported on the outcome and identified areas for improvement. This ensured staff would have the practical capabilities and skills needed in an emergency.

Assessment of patient risk

Staff used a recognised risk assessment tool to assist their evaluations of patients' individual risks. We reviewed four patient risk assessments. Records showed that staff completed a comprehensive risk assessment for each patient following admission. This included an assessment of each patient's mental, physical and social risk history.

Management of patient risk

Staff identified and responded to changing risk to or posed by patients. Staff reviewed patients' risks every week in the multidisciplinary meetings and daily in safety huddles.

Patients assessed as having physical health risks, such as diabetes or cardiac problems, had a risk management plan in place. For example, a patient had a risk management plan for their seizures. Staff monitored and put a plan in place following a recent incident of self-harm when a patient was banging their head. This included distraction techniques to use when they felt distressed. Another patient had a plan in place to manage the risk of their high body mass index.

Staff did not always complete patients' physical heath observations in line with the providers policy. Staff regularly checked patients' vital signs and recorded these on a Modified Early Warning Score (MEWS) chart. Staff completed these observations at different frequencies determined by the patient's physical health risk. However, we reviewed six MEWS charts and found that three charts had a score of three or above and it was unclear whether

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the appropriate escalation had taken place. For example, one patient had a high pulse rate, which staff did not score. The provider's policy showed that such a high pulse rate should be escalated to a senior clinician to assess. In addition, another patient with diabetes did not have their score recorded for three different days in November after staff had completed their physical health observations. There was a risk that this could impact the clinical team's ability to identify deteriorating patients. Senior managers acknowledgedthat this was an area that needed to improve.

Staff followed the provider's policy and procedures when carrying out observations. The multidisciplinary team assessed the level of observation patients required. Most patients were on observations every 15 minutes or random checks four times every hour. Some patients were on one-to-one observations if they had a high level of risk. In addition, staff carried out hourly checks on the ward environment. This was to reduce the risk of harm to the patients themselves or to others.

Staff followed the provider's policies and procedures when they needed to search patients or their bedrooms to keep them safe from harm. Staff received training in searching patients effectively and safely. Staff searched patients when they returned from leave and risk assessed those patients that needed regular searches due to the risk presented.

Use of restrictive interventions

The service analysed incidents of physical restraint on the ward. The service had 34 incidences of restraint and one incident of prone restraint between 1 February 2019 and 31 July 2019. However, the number of prone restraints had increased in the period between August and September 2019 to three incidents in a two-month period.

Between August and September 2019, staff reported six incidents of restraint that had resulted in administering rapid tranquilisation to the patient. Staff recorded incidents of restraint appropriately. For example, how the restraint was carried out, which staff were involved and for how long they were in the prone or supine position.

Staff understood and used correct techniques when using physical interventions. Staff only used restraint after de-escalation had failed. Staff devised plans to manage behaviours that challenged. Staff used the 'Safewards' model to reduce the risk of the use of restrictive interventions. Staff told us how they tried to establish

rapport with patients and talked to them when they were distressed with the aim of reducing the need for restraint. In addition, staff used a 'calm down box', which contained items selected by patients to help manage their distress.

Staff did not always complete physical health checks after administering rapid tranquilisation in line with the providers policy and the National Institute for Health and Care Excellence guidance (NICE). In many cases, patients declined physical health checks immediately after the staff administered the medicine. However, staff did not make any further attempts to carry out physical health checks. Rapid tranquillisation is when medicines are given to a person who is very agitated or displaying aggressive behaviour to help quickly calm them. We reviewed two incidents of rapid tranquilisation. In one incident the patient refused physical health observations after rapid tranquilisation, staff did not record or show that non-contact physical health observations had been completed such as the patient's respiratory rate or sedation levels, or that there were repeat attempts to monitor vital signs. This meant that staff may not have been able to intervene quickly if the patient was experiencing adverse effects of the medicine. Senior managers acknowledged that this was an area that needed to improve.

Staff were working to reduce blanket restrictions on the ward. Staff participated in the provider's reducing restrictive practices initiative. This included implementing a reducing restrictive practice champion on the ward. The staff team had worked actively to reduce restrictive interventions and to not apply restrictions in a blanket manner. For example, patients were now able to use their mobile phones on the ward. Staff said they used to stop patients' leave automatically after they self-harmed but now this was not a blanket rule, each patient's level of risk was assessed individually. The ward also used to restrict access to hot water for drinks, but this had now ceased.

Staff knew and followed the provider's observation policies and procedures. The multidisciplinary team assessed the levels of observation the patients needed. All but one patient was on hourly observations or intermittent observations. Staff always changed observation levels when a patients' risk changed. In addition, staff carried out twice daily checks on the environment.

Safeguarding

Personality disorder services

Staff were trained in safeguarding and knew how to identify and report any concerns about abuse or neglect. The provider's social work team maintained a database of safeguarding concerns and had an effective system to maintain links with the police and the local authority. This ensured that incidents were investigated in line with multi-agency procedures and patients were protected from harm. All staff teams had a safeguarding champion.

The social work team clarified any safeguarding risks in relation to the patient's family or children and ensured that these were considered by the multi-disciplinary team when planning home leave or the patient's discharge from the ward. Patients' contact with children was planned in in advance and subject to risk assessment. If necessary, a room could be used off the ward for patients to meet with children.

The social work team collected information on lessons learnt from safeguarding incidents and had improvement targets for the service. These included, ensuring safeguarding information was obtained during the referral process, that body maps were carried out to record any injuries, that safeguarding incidents were fully documented and that there was thorough documentation of debriefs with patients and staff. The safeguarding team were monitoring progress with these aims and promoting improved practice through regular training and workshops for staff.

Staff access to essential information

At the time of the inspection, staff were using both paper and electronic patient records. Staff knew where to find key information. Staff told us that the current paper-based systems for incident reporting were quite time consuming and often they were recording in three different places. This could lead to errors in transferring data or in finding accurate information when needed.

Staff told us the provider was intending to move to a fully electronic patient record system soon, but they had not yet been given an implementation date.

Medicines management

The service used systems and processes to safely prescribe, administer, record and store medicines. We checked medicine administration records for five patients. Patients prescription charts included important information, such as patient allergies, and were kept with records of patients'

blood tests and electrocardiograms. This meant that when medicines were prescribed, information regarding patients' physical health was readily available. The service contracted an external pharmacist who attended the ward once a week. The pharmacist completed weekly audits of room and fridge temperatures, storage, medicine errors and stock checks. Where medicines were being used for rapid tranquilisation of patients, they were prescribed and recorded in line with the provider's policy and NICE guidance.

However, when patients were prescribed 'as required' medicines staff did not always review them regularly in line with NICE guidance and the provider's policy. We found three patients' prescription charts showed that they had been prescribed 'as required' medicines for over two weeks. Staff had not conducted a review and recorded this in patient care and treatment records. For example, one patient had been prescribed a medicine 'as required' for over a month and staff had not completed a review of this medicine to see whether it was necessary.

Staff reviewed the effects of each patients' medication on their physical health according to NICE guidance. There was a policy in place for the monitoring of any high dose anti-psychotic treatment as well as the risk of harm from anti-psychotic. At the time of the inspection, no patients were prescribed high doses of anti-psychotic medicines.

Track record on safety

The ward had a good track record on safety. Between 1 February and 31 July 2019 there was 10 serious incidents reported across the hospital. Of these, four were attributed to New Dawn Ward.

Reporting incidents and learning from when things go wrong

Staff knew what incidents to report and how to report them. Staff reported all incidents they should report. Between August and September 2019, staff had reported 93 incidents on the ward. These included, medicines errors, self-harming and a patient absconding from leave.

Staff were aware of a serious incident, which had occurred in other services within the organisation. Staff received monthly learning bulletins about serious incidents and themes that had occurred in other services.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full

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explanation when things went wrong. Duty of candour is a legal requirement, which means providers must be open and transparent with patients about their care and treatment. This includes a duty to be honest with patients when something goes wrong.

The service supported staff and patients after a serious incident had occurred. Staff met to discuss feedback after incidents. The provider told us that emphasis was placed on de-briefs with both staff and patients to ensure lessons were learnt about using the least restrictive intervention. For example, patients identified their triggers for the incident in order to devise a plan for supporting them next time.

Staff made changes in response to feedback from initial incident investigations. For example, staff on the ward discussed the importance of boundaries when supporting patients on the ward. Staff had set up a working group with patients to review the mutual expectations ('Safewards') that existed between staff and patients.

Are personality disorder services effective?
(for example, treatment is effective)

Good 🟢

Assessment of needs and planning of care

Staff assessed the physical and mental health of all patients on admission. We reviewed four patient care and treatment records during our inspection. Records demonstrated good practice in terms of assessment, treatment and risk management. Staff completed a comprehensive mental health assessment of patients in a timely manner at, or soon after, admission. Staff from the assessment team visited patients, before they moved to the service, to complete a comprehensive assessment to ensure they were suitable for specialist support.

Staff recorded patients' physical health needs and updated care plans to reflect this. For example, one patient had a specific care plan for treating and supporting her with her seizures. The patient had been assessed by the ward doctor and supported to specialist medical services at the neighbouring acute NHS trust. This ensured staff knew how to support patients.

Care plans were personalised, holistic and recovery orientated. Staff demonstrated optimism in patient's recovery. Staff adopted a recovery oriented, personalised approach with patients. Patients had personal timetables reflecting their personal interests and specific needs. Care plans included patients' own recovery-oriented goals. For example, one patient had goals to get back into employment as that was important to her. Another patient had a goal for staff to support her with using public transport.

Patients each had a named nurse and had regular one-to-one key worker sessions as part of their care plan.

Best practice in treatment and care

Staff provided a range of treatment and care for patients based on national guidance and best practice. Staff followed National Institute for Health and Care Excellence (NICE) guidance for supporting people with personality disorders and prescribing medicines.

The service was able to provide psychological interventions in line with NICE guidance. This included access to psychological therapies and support for self-harming. The service employed a full-time psychologist with support from assistant psychologists. Staff encouraged patients' recovery through a programme of regular one-to-one dialectal behavioural therapy (DBT) as well as group sessions. In addition, patients received support from an occupational therapist (OT) who worked on the ward.

Staff were implementing the Safewards model (an evidence-based approach to conflict and containment) interventions on the ward. These interventions included the use of talk down, knowing each other, positive words, bad news mitigation and clear mutual expectations. A 'calm down' box containing suitable items was available to patients when needed.

Staff helped patients live healthier lives by supporting them to take part in programmes or giving advice. Staff offered smoking cessation support and worked with patients to reduce their smoking. The service had a dedicated gym onsite with support staff to educate and support patients to exercise. In addition, patients could take part in exercise games on the ward. All patients saw a dietitian after admission and could obtain dietary advice.

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Staff used recognised ratings scales to determine severities and outcomes for patients. For example, staff used the Global Assessment of Progress to monitor and review patients' wellbeing throughout their stay.

The service monitored the effectiveness of care and treatment and used the findings to improve them. The service gathered data on the environment, medicines, care planning and risk assessment.

Skilled staff to deliver care

The ward team included or had access to the full range of specialists required to meet the needs of patients. The team included skilled staff from a range of disciplines including nurses, an occupational therapist and assistants, a doctor, a clinical psychologist and a social worker.

Managers ensured staff had the right skills, qualifications and experience to meet the needs of the patients in their care, including bank and agency staff. Staff could attend conferences and share best practice throughout the multidisciplinary team. Managers ensured that nursing staff received the necessary specialist training for their roles. Staff had undertaken training in dialectical behaviour therapy, a therapy used to treat borderline personality disorder. Some staff had also received training in working with psychosis, motivational interviewing, learning disability and autism.

Managers supported staff through regular, constructive appraisals of their work. The manager provided staff with supervision. Staff said they received regular supervision and an annual appraisal. In addition, staff took part in regular reflective practice meetings with the lead psychologist to discuss complex cases.

Multi-disciplinary and inter-agency teamwork

Staff held regular and effective multidisciplinary meetings. Doctors, nurses and other healthcare professionals supported each other to provide good care. The multidisciplinary team met together daily to hand over any pertinent issues about patient care. The multidisciplinary team also met together weekly to discuss patients' care and treatment with input from the patient and their families.

Staff shared pertinent information about patients at effective handovers within the team. For example, at the beginning of each shift nursing staff met to discuss any incidents, safeguarding or planning from the previous shift.

In addition, staff met daily, including the MDT, to discuss staff and patient safety for the day in safety huddles. Staff met monthly to discuss the running of the service in team meetings.

Staff had effective working relationships with other relevant teams within the organisation. For example, the senior managers met monthly with each other to discuss best practice. The minutes for the previous months showed staff discussing clinical effectiveness, incidents, staffing, blanket restrictions and discharges. The manger then fed this into the monthly staff meetings to share pertinent issues.

The teams had effective working relationships with teams outside the organisation to support patients holistically. Staff tried to keep in contact with patients' care coordinators and involve them in care programme approach meetings. Staff often found it difficult to regularly meet and discuss patient care with care coordinators outside of London.

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

Staff understood their roles and responsibilities under the Mental Health Act 1983 (MHA), the code of practice and its guiding principles. At the time of this inspection, nine patients were detained under the MHA. MHA training was mandatory, and all staff had completed this.

Staff had easy access to administrative support and advice on the implementation of the MHA.

Patients had easy access to information about independent mental health advocacy (IMHA). The ward displayed posters with the contact details of the local advocacy service. Advocates attended the ward each week.

Staff explained to patients their rights under the MHA in a way they could understand and repeated it as needed. When staff explained patients' rights to them, they recorded they had done so. Records showed that staff explained to patients their rights under the MHA at least once a month and whenever their MHA status changed.

Staff authorised and administered medicines for detained patients in line with the MHA code of practice.For example, clinicians completed patients' consent to treatment forms accurately and kept them with patients' medicine administration records.

Good practice in applying the MCA

Personality disorder services

Most staff had a good understanding of the Mental Capacity Act (MCA), and the five statutory principles. Staff knew how to support patients who lacked capacity to make decisions about their care. Training for staff in the MCA and deprivation of liberty safeguards (DoLS) was mandatory and all staff had completed the training.

Staff gave patients every possible assistance to make a specific decision for themselves before they assumed a patient lacked capacity.

Staff understood the need to seek consent from patients before providing care. For example, staff discussed with patients the level of involvement they wanted from their families.

When patients lacked capacity, staff made decisions in their best interests and recognised the person's wishes, culture and history. For example, records showed staff decided in a patients' best interest where they were unable to weigh up the decision regarding their treatment. This meant staff could look at the patient's needs holistically and consider their wishes and history when deciding on next steps.

Are personality disorder services caring?

Good ●

Kindness, privacy, dignity, respect, compassion and support

Staff treated patients with compassion and kindness. We spoke to five patients and most fed back positively about staff and how they were treated. The majority said that what they liked most about the service was that there had been improvements to the activities and group work. Most patients said that staff supported them and treated them with dignity and respect. Patients enjoyed the sensory group and really liked the occupational therapists. However, most patients said what they would like to improve was the staffing levels to meet their needs.

Staff interacted with patients in a thoughtful and respectful way. We observed the ward's 'mind and medicines' group, which was a teaching session facilitated by the consultant psychiatrist for the women on certain topics related to medicines. Staff asked the patient group questions, so it was a two-way process and asked and explained things if

anyone did not understand. General observations throughout the inspection, showed staff speaking to patients in a caring and calm way. Staff took time to diffuse situations where patients were becoming distressed.

Staff understood the individual needs of the patients, including their personal and social needs. Staff supported patients to maintain social activities that they had an interest in.

Staff reported they felt able to report concerns about disrespectful or discriminatory attitudes towards patients.

Staff maintained the confidentiality of information about the patients. Staff discussed patients' care in private and covered the whiteboard in the nurse's station, so people could not see patient information.

Involvement in care

Staff involved patients in their care. Staff oriented patients to the service when they first arrived. Patients received a recovery folder on admission that included information about the service, activities and patient rights.

Staff involved patients in care planning and risk assessment and actively sought their feedback on the quality of care provided. Patients said that staff involved them in their care and treatment planning. Patients decided to attach parts of their care plans to the outside of their bedroom doors. Patients included how they would like to be supported by staff when they felt low in mood or distressed. This ensured that staff knew how to support each patient in a personalised way.

As part of the 'Safewards' model staff and patients took part in agreeing mutual expectations. These are joint expectations that work both ways, and just as the staff have expectations of patients, patients have expectations of the staff. This ensures consistency and lowers stress and anxiety to aid patients' recovery.

Staff involved patients in decisions about the service, when appropriate. The service held monthly people's council meetings. These meetings comprised patients from across the hospital and an expert by experience discussing social activities, projects such as 'Dragons Den' and patient involvement. Patients co-produced the hospital newsletter, outlining what activities and projects the hospital was

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hosting. In addition, the service involved patients on recruitment panels to support interviews of potential staff. Patients could join the integrated governance meetings as a service user representative.

Staff supported patients to give feedback about the service they received. The service had a 'you said we did' board, which highlighted any requests or suggestions that patients had made and what actions had been completed. For example, the patients had asked for the activities timetable to be reviewed. In response staff put together a new timetable that had started. This showed staff listened to patients' feedback.

Staff ensured patients had access to advocates to have their voice heard.

Involvement of families and carers

Staff enabled families and carers to give feedback on the service. Staff invited families and carers to ward rounds. The hospital occupational therapist lead was working on further improving family and carer involvement through regular carers forums and launching a new project promoting families and carers. In addition, families and carers could provide feedback to the service through a survey on an electronic device. However, most patients were from outside London, so this was difficult for families and carers to visit their loved ones and input into their care.

Whilst staff tried to involve families and carers in patients' care and treatment this was not always reflected in patient care and treatment records. For example, one patient was married and supported by their spouse, but their care plan did not show where staff had tried to involve her husband.

Are personality disorder services responsive to people's needs?
(for example, to feedback?)

Good ●

Access and discharge

Bed management

The service managed the use of beds well. At the time of the inspection the ward was full with 18 patients. Places were funded by clinical commissioning groups in the areas where patients lived permanently. Patients were mainly out of area at the time of the inspection. Most patients were from outside London.

All admissions came through a centralised assessment team. This team was internal within the organisation but sat separately from the service. This dedicated team screened all admissions and undertook face to face assessments. After the assessment, the multidisciplinary team met and discussed whether the person was appropriate for the service. This meant that it gave staff at the service more time to provide frontline care and support to patients.

The service had clear admission and exclusion criteria for referrers.

Discharge and transfers of care

At the time of the inspection, the discharge from hospital of one patient was delayed. Delays were often due to finding a suitable placement. The average length of stay for patients was 18-24 months. However, a few patients had been at the service for over three years. Between July – September 2019, one patient had been discharged from the ward.

Staff planned for patients' discharge. When patients were admitted, staff identified any potential barriers that could delay discharge in the future. Staff created individualised discharge plans with patients. In addition, staff set goals with patients that would support them to move on. However, staff noted that it was often difficult to get patients' care coordinators from outside of London to attend care programme approach meetings and multidisciplinary meetings to facilitate discharge.

The facilities promote recovery, comfort, dignity and confidentiality

The design, layout, and furnishings of the ward/service supported patients' treatment, privacy and dignity and promoted their recovery. Patients had their own bedroom which had their own toilets and wash basins but shared shower facilities with other patients. Patients personalised their own bedrooms and ensured they were homely with their own pictures and belongings.

Staff and patients had access to a full range of rooms and equipment to respond to patients' needs. The ward had an

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assisted living kitchen, sensory room, quiet room and communal lounge to support patients' recovery and wellbeing. In addition, patients accessed an outside space from a large balcony garden.

Patients had a lockable space in their bedrooms for their belongings and space in fridges and freezers to store their own food. Patients had access to hot and cold drinks throughout the day and night.

Patients had a quiet area they could meet with visitors.

Patients had access to therapeutic activities. The occupational therapist developed a timetable for patients to take part in a range of activities. Activities included, pampering, arts and crafts and cooking groups. In addition, patients could access the service's recovery college to take part in educational courses based on mental wellbeing and skills development.

Patients' engagement with the wider community

Staff ensured that patients had access to education and work opportunities. The service offered patients ward based jobs, such as gardening and sitting on recruitment panels.

Staff tried to encourage patients to develop and maintain relationships with people that mattered, for example family members and friends. Staff were supportive of patients who were lesbian, gay, bisexual and transgender (LGBT+). They said they tried meet the needs of people with disabilities and support patients with their religious needs. From the recent patient survey, 56% of patients said the ward environment promoted their diverse needs.

Meeting the needs of all people who use the service

The service met the needs of all patients who used the service, including those with a protected characteristic. The service made suitable adjustments for patients with disabilities to access the premises. The service had a lift that patients, who were less mobile, could use to go up and down rather than use the stairs.

Staff ensured patients obtained information on their rights, how to complain, local services and treatments available through a welcome information leaflet.

Staff provided information in the English language. However, for patients whose first language was not English staff would provide interpreters or source information available in other languages.

Patients had a variety of meal choices that supported their dietary requirements. This included foods to meet patients' individual religious needs such as halal or kosher foods. The majority of patients who responded said that the quality of food was good in the most recent patient satisfaction survey.

Listening to and learning from concerns and complaints

The service treated concerns and complaints seriously, investigated them and learned lessons from the outcomes. Between July – September 2019, the service overall received 29 complaints. Eight of these complaints we upheld and four were partially upheld. Patients complained about their care and treatment or staff attitudes.

Patients knew how to complain and felt able to do so. When patients were admitted to the service, they signed to say they knew and understood the complaints process. Staff displayed this information on the noticeboards.

When patients complained, staff provided them with feedback from investigations. We looked at four complaint investigations across the service. For example, the manager wrote to the patient and verbally discussed the outcome with them. One complainant was provided with a response of what changes they had made because of their complaint about the inconsistent use of personal mobile phones for patients.

Managers handled complaints appropriately, but improvements needed to be made to their timeliness. The general manager kept a log of all formal and informal complaints. Records showed the managers discussed complaints with staff at their monthly team meetings and shared any learning that had resulted. The service knew they had further work to do on improving their response times. For example, the hospital clinical governance meeting reported that 19 of the 29 complaints about the service received I July 2019 to 30 September 2019 had not been responded to within the provider's 20-day target. This meant complaints were not responded to promptly, so the complainant can proceed with their complaint in a timely way.

The service collected compliments. The service had received five compliments in the same period.

Personality disorder services

Are personality disorder services well-led?

Good ●

Leadership

Staff said that the senior managers in the service were visible and approachable. The hospital manager had worked at the service for several years and knew the patients and staff well. The service had recently invested in strengthening their senior leadership team. This included permanent consultant psychiatrists, leads for psychology, safeguarding and occupational therapy as well as a new medical director.

The ward had recently appointed a new manager and staff fed back that positive changes had been made as well as a more stable team. Leadership development opportunities were available, including opportunities for staff below team manager level. Staff could apply to participate in training courses through the provider's academy.

Vision and values

Staff understood the vision and values of the service. They tried to deliver care in accordance with these values. The service had recently implemented a values–based recruitment programme, which based the recruitment application and assessment on the service's new collaborative objectives. The provider aimed to help people rebuild their living and vocational skills, ready to regain their place in the community. Staff emphasised optimism in patient's recovery and treated them with dignity and respect.

Culture

Staff felt well supported by their colleagues. They felt able to speak up if they had any concerns and were confident they would be listened to. Staff described good morale and a supportive, cohesive team.

Staff had access to support for their physical and emotional wellbeing in the workplace. The service had an external employee assistance programme that staff could access confidentially.

Staff performed well against the provider's sickness target of 2%. However, New Dawn Ward had the highest sickness absence and was above the target at 3% as of October 2019.

Staff could feedback about the service to help improve the running of it. Staff completed an annual survey in 2018. The results showed that 22% of staff felt that the Pay and Reward system was not transparent, and they were disadvantaged. For example, they should be paid be paid London weighting. Most staff (92%) felt that there should be more opportunities for specialist training to develop in their role. Managers listened to staff and completed an action plan from their feedback to improve staff experience.

Governance

Our findings from the other key questions demonstrated that governance processes were effective at ward level and that performance and risk were managed well. For example, managers checked incident reports to ensure that, when appropriate, there had been a de-brief with the patient and staff involved. The data collected was used as a key performance indicator, which was monitored at a monthly hospital-wide clinical governance meeting and at board meetings.

However, during the inspection we identified that the provider's governance processes for monitoring patient physical observations and escalating physical health deterioration promptly needed further work. For example, clinical governance meetings had highlighted this as an area for improvement, but we found this was still an issue.

The service had a monthly staff meeting and a monthly business meeting. These meetings were well-organised with standard agendas. Records were kept of issues raised and planned actions. Learning from incidents, safeguarding alerts and complaints was routinely discussed at staff meetings. Staff told us that meetings were well-run and informative, and they were emailed a copy of the minutes, so they were kept informed if they were unable to attend the meeting.

The hospital-wide clinical governance meeting reviewed performance across key aspects of care and treatment. For example, the meeting reviewed compliance with the provider's schedule of audits and checked that audit findings were actioned at ward-level to improve the quality of the service.

Personality disorder services

Staff had implemented recommendations from reviews of deaths, incidents, complaints and safeguarding alerts at the service level. Staff across the service had reported an increase in safeguarding incidents between June – September 2019 relating to patients alleging that staff had physically or verbally assaulted them. Eight safeguarding incidents of this kind were reported during this period. Each allegation was raised by either staff members on the ward or by the patient. The senior team attributed this to several varying factors, including lack of management oversight on New Dawn Ward over the summer. The ward now has a permanent ward manager in post. Managers investigated these allegations and reported them to the police. Across the hospital two of these incidents were substantiated and as a result the staff members involved were dismissed. The service had improved their safeguarding systems by strengthening the safeguarding leadership and empowering staff and patients to speak up if they had concerns. In addition, each ward has a permanent consultant psychiatrist in post to provide clinical leadership and oversight to staff.

Management of risk, issues and performance

The managers used systems to identify, understand, monitor, and reduce or eliminate risks that were mostly effective. They ensured risks were dealt with at the appropriate level. The service had a local risk register, which the manager added to when needed. Risks included the management of ligature points and illicit substances coming into the hospital. The hospital manager said the top challenge for the service was staff recruitment and retention.

The service had a recruitment initiative in place to support with the recruitment of new staff. For example, one of the biggest challenges to recruitment was staff salaries and the comparison to other services.

The provider ensured they carried out the necessary checks on staff prior to employment. We checked the personnel files of ten staff across the service and found that each had appropriate checks in place. This included two references from a previous employer to check an employee's experience and skills to carry out their job role. The service had systems in place to check that all staff received a criminal record check. This meant managers could be confident that staff were suitable to work with vulnerable adults.

The service had plans for emergencies. Business continuity plans covered a range of scenarios such as a terrorism bomb threat or a no deal Brexit.

Information management

The service collected reliable information and analysed it to understand performance and to enable staff to make decisions and improvements. The service had a dashboard that held pertinent data about the service, for example, discharges and length of patient admissions.

The information systems were integrated and secure. Information was recorded in a combination of an electronic record system and paper records. Staff completed serious incident records on paper, the ward clerk then copied out the completed incident report into the electronic system. However, we found that staff recorded patients' physical health observations in three different places. Therefore, staff missed some recordings of physical health observations. This meant that patient notes were not always comprehensive, and staff could not easily access them.

The service notified the Care Quality Commission of notifiable incidents, including incidents involving the police.

Engagement

The service engaged well with patients, staff, the public and local organisations to plan and manage appropriate services. Staff could attend the organisation's quarterly staff representative group. In addition, the service produced a quarterly newsletter co-produced with patients for patients. This included what projects were going on within the service and individual patient stories. Staff and patients attended the provider's National Service User Awards 2019 in the summer.

Patients and carers had opportunities to give feedback on the service. For example, the service conducted an annual patient survey. In addition, patients gave staff feedback in weekly community meetings and on the service's 'you said, we did' boards.

The managers used the feedback from surveys to make improvements. The patients completed a satisfaction survey each quarter. The most recent results showed that 11% of patients felt that their overall care at the service was excellent and 33% felt that is was good. Most patients

Personality disorder services

(56%) felt safe at the service sometimes and 56% felt they were sometimes involved in their care and treatment with 44% saying they always felt involved. Staff listened to patients and used their feedback to improve the service.

Patients and carers were involved in decision-making about changes to the service. For example, patients had been involved in recruitment panels to interview prospective new staff.

The service collaborated with partner organisations to help improve services for patients. However, there was more work the provider could do to improve effective communication with other professionals working with patients. This included community mental health teams and social workers. This would help ensure that staff worked with others to deliver consistent care and treatment for patients.

The lead occupational therapist had recently launched a Working Together group to involve families and carers in their loved one's care. Part of the group was holding regular carers forums and producing a newsletter with families. However, this was relatively new and still needed to embed across the hospital.

Learning, continuous improvement and innovation

Staff could not describe any quality improvement initiatives taking place, although they talked about overall improvements over time, particularly related to reducing restrictions on patients on the ward.

Outstanding practice and areas for improvement

Outstanding practice

- Staff worked hard to support patients to be involved and collaborate in their care. This included supporting patients at the hospital's monthly Peoples Council to discuss projects such as 'Dragons Den', social activities and reducing restrictions on the wards. Patients co-produced the seasonal hospital newsletter that displayed useful information in an accessible format. The service had an expert by experience working across the wards.
- Patients were also able to attend a wide range of groups and activities through the service's Recovery College (not usually found in independent healthcare).
- Patients on Hansa Ward had a calm card attached to their medicine's administration records. The information on these cards were generated by patients and were used before staff and patients considered using 'when required' medication. The calm cards we saw included things like 'offer a cup of tea', 'call nan for a chat' and 'go for a walk in the fresh air'.
- Staff on Hansa Ward They knew about and worked towards achieving the aims of the STOMP programme (stop over-medicating people with a learning disability).
- Hansa Ward had two least restrictive champions, and one was a patient. These champions raised issues and provided feedback on restrictive interventions and restrictive practices to the ward team and senior hospital management.

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that staff on Bewick and New Dawn Wards take all reasonable steps to ensure that physical health checks are carried out and recorded after patients receive rapid tranquilisation, including when a patient refuses to have their vital signs taken.
- The provider must ensure that information about patients' physical health care on Bewick and New Dawn Wards is recorded accurately in line with best practice guidance and the providers policy. and that the information is transferred promptly on to patients' electronic records so that it can be followed up quickly when concerns are identified. Where decisions have been made not to escalate concerns these should be clearly recorded in patient care plans.
- The provider should ensure that there is an effective system in place on Hooper Ward to ensure staff administer medicines safely and take prompt action in response to learning from previous errors.

Action the provider SHOULD take to improve

- The provider should ensure that all patients have access to an alarm to call for help in the event of an emergency.
- The provider should ensure they review their use of restricting patients' access to snacks on Hooper Ward to ensure that they are appropriately applied, based on patients' individual needs and preferences.
- The provider should ensure it continues to work to improve recruitment and retention within the service to address staff vacancies across the hospital but particularly on Bewick Ward.
- The provider should ensure that staff on the Bewick Ward record clearly when equipment has been properly cleaned.
- The provider should ensure that staff reflect patients' families and carers involvement in their care and treatment records.
- The provider should ensure they respond to complaints within their target time.

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **Regulation 12 HSCA (RA) Regulations 2014 safe and care treatment**