Care Quality Commission

Good

Sheffield Health and Social Care NHS Foundation Trust

Forensic inpatient/secure wards

Quality Report

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Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
TAHXN	Forest Lodge	Assessment Ward	S35 0JW
TAHXN	Forest Lodge	Rehabilitation Ward	S35 0JW

This report describes our judgement of the quality of care provided within this core service by Sheffield Health and Social Care NHS Foundation Trust. Where relevant we provide detail of each location or area of service visited.

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

Where applicable, we have reported on each core service provided by Sheffield Health and Social Care NHS Foundation Trust and these are brought together to inform our overall judgement of Sheffield Health and Social Care NHS Foundation Trust.

Summary of findings

Ratings

We are introducing ratings as an important element of our new approach to inspection and regulation. Our ratings will always be based on a combination of what we find at inspection, what people tell us, our Intelligent Monitoring data and local information from the provider and other organisations. We will award them on a four-point scale: outstanding; good; requires improvement; or inadequate.

Overall rating for the service	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 / Deprivation of Liberty Safeguards
We include our assessment of the provider's compliance with the Mental Health Act and Mental Capacity Act in our overall inspection of the core service.

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

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

Summary of findings

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Summary of findings

Overall summary

We rated forensic inpatient and secure wards as good because:

- Staff treated patients with kindness and respect. Carers and most patients gave positive feedback about the care and treatment they received. Staff involved patients in meetings about their care and treatment.
- Staff completed a comprehensive risk assessment prior to patients taking authorised leave. The wards had low incidents of restraint, seclusion and use of rapid tranquilisation.
- Staff informed patients of their rights under the Mental Health Act at regular intervals and records contained valid consent to treatment documentation.
- A multidisciplinary team was involved in ward rounds and bed management meetings to manage care and treatment to current and prospective patients collaboratively.
- Staff felt supported by their managers and colleagues. All staff received regular supervision and appraisal.
- Patients had access to advocacy involvement and an advocate led patient community meetings on the wards.

However:

- Systems did not ensure that staff received mandatory training and sufficient staff to provide care and treatment on the wards. The overall training compliance rate was 57%. A number of shifts did not have enough staff to provide care and treatment.
- Staff imposed a blanket restriction in relation to the searching of patients on return from unescorted leave. The assessment ward had an illogical restriction where staff denied patients access to the tea pantry on the assessment ward. Staff did not undertake an individual risk assessments when applying these restrictions.
- The seclusion suite and its use did not comply with the Mental Health Act code of practice. Staff could not see patients in the toilet area of the seclusion suite. A door to the bathing area in the seclusion suite could be used by patients to harm themselves or others. Independent multidisciplinary team reviews did not always take place for episodes of seclusion in line with the Mental Health Act code of practice.
- Ward environments had a number of ligature risks which included taps and door handles. Environmental risk assessments did not identify the precise locations of ligature risks and risk management plans contained limited information to explain how staff managed and mitigated identified risks.
- Patients sometimes received their medication from the nurses' station on the rehabilitation ward and the clinic room door on the assessment ward. This did not promote privacy and dignity.
- Patient involvement in care planning was limited and only one patient told us that they had a copy of their care plan.
- Patients did not have a dedicated space to practice their religious and spiritual beliefs.
- Activity timetables in place at the time of the inspection were dated months previously. Activities provided took place mainly between Monday to Friday each week. Some patients told us that they felt bored of the activities available.
- The average waiting time from referral to assessment was 50 days for the assessment ward and 127 days for the rehabilitation ward.

Summary of findings

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

Are services safe?

Requires improvement

We rated safe as requires improvement because:

- Mandatory training rates showed that overall training compliance was 57%. The completion rate of mandatory training was not up to date for 13 out of 22 mandatory training courses required. This included training which was required to ensure the safe delivery of the service including administration of rapid tranquilisation and physical interventions.
- Staff used a blanket restriction routinely across the two wards. Staff routinely searched all patients on return from section 17 unescorted leave. Patients did not have individual risk assessments in relation to these restrictions.
- Patients on the assessment ward could not access the tea pantry.
- The seclusion suite on the assessment ward did not allow staff to observe patients at all times. The seclusion suite had a solid door between the toilet and sleeping area. When this door was closed staff could not see patients in this area. The door to the toilet and bathing area in the seclusion suite could be used by patients to harm themselves or others.
- Ward environments had a number of ligature risks which included taps and door handles. Environmental risk assessments identified potential ligature risks. However, documentation in use on the wards did not state the specific locations of ligature points and management plans contained limited and basic information on how staff managed these risks on the wards.
- We identified two episodes of seclusion which lasted longer than eight consecutive hours did not have an independent multidisciplinary review promptly. On one occasion an independent multidisciplinary review took place 26 hours after seclusion commenced. On the other occasion a multidisciplinary review took place 17 hours after seclusion. This was not an independent review. This was not line with the Mental Health Act code of practice.
- The trust did not fill all shifts with bank or agency staff. This meant that some shifts did not have the required amount of staff to provide care and treatment to patients.

However:

Summary of findings

- Staff completed a comprehensive risk assessment prior to patients leaving the ward for section 17 leave. This included assessing patients' understanding of their leave conditions and their mental state.
- The wards had low incidents of restraint, seclusion and use of rapid tranquilisation. Staff told us that they managed this through knowledge of patients' needs and the use of effective de-escalation techniques.

Are services effective?

We rated effective as good because:

Good

- Staff informed patients of their rights under section 132 of the Mental Health Act at regular intervals. Patients' records contained correct and up to date documentation for consent to treatment which was in line with legislation and guidance.
- Care plans contained detailed and holistic information about patients' needs. This included patients' physical and mental health needs.
- Ward rounds involved the multidisciplinary team and staff worked collaboratively to review patients' holistic needs and agree actions to meet patients' needs and achieve objectives.
- Staff received regular supervision and all staff received a performance appraisal.

Are services caring?

We rated caring as good because:

Good

- Observations of interactions between staff and patients showed that staff treated patients with respect, kindness and had a positive rapport. Staff knew patients and their needs in detail.
- Patients told us that staff treated them well and they felt respected.
- A carer that we spoke with told us that they felt involved in the care of their relative and had positive relationships with staff.
- Staff involved patients in meetings regarding their care and treatment.

However:

- Most patients were not involved in the development of their care plans and only one patient told us that they had a copy of their care plan.

- Patients sometimes received their medication from the nurses' station on the rehabilitation ward and the clinic room door on

the assessment ward. This meant that other patients, staff and visitors could see patients taking their medication. These patients were not afforded privacy and dignity when taking medication.

Are services responsive to people's needs?

Good

We rated responsive as good because:

- Staff attended bed management meetings each week where the multidisciplinary team discussed referrals to the service, reviewed current patient stays and discharge plans.
- Advocates led patient community meetings on the wards. Patients had the opportunity to give feedback on the service.

However:

- The activity timetables in place at the time of the inspection were dated August 2016, featured activities mainly between Monday to Friday and some patients told us that they felt bored with the activities available.
- The pay phone on the assessment ward did not have a hood. This meant that patients using the phone did not have privacy when making phone calls.
- The wards did not have access to dedicated space for patients to practice their religious and spiritual beliefs.
- The average waiting time from referral to assessment was 50 days for the assessment ward and 127 days for the rehabilitation ward.

Are services well-led?

Good

We rated well-led as good because:

- Staff felt supported by their managers and their colleagues.
- Staff could explain the trust's values and observations showed that staff demonstrated these in practice.
- Systems ensured that staff received regular supervision and appraisal.
- At the time of our inspection the trust was developing a recovery college and staff were aiming to reduce restrictive practices as part of commissioning for quality and innovation targets.

However:

- Systems did not ensure that staff received up to date mandatory training when this was required.

Summary of findings

Information about the service

Forest Lodge is a purpose built hospital at Middlewood in Sheffield. Sheffield Health and Social Care NHS Foundation Trust run the hospital. There are two inpatient facilities based on this site. It is registered to take up to 22 patients that have been detained under the Mental Health Act 1983. Forest Lodge provides low secure accommodation for mentally disordered male patients with an offending background or whose mental health needs require assessment, treatment and rehabilitation within a secure environment. Patients are aged between 18 and 65 years of age.

The assessment ward provides care for up to 11 patients who require high levels of support, assessment and interventions. The rehabilitation ward provides care for up to 11 patients who require less intensive support than those on the assessment ward. Staff focus on working with patients to move onto the next stage in their care.

We last inspected these forensic inpatient and secure wards in October 2014 under the current methodology. At that inspection, we rated the core service as overall 'outstanding'. The trust met the requirements of the regulations. There were three areas for improvement that we told the provider it should take action to improve. These were that:

- The trust should replace the seclusion room observation panel with one which enables effective communication between staff and patients.
- The trust should ensure there is a way for a patient using the disabled access shower room on the rehabilitation ward to call for assistance if needed.
- The trust should review and remove all ligature risks where patients have unsupervised access.

During this inspection, we found that the provider had addressed the concerns from the last inspection in relation to the seclusion room observation panel and disabled shower room assistance.

Our inspection team

Our inspection was led by:

Chair: Beatrice Fraenkel, Chairman, Mersey Care NHS Foundation Trust.

Head of Inspection: Jenny Wilkes, Head of Hospital Inspection, Care Quality Commission

Team Leader: Jenny Jones, Inspection Manager, Care Quality Commission

The team that inspected this core service comprised two Care Quality Commission inspectors and three specialist advisors who were: a consultant psychiatrist, a mental health nurse and an occupational therapist.

Why we carried out this inspection

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

How we carried out this inspection

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

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

Summary of findings

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

During the inspection visit, the inspection team:

- visited both of the wards at Forest Lodge and looked at the quality of the ward environment and observed how staff were caring for patients
- spoke with eight patients who were using the service
- spoke with the managers or acting managers for each of the wards
- spoke with 15 other staff members; including a consultant psychiatrist, junior doctors, a senior clinical psychologist, an occupational therapist clinical lead, nurses, support workers, occupational therapy assistants and a receptionist
- attended and observed one hand over meeting, seven ward rounds and one care programme approach meeting
- looked at 14 care and treatment records of patients
- carried out a specific check of the medication management on both wards
- completed a review of five seclusion records
- looked at a range of policies, procedures and other documents relating to the running of the service
- spoke with one relative of a patient using the service.

What people who use the provider's services say

Prior to our inspection we asked patients to provide feedback about their experience of using the service using comment cards. We did not receive any feedback from patients on these comment cards. However, we completed two focus groups and two patients attended these. During our inspection we spoke with eight patients who were using the service. We also received feedback from one carer and relative of a patient using the service.

Patients and the carer we spoke with felt included in decisions made about their care and treatment. Patients told us that they knew who their named nurse was and could spend time with them. They told us that they attended meetings about their care and treatment and staff informed them of their rights under the Mental Health Act regularly. Most patients gave positive feedback about the staff that worked with them. They told us that staff treated them with respect and were polite and supportive.

Patients told us they could access a range of different activities and advocacy and spiritual support was available. However, three patients told us that they felt bored with the activities available. Patients told us they knew how to raise concerns or complaints and could give feedback on the service through patient community meetings.

Good practice

After a significant event that occurred outside of the service, staff arranged for support from the hospital chaplain for patients. Staff also arranged for the wards to have a service at Forest Lodge for all patients who wished to attend.

Independent mental health advocates led patient community meetings on the wards.

Summary of findings

Areas for improvement

Action the provider MUST take to improve

- The trust must ensure that staff receive up to date mandatory training.
- The trust must ensure that restrictive practice is based on individual risk of patient and not applied to all patients routinely as a blanket restriction.
- The trust must ensure that the seclusion suite is compliant with the requirements of the Mental Health Act code of practice.
- The trust must ensure that work is completed according to the business case submitted to the trust to reduce and remove the ligature risks identified.
- The trust must ensure that that all documentation in relation to the risk assessment and mitigation of ligature risks is present and in use on the wards.
- The trust must ensure that documentation in relation to the identification of ligature points clearly identifies the location of ligature risks and risk management plans must contain detailed information to explain how the trust manages and mitigates the risk of ligatures.

Action the provider SHOULD take to improve

- The trust should ensure that patients’ privacy and dignity is upheld when taking medication.
- The trust should ensure that independent multidisciplinary team reviews of seclusion are promptly undertaken as outlined within the Mental Health Act code of practice.
- The trust should review the facilities at Forest Lodge for the provision of dedicated space for patients to practice their spiritual and religious beliefs.
- The trust should ensure that there are enough staff on shift to meet the minimum staffing requirements of the wards.
- The trust should review activity timetables regularly to ensure that meaningful and engaging activities are available across the seven day week for patients to access.
- The trust should ensure that the waiting time from referral to assessment for admission to the assessment and rehabilitation wards is reduced.
- The trust should ensure that staff involve patients in the development of their care plans.

Care Quality Commission

Sheffield Health and Social Care NHS Foundation Trust

Forensic inpatient/secure wards

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Assessment Ward	Forest Lodge
Rehabilitation Ward	Forest Lodge

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.

All staff received training in the Mental Health Act as part of their mandatory training. Ninety four percent of staff completed this training. Staff had a reasonable level of understanding of the Mental Health Act and Mental Health Act code of practice 2015.

Some practices on the wards did not comply with the Mental Health Act code of practice 2015. Staff searched all patients routinely on return from unescorted section 17 leave. Seclusion episodes did not always follow the code of practice guidance. On one occasion, an independent multidisciplinary review took place 26 hours after seclusion commenced. On another occasion seclusion was ended on the review of the multidisciplinary team which was not independent. This took place 17 hours after the episode of seclusion commenced.

The wards had a system was in place on admission to ensure Mental Health Act documents were correct and in order. Staff undertook regular audits of Mental Health Act documentation. A central Mental Health Act office in the trust provided support. Staff informed patients of their rights at regular intervals. Patients understood their leave and any reasons for leave being suspended. Care and treatment records contained correct and in order consent to treatment documentation. This was in line with legislation and guidance.

Detailed findings

Noticeboards on the wards contained information regarding access to independent mental health advocacy. Independent mental health advocates visited the wards each month and led the patients' community meetings.

Mental Capacity Act and Deprivation of Liberty Safeguards

The Mental Capacity Act is legislation which is aimed at maximising an individual's potential to make informed decisions for themselves. Where individuals are unable to make informed decisions the act and the Mental Capacity Act code of practice provides processes to be followed to ensure that decisions made on behalf of individuals are in their best interests and are the least restrictive on their rights and freedoms.

Training in the Mental Capacity Act was a mandatory requirement for all staff. The trust provided training in the Mental Capacity Act at level one and level two. Training compliance rates for both of these training courses was below the trust target of 75%. Information provided by the trust showed that nine out of 33 eligible staff (27%) of staff attended Mental Capacity Act level one training. Nine out of 19 eligible staff (47%) attended Mental Capacity Act level two training. However, despite low training compliance rates staff understood that the Mental Capacity Act involved processes around individuals making decisions. Staff told us that capacity should be presumed unless assessed otherwise and explained the best interest process should be used when individuals lack capacity.

Ward round documentation contained a section for staff to record potential capacity issues for discussion and one patient's care and treatment record contained a completed capacity assessment regarding making financial decisions.

The forensic inpatient and secure wards provided care and treatment to patients detained under the Mental Health Act. This meant that the wards did not use the Deprivation of Liberty Safeguards.

Requires improvement

Are services safe?

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

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

Our findings

Safe and clean environment

Forest Lodge had two low secure wards. One ward was an assessment ward and the other a rehabilitation ward. Both wards were laid out with rooms situated off one long corridor. The ward layout did not enable staff to observe all areas of the ward at all times. However, staff completed regular observations on both wards and on the assessment ward a member of staff was allocated to corridor observation at all times.

During our last inspection we told the trust that they should review and remove all ligature risks where patients had unsupervised access. A ligature risk or a ligature point is anything which items could be secured onto for the purpose of strangulation or hanging. On this inspection we found that wards continued to have a number of ligature points in ward areas which patients had unsupervised access. These included bedroom door handles and taps. During our inspection we reviewed the ligature and environmental risk assessments completed in March 2016. Staff completed these annually. These stated what the ligature points were in each area of the ward and an action taken to reduce the ligature risk. These records did not state the exact location of ligature points only the area of the ward. The risk management plan was basic and stated that staff observations mitigated the risks of ligature points.

After our inspection we requested information from the trust about ligature risks on these wards and plans to remove these. The trust provided information regarding a business case submitted in September 2016 for the removal of ligature points through the replacement of taps, door handles and wardrobes on the wards at Forest Lodge. At the time of our inspection the trust had not authorised this business plan and therefore the trust could not provide a timescale for completion of this work. The trust also provided an electronic copy of a safety assessment in patient accessible areas document completed in March 2016. We did not see this document in use at the time of our inspection. This document stated that the ligature risks would be mitigated through patients' individual risk assessments and preventing or restricting access to areas of the ward where patient risk identified risk of self-harm.

Some areas within Forest Lodge were restricted for use under staff supervision at all times. The areas this applied to which were off ward areas included: laundry room, occupational therapy department, property room, child visiting room, recreational area. The ward meeting room on the assessment ward was beyond the secure internal perimeter and the ward meeting room on the rehabilitation ward had a window which opened onto the car park which meant that patients could not access these areas without staff supervision. The tuck shop was operated under the supervision of staff. One bathroom on the assessment ward and the assessment ward garden area were accessible only with the supervision of staff. Patients did not have any access to the tea pantry on the assessment ward. Patients' care and treatment records did not contain specific information about the restriction of access to the assessment ward bathroom, assessment ward tea pantry and the assessment ward garden area and why this was justified for individual patient risk.

The seclusion suite on the assessment ward had a mattress and had a solid door to the toilet and sink area of the suite. The door to the toilet and sink area of the seclusion suite contained an intumescent strip which was fixed onto the inner section of the door. Intumescent strips are installed into fire doors and expand in the event of a fire to provide a seal to prevent the spread of fire and smoke. This created a potential risk to patient safety as patients could have removed this strip and used this to try and ligature. The environmental risk assessment in use at the time of our inspection did not identify this as a potential hazard. Patients in the seclusion suite could open and close this door and this meant that they could conceal themselves from the line of sight of staff in the bathing area or behind the door in the open position. As a patient could move this door open and closed they could use the door to harm themselves or staff entering the suite by using the door with force. However, staff told us that if they had concerns about patients in the seclusion suite they could lock the door in a closed position. The seclusion suite intercom did not facilitate two way communications clearly. From inside and outside of the seclusion suite communication could not be heard in both directions due to a high pitched sound interference in the system. During our inspection, we raised issues identified with the seclusion suite to the trust

in relation to meeting the requirements of the Mental Health Act code of practice 2015. The trust's estates department completed work to remove the intumescent strip from the door and to repair the intercom system for the seclusion suite. In addition, the trust submitted an action plan to us to detail the action taken in response to these concerns. This action plan recorded the completed actions of removing the intumescent strip and ensuring that the intercom system worked. The trust set further action points of reviewing the quality of the intercom system in place, to consider a locking system or door replacement for the door to the toilet area to enable this to be fixed open. In addition, the action plan stated that the trust would review the initial risk assessment for the seclusion suite which identified the use of a mattress only. This stated that the reason for this was due to the type of physical interventions used by the trust and the space within the seclusion suite. The action plan identified the trust would enter the door to the toilet area and risk of self-harm and the seclusion room not having a bed onto the risk register. However, the seclusion suite had access to natural light through a window, externally controlled lighting and temperature control, an outward opening door, access to a clock for orientation to time and access to toilet and washing facilities.

Wards provided mental health services for male patients only. This meant that wards complied with guidance on mixed sex accommodation.

The assessment ward had a clinic room. The clinic room contained equipment to complete physical health monitoring. Staff checked this equipment regularly checked and it was in date. Wards had resuscitation equipment and staff checked this regularly to ensure that this was ready for use when needed. Staff had access to emergency drugs and these were in date. Staff recorded fridge and room temperatures and logs showed that these were within the recommended range for safe storage of medication. The clinic room had sharps disposal for used equipment. The clinic room did not have an examination couch. The rehabilitation ward did not have a clinic room. Physical examinations took place in patients' bedrooms or in the meeting room on the ward. The rehabilitation ward was situated next to the assessment ward. Medicines for the rehabilitation ward were stored in appropriate secure storage in the nurses' station. The ward stocked medicines in a locked drugs trolley and excess medication in stock was stored in a wall mounted locked metal cabinet. Staff ensured that any medicines requiring refrigeration were stored in the secure fridge on the assessment ward. Equipment to complete physical health examinations was stored in the nurses' station.

The overall patient led assessment of care environments survey score was 99% for cleanliness and 97% for condition, appearance and maintenance. These scores were above the England average. During our inspection domestic staff undertook cleaning tasks in different areas of the wards. Patients and staff told us that domestic staff completed cleaning regularly. Cleaning schedules showed the tasks to be completed and the frequency that this was required to be completed. Domestic staff visited the wards each day. The trust maintained the decoration of the wards and furniture in place was in a reasonable state of repair. The quiet room on the assessment ward appeared sparse of furniture. The quiet room contained a book shelf, two table chairs and a bean bag.

Staff carried anti-bacterial hand gels whilst on shift. Reception staff issued these to staff. Throughout the ward areas everyone had access to hand gels. Staff and patients could access sinks equipped with hand wash throughout the ward areas. During our inspection, we observed staff ensured that they used hand washing facilities to uphold infection control practice. However, only 53% of staff had completed hand hygiene training.

Reception staff issued all staff and visitors to the wards with mobile alarms. Once activated these alarms sounded and linked to the infrared system installed on the ward which identified the location of where the alarm had been activated. All staff knew what to do in response to the alarm sounding and told us they would respond to this immediately.

Safe staffing

Information provided by trust showed the establishment staffing levels for the assessment and rehabilitation wards as of 13 October 2016 was 14.1 for qualified nurses and 27.3 for nursing assistants whole time equivalent. The trust also reported vacancies for 4.3 whole time equivalent nursing assistants.

In the three months leading up to the 13 October 2016 the trust reported that bank staff covered 267 shifts. The trust reported that agency staff did not cover any shifts in this period. Between the 01 June 2016 and 22 November 2016 the trust reported that 129 shifts were not covered by bank

or agency staff. By ward this was reported as 99 shifts for the rehabilitation ward and 33 for the assessment ward. This meant that these shifts did not have the number of staff required to provide care and treatment to patients.

The trust reported that in the 12 months leading up to 12 October 2016 that the staff turnover rate was 14% and the staff sickness rate was 5%.

Managers reported that they could adjust the staffing levels of the ward when required. Wards had a minimum number of staff and grades required. These were:

Assessment ward

Early shift (07.30am to 3.30pm) and late shift (1.30pm to 9.30pm) two qualified nurses and five nursing assistants. Night shift (9.00pm to 07.30am) one qualified nurse and four nursing assistants.

Rehabilitation ward

Early shift and late shift two qualified nurses and four nursing assistants. Night shift one qualified nurse and two nursing assistants.

The assessment ward had a rota which allocated nursing assistants as 'corridor supervisor' at half hourly intervals throughout the 24 hour period. This member of staff was required to maintain a presence around communal areas, undertake routine observations, observe patient interactions and report any concerns to the nurse in charge. The rehabilitation ward had no formal observation procedures for communal areas. Staff completed patient observations on the rehabilitation ward in line with trust policy. Staff reported that if a patient required increased observations consideration would be given to transferring the patient to the assessment ward for increased support.

Staff told us that all patients had a named nurse who regularly spent time with them. All patients told us that they knew who their named nurse was and said that they spent time with them regularly.

Between June 2016 and 14 November 2016 the trust reported 15 occasions where section 17 leave was cancelled. Of these, eight occasions were due to resource issues and seven due to the patient cancelling leave.

When required staff could access out of hours medical cover through the trust switchboard. Consultant psychiatrists from across the trust took part in an on call rota. In the event of an emergency a doctor could attend the ward promptly.

Information provided by the trust showed that as of 13 October 2016 the overall compliance rate for mandatory training was 57%. Thirteen out of the 22 mandatory training requirements fell below the trust target of 75% completion rate.

The training requirements below the trust target of 75% were: dementia awareness 11%, autism awareness 18%, Mental Capacity Act level one 27%, health and safety 33%, slips trips and falls 38%, Mental Capacity Act level two 47%, respect level two 50%, respect level three 51%, hand hygiene 53%, information governance 55%, equality diversity and human rights 58%, rapid tranquilisation 60% and safeguarding children level two 74%.

Some of this training was essential to ensure the safe delivery of the service including respect training, hand hygiene and administration of rapid tranquilisation. In order to ensure that the staffing on shift could provide physical interventions safely, managers would need to ensure that there was adequate amounts of staff on shift who were up to date with these training requirements.

Assessing and managing risk to patients and staff

The trust reported that between March 2016 and August 2016 that there were seven episodes of seclusion. The assessment ward had the highest episodes of seclusion with six and the rehabilitation ward had the lowest with one episode of seclusion.

In the same time period, the trust reported 12 episodes of restraint in relation to four different patients. Staff on the assessment ward used restraint on 11 occasions and staff on the rehabilitation ward had used restraint once. The trust reported a zero use of prone restraint. Staff and patients reported that the use of restraint was infrequent. Staff told us that they thought that this was because they knew patients and their needs well and this meant they could effectively deescalate potential incidents quickly.

The multidisciplinary team planned admissions to the assessment and rehabilitation wards. Staff told us that this

enabled them to obtain information prior to the patient entering the service about patient risk. Managers and staff told us that all patients had an initial risk assessment in place prior to their admission to the wards.

Staff told us that all patients' care and treatment records contained a risk statement document and a historical clinical and risk management – 20 risk assessment tool document. On admission patients had a completed risk statement and staff completed the historical clinical and risk management – 20 risk assessment alongside the patient's first care programme approach review. The care programme approach is a system for co-ordinating the care and treatment for people with mental disorders. During our inspection we reviewed 14 patients' care and treatment records. All patients records contained a risk statement. Staff reviewed patients' risk statements regularly and these contained information about patients' current risk and background risk which included: mental health history, absconding risk, violence and aggression, criminal activity, drug and alcohol use, physical health, property damage, weapons and diagnoses.

Prior to all patients leaving the ward for section 17 leave qualified staff completed a comprehensive risk assessment to assess patients' mental state and their understanding of their leave requirements including times and places agreed.

Most patients' care and treatment records contained a completed and regularly reviewed historical and clinical risk management 20 risk assessment. One record did not contain this document. Staff told us that this was because the first care programme approach review had not yet been completed. One care and treatment record contained this risk assessment but following a care programme approach review this had not been updated. This meant that between January and November 2016 this document had not been reviewed or updated. However, all care and treatment records contained a regularly reviewed risk statement.

Wards had a blanket restriction in place which staff did not individually risk assess. A blanket restriction is defined by the Mental Health Act code of practice 2015 as rules or restrictions that restrict a patient's liberty or other rights which are applied routinely to all patients without an individual risk assessment to justify their application. Wards had a blanket restriction in relation to the searching of all patients on return from unescorted section 17 leave.

Staff and patients told us that on return from leave that staff asked all patients to show the contents of their pockets and staff used a metal detector wand to check patients for any potential risk items entering the ward. The personal search policy provided by the trust was due for review in November 2008, but had not yet been reviewed. The trust internet site also contained this policy. This policy was not in line with the current Mental Health Act code of practice 2015. The policy referred to searching as justifiable when staff had suspicion relating to possession of a risk item/s or substances and stated that routine searching should only be completed in response to exceptional circumstances. The trust had ratified a new policy on personal searching in October 2016. At the time of our inspection this had not been implemented. Forest Lodge had standard operating procedures in relation to searching patients. This referenced that staff could find guidance on searching in the Mental Health Act code of practice 2015. Patients' care and treatment records contained a paragraph, which stated that Forest Lodge had a blanket approach to searching all patients on return from unescorted leave. Patients' care and treatment records contained information regarding their current and historical risks. However, the relationship between individual patient risks as a justification for undertaking routine searching of each individual patient was not clear. In addition, records did not contain an individual risk assessment in relation to searching. The trust risk register did not contain any items in relation to personal searches undertaken. The governance meeting minutes recorded that Forest Lodge had a blanket approach to undertaking personal searches on all patients return from unescorted leave and staff were awaiting the new trust policy implementation. The searching of all patients on return from unescorted leave was not line with the Mental Health Act code of practice 2015.

The assessment ward had an illogical restriction for access to the tea pantry. The tea pantry was kept locked at all times. The environmental risk assessment in place for this area stated that patients had no access as a control measure for potential ligature risks. However, restricting all patients access to the tea pantry for that reason was not logical as all the ward areas had ligature risks including door handles and taps to which patients had access. We observed that the tea pantry was kept locked during our visit. Patients asked staff to make them hot drinks. A Mental Health Act monitoring visit in October 2016 also identified

this as a restriction. The Mental Health Act reviewer provided feedback to staff at the end of the visit. Minutes from clinical governance meeting noted discussion of this restriction however, the minutes stated that staff felt that changes to this practice were not necessary. Patients' individual care and treatment records did not contain information relating to any restriction in place for access to the tea pantry. We did not see evidence of how this had been individually risk assessed. Staff that we spoke with did not inform us of any other risk for this area not to be accessible to patients.

The trust implemented a smoke free policy, which meant that patients were not permitted to smoke cigarettes or tobacco on the hospital grounds. The policy further stated that patients could not smoke cigarettes whilst on escorted leave and could not store any smoking equipment on hospital premises. Staff and patients told us that this had resulted in patients smoking all their tobacco or cigarettes before returning from leave, giving away their cigarettes and tobacco or hiding these in the community so that these could be retrieved on their next unescorted leave from the ward.

On both wards, staff completed observations to ensure patients' safety between 07.30am and 9pm every two hours and between 9pm and 07.30am every 30 minutes.

Staff told us they rarely administered rapid tranquilisation. Rapid tranquilisation is the name for medicines administered to a person who is very agitated or displaying aggressive behaviour to quickly calm them. The purpose for administering this medication is to reduce the risk to the individual or others and enable the appropriate medical treatment to be given. Rapid tranquilisation is given by parenteral route. Staff recalled one occasion in the past six months where rapid tranquilisation was administered. We reviewed medication charts as part of our inspection, there was one administration of rapid tranquilisation recorded in the last six months. Post administration, staff monitored physical health appropriately as recommended by the guidelines from National Health and Care Excellence.

During our inspection, we reviewed eight seclusion records. Staff kept seclusion records securely and in order. Records showed that the shortest episode of seclusion was recorded as one hour and 55 minutes and the longest episode lasted 26 hours and 40 minutes. Nursing staff completed a record every five minutes throughout episodes of seclusion. Doctors completed a medical review promptly after the episode of seclusion commenced. However, the ending of seclusion and independent multidisciplinary team review was not in line with the Mental Health Act code of practice 2015 guidance. One record showed that an independent multidisciplinary team review took place 26 hours after seclusion commenced and following this the seclusion ended. The code of practice 2015 states that an independent multidisciplinary team review should be promptly undertaken where a patient has been secluded for over eight hours consecutively. According to the record, this meant that there had been a delay of 18 hours for the independent multidisciplinary review to take place. The decision of this review was to end seclusion. This delay may have meant that seclusion continued for longer than warranted which was not in line with the Mental Health Act code of practice 2015. Another record we reviewed showed that seclusion ended after 17 hours, this episode of seclusion was ended by a multidisciplinary team review, which was not independent. This was not in line with the code of practice. The trust policy was updated in November 2016; these episodes of seclusion took place prior to the implementation of this policy.

Staff received training in safeguarding adults level two and safeguarding children level two and level three. Mandatory training records showed that the training compliance rates for safeguarding children level two was below the trust target at 74%. Staff understood their responsibilities in reporting potential safeguarding concerns to managers or the nurse in charge on shift when out of hours. Staff could explain what types of concerns could be considered as potential safeguarding issues. Staff gave us examples of the types of concerns that they had raised to their managers. Managers told us that they raised safeguarding alerts to the relevant teams at the local authority when needed. They told us that the trust had a safeguarding lead who they could contact for advice.

Staff managed medicines safely. Staff stored medication appropriately in secure storage. They ensured that room and fridge temperatures were within the recommended range for the safe and effective use of medicines. On each shift the nurse in charge was responsible for the keys to access medication. Nurses kept keys attached to them on person. During our inspection, all medicines were in date

and we saw that staff regularly checked medicines. Patients told us that staff had ensured that they had received medical treatment when required for physical health conditions.

Patients could have children to visit them. Forest Lodge had designated space off the ward to facilitate visits from children. Staff told us that patients were required to book this room in advance. Staff also told us that they liaised with other professionals, families and carers to ensure that staff facilitated visits in a safe and appropriate way. All staff received mandatory training in safeguarding children.

Track record on safety

Information provided by the trust reported the number of incidents reported on the Strategic Executive Information System between 1 April 2015 and 31 March 2016, none of the incidents were attributable to forensic inpatient and secure services.

However, since March 2016, there was one serious incident requiring investigation in relation to forensic inpatient and secure services. The trust completed an internal investigation following this incident to look into the events leading up to the incident. Staff told us that the outcome of this investigation concluded that it would not have been possible to anticipate this incident occurring. Staff told us that there had been some changes to practice since this incident, which included staff corridor observations to be completed with staff standing and not in a sitting position. The rota for corridor observations rotated staff every 30 minutes due to staff standing instead of sitting.

Reporting incidents and learning from when things go wrong

Staff completed incident reports using an electronic form available on the trust's intranet page. All staff knew what to report and how to report incidents. Staff explained that the format of the document changes as options were selected to make the form appropriate for reporting specific types of incidents. The electronic incident form had a section on the duty of candour for incidents reported.

Staff told us that they had a good relationship with patients and explained that they were open and transparent with them. Staff could not recall specific occasions where something had gone wrong however, demonstrated that they would be open and transparent with patients if this happened.

Staff told us about the serious incident that occurred and explained the outcome of the investigation of this incident. Team meetings took place regularly where information could be provided to staff following incidents. Post serious incidents the trust arranged a formal debrief for staff led by the psychologist.

Are services effective?

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

Our findings

Assessment of needs and planning of care

Prior to admission to the service, a doctor and a nurse completed a joint medical and nursing for prospective patients referred to the service. Information from this assessment formed part of the assessment on admission to the service. On admission, patients had an assessment of their needs. Care and treatment records contained evidence of physical health examination on admission. Staff referred patients with high body mass index for input from a dietician.

Patients received ongoing monitoring of their physical health issues. Staff completed blood monitoring of patients where appropriate and this was discussed during ward round and care programme approach reviews. All patients had an annual health check. Some patients' care and treatment records contained information in relation to a range of different physical health conditions. These showed how staff supported patients to maintain their physical health and access relevant services to manage and maintain their health conditions. Care and treatment records showed that patients had conditions which included: asthma, diabetes, renal failure and skin conditions.

During our inspection, we reviewed 14 care and treatment records. All patients had a care plan. We saw that these included sections to show if patients had been provided with a copy of their care plan and whether or not they had accepted this. Care plans covered a range of aspects relating to individual patients that included: mental health, risk, leave, physical health, speech therapy, activities, observations, smoke free, devices including mobile phones, self-medication, debt management and discharge. Staff wrote care plans in a recovery orientated format.

The trust had an electronic patient record system which stored care and treatment records. A separate electronic system was used for medication records. All staff had an individual password which enabled access to the system. Information could be accessed by all staff when this was required.

Best practice in treatment and care

Consultant psychiatrists told us that they referred to guidance from the National Institute for Health and Care Excellence when prescribing medication and were able to give examples.

Patients had access to therapies recommended by the National Institute for Health and Care Excellence. Staff told us that they worked with patients to deliver cognitive behavioural therapy based interactions. However, they told us that they also reference a range of other psychological models within their interactions with patients. Information provided by the trust stated that they could also provide other specialist psychological therapies. They told us that sessions were bespoke to the individual and their needs and were dependent on the engagement of the patient in psychological therapy. Staff told us that they frequently worked with patients on their feelings of anxiety and exploring the relationship between mental ill health, substance misuse and offending behaviours. Staff completed psychological assessments of patients which included international personality disorder examinations, the state trait and anger expression inventory and other neuropsychological testing to look at executive functioning of the brain. Executive functioning involves understanding individuals' cognitive processes and can provide insight into responses including impulse and emotional control.

Records showed that patients received regular access to physical health care treatment. All patients told us that they received monitoring and checks of their physical health. Five patients described to us specific physical health conditions that staff provided care and treatment for. This included accessing outpatient services at local hospitals. Patients had access to a dentist and GP and they visited the wards when required to complete physical health treatment. Staff supported patients on the rehabilitation ward with developing skills to dispense and administer their own medications in preparation for their discharge. We saw that staff observed these patients preparing their own medications ready to take at medication times.

Staff used ratings scales to assess and record severity of side effects and outcomes of treatment. Outcome measures used included: Krawieka Goldberg and Vaughn

Are services effective?

Good

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

scale, Liverpool university neuroleptic side effect scale, health of nation outcome scales for secure services, model of human occupation screening tool and my shared pathway

Staff completed audits of physical health monitoring, prescribing of anti-psychotic therapy medications, administration of rapid tranquilisation, medicines in stock, Mental Health Act documentation, health and safety, supervision rates, temperatures of fridge and rooms where medication was stored, contents of the safe and infection control. The trust also provided information which showed that the amount of leave taken against searches completed was audited. Where a search was not completed on return this was highlighted in red.

Skilled staff to deliver care

Staff from a range of different professional backgrounds made up the multidisciplinary team. These included: consultant psychiatrists, junior doctors, forensic social workers, clinical psychologist, psychologist assistant, occupational therapist, occupational therapy assistants, nurses and nursing assistants. Staff employed had experience and qualifications to enable them to complete their roles. All staff had a set mandatory training requirement of courses needed to enable them to effectively fulfil their role. However, not all staff had received all mandatory training courses and this may have had an impact on their knowledge and skills.

All staff received an appraisal of their performance and all eligible staff had been revalidated. Information provided by the trust showed that 82% of staff received regular clinical supervision. This was above the trust target of 80%. Staff also told us that they received regular supervision. Each ward had a team meeting that took place monthly. Where cover was in place for the wards staff could attend team meetings.

Managers told us that the trust had policies and procedures in place to address any performance management issues. In this case they could seek advice from the human resources department within the trust.

Multi-disciplinary and inter-agency team work

During our inspection we observed seven ward rounds, one care programme approach meeting and one handover. Multidisciplinary meetings included the views of different professionals. Staff discussed potential issues such as leave and patient risk. All members of the multi-disciplinary team shared their views as part of the discussion. As part of the care programme approach meeting reports produced by each discipline on the progress of care and treatment were shared for reading and discussion.

Each week the wards had a joint bed management meeting where prospective patients and discharge for current patients was discussed. The bed management meeting discussed all referrals for low secure accommodation for the area. Staff discussed the referrals for care and treatment for Forest Lodge and arrangements were made for medical and nursing assessments for prospective patients. These meetings were also used as a forum to feedback on assessments completed to discuss the suitability of patients for Forest Lodge.

Staff reported to have working relationships with external organisations such as the service commissioners, local authority social work teams, GP and dentist. The service reported regularly to the Ministry of Justice in relation to restricted patients and provided reports on the progress of patients. Restricted patients are offenders that are detained to hospitals under the Mental Health Act 1983 for mental health treatment under special rules due to the level of risk that they pose. There are specific controls set which are under the authorisation of the Justice Secretary.

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

As part of our inspection we reviewed the adherence to the Mental Health Act and the Mental Health Act code of practice 2015. Admission to wards at Forest Lodge was planned and staff told us that they ensured the correct Mental Health Act documentation was in place when patients were admitted to the wards. The hospital had a Mental Health Act office and staff knew how to contact this. Staff audited Mental Health Act documentation regularly including detention documents, leave forms and consent to treatment documents. The trust completed a trust wide audit of Mental Health Act documentation.

The service had a file to record all section 17 leave status for patients. This included the current leave granted to patients. Patients had access to section 17 leave from the ward. All patients reported that they had leave from the ward. Two patients told us that their leave had been suspended. Patients knew the reason why their leave had been suspended. These patients told us when they thought they may have this reviewed by the multi-disciplinary team.

Are services effective?

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

Patients and staff told us that staff informed patients of their rights under section 132 of the Mental Health Act every three months.

Training in the Mental Health Act was a mandatory training requirement and 94% of staff had completed this training. Staff had a reasonable understanding of the Mental Health Act and Mental Health Act code of practice 2015. However, we found that there was a blanket restriction in operation on both wards in relation to the searching of all patients on return from unescorted leave.

Consent to treatment documentation was in place and correct. Medication records contained valid consent to treatment documents which were either T2 certificates (where the patient has provided informed consent) or T3 certificates (where the patient cannot or will not consent and their treatment has been authorised by a second opinion appointed doctor from the Care Quality Commission). Consent to treatment documentation corresponded with the medicines prescribed on medication charts.

Information was displayed on the wards regarding access to independent mental health advocacy. Independent mental health advocates visited the wards each week and led the patients' community meetings.

Good practice in applying the Mental Capacity Act

As part of our inspection we reviewed the adherence to the Mental Capacity Act. The Mental Capacity Act is a piece of legislation which is aimed at maximising an individuals potential to make informed decisions for themselves. Where individuals are unable to make informed decisions the act and the Mental Capacity Act code of practice provides processes to be followed to ensure that decisions made on behalf of individual's are in their best interests and are the least restrictive on their rights and freedoms.

All patients at Forest Lodge were detained under the Mental Health Act 1983. We did not inspect the Deprivation of Liberty Safeguarding as it was not applicable to these wards.

Training in the Mental Capacity Act was a mandatory training requirement for staff. The trust provided training at levels one and two. Both of these mandatory training courses fell below the trust target rate of 75%. Training compliance rates for the Mental Capacity Act were 27% for level one and 47% for level two. However, staff could explain how the Mental Capacity Act related to making informed decisions, staff told us that capacity should be presumed unless established otherwise and where individuals lack the capacity to make decisions any actions taken should be within an individual's best interests. Staff prepared a weekly review document in preparation for ward round. This contained a section for any mental capacity issues which could be discussed in ward round. One care and treatment record contained a mental capacity assessment in relation to making decisions around finances.

Are services caring?

Good

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

Our findings

Kindness, dignity, respect and support

Observations of interactions between staff and patients showed that staff knew patients and their needs well. Staff treated patients with kindness and respect. Patients provided mixed feedback about staff that provided care and treatment to them. Six patients gave positive feedback about staff. They told us that staff were polite, respectful, flexible, supportive, friendly and had a good sense of humour. One patient told us that staff always knocked on patients' bedroom doors before entering. Two patients told us that that they thought that some staff did not have a positive approach towards patients. One patient told us that they felt that at times that staff did not listen to them.

The rehabilitation ward did not have a clinic room. Staff stored medicines on this ward in a locked drugs trolley and wall mounted secure cabinet in the nurses' station. One patient on the rehabilitation ward told us that they received their medication from the nurses' station. They also told us that other patients and staff could see them receiving their medication and sometimes patients queued to received their medication. During our inspection, we observed that the door to the nurses' station could be opened at the top to create a hatch space and staff administered medication to patients from this. The assessment ward had a clinic room. However, during medication administration we observed that the clinic room door was opened at the top to create a hatch and patients received their medication from this. Other staff and patients on the ward could see patients receiving their medication and could hear discussions that took place. This did not promote the privacy and dignity of patients whilst they were taking their medication. However, a notice was displayed in the nurses' station which stated that where patients requested to take their medicines in private that this could be done using the meeting room. Staff told us that two patients preferred to take their medicines in the meeting room on the rehabilitation ward

The patient led assessment of care environments score for the assessment and rehabilitation wards for privacy, dignity and well-being was 93%. This was below the trust average which was 99%. However, it was higher than the average for England which was 88%.

The involvement of people in the care that they receive

On admission to the service patients received an information pack. This contained information which explained the service, provided information patients may need to know before they arrived at Forest Lodge including: meal times, medication, routines, visiting arrangements and various pieces of other information. In addition information was supplied about clinical psychology, other sources of help and information which included: advocacy, legal, charities and community organisations and information to explain the different types of staff who may be involved in their care and treatment.

During our inspection we reviewed 14 patients' care and treatment records. Staff told us that patients did not often engage with the creation or the development of their own care plans. Patients told us that nurses wrote their care plans and risk assessments. Two patients told us that they had been involved in the development of their care plan. One patient told us that they had a copy of their care plan However, patients attended their ward round meetings and care programme approach reviews with their responsible clinician and other staff involved in their care and treatment. During our inspection we observed seven ward round meetings and one care programme approach meeting. We saw that staff involved patients during meetings. They listened to patients' views and took the time to ensure that they clearly explained information to involve patients in decisions made about their care and treatment. At the end of meetings staff ensured that they summarised the meeting for clarity and asked patients if they had any questions they would like to ask staff before ending the meeting.

Advocates visited the ward weekly. Advocacy staff led patient community meetings each month on the wards for patients to attend, give feedback about the service and raise any issues or concerns. Advocates then communicated with staff to ensure that information was fed back to the wards from patients. Patients told us that they could attend community meetings to share their views and raise issues.

During our inspection, we spoke with one carer of a patient. They told us they felt involved in the patient's care and treatment and could contact the service to speak with the patient's named nurse if needed.

Are services responsive to people's needs?

Good

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

Our findings

Access and discharge

The average bed occupancy rate for the assessment ward was 94% and for the rehabilitation ward this was 98%. The trust reported that the average lengths of stay were as follows:

Assessment ward

The average length of stay for current patients on the ward was 451 days. The average length of stay for patients discharged from the ward was 260 days.

Rehabilitation Ward

The average length of stay for current patients on the rehabilitation ward was 373 days. The average length of stay for patients discharged from the ward was 694 days.

The trust reported that there were no out of area placements. Forest Lodge had a weekly bed management meeting. Members of the multidisciplinary team attended this meeting. Attendees discussed current patients and their discharge plans and reviewed new referrals for patients for low secure accommodation. The trust reported an average waiting time from referral to assessment for the assessment ward as 50 days and for the rehabilitation ward as 127 days. Bed availability for patients living in the local area was dependent on the capacity of the wards. Staff reported that they worked with commissioners to ensure that occupancy rates remained above their target set by commissioners. The ward did not admit patients to the ward when patients were on leave. This meant that patients on leave always had a bed on the ward to return to.

Staff and patients told us that on admission to Forest Lodge that patients were admitted to the assessment ward and progressed onto the rehabilitation ward throughout their treatment programme. Staff from the multidisciplinary team planned and co-ordinated patient discharges from Forest Lodge. Dependent on the type of detention of the individual patient under the Mental Health Act, discharge from the ward could take longer. This was in relation to restricted patients where the relevant authorisations were required from the Ministry of Justice. Between 01 February 2016 and 31 July 2016, the trust reported no delayed discharges and no readmissions within 90 days.

The trust did not provide medium secure services, where a patient's needs or risks could not be met within a low secure environment staff told us that this issue would be raised for more appropriate services to be accessed through the commissioners.

Care plans contained information about a patient's eligibility for section 117 aftercare services under the Mental Health Act. The Mental Health Act and code of practice sets out responsibilities for providing free ongoing aftercare services post discharge from section for patients who require ongoing care to meet their mental health needs in relation to their mental disorder which resulted in their detention under the act.

The facilities promote recovery, comfort, dignity and confidentiality

The wards had a range of rooms to support treatment and care. There was one main entrance to Forest Lodge. Once through the main air lock area there was a central recreation area. This was a large area that contained areas for patients to watch television and was equipped with a pool table. Forest Lodge had an occupational therapy department accessible from this area. Each ward had access to outdoor space, a lounge, dining area, and a quiet room. The rehabilitation ward also had a conservatory. Both wards had meeting rooms. The quiet rooms and meeting rooms could be used by patients to meet with visitors. The assessment ward's quiet room was sparsely furnished. This was a medium sized room which contained a book shelf, a bean bag and two table chairs. A room was available off the wards for patients to have visits from children.

The rehabilitation ward did not have a clinic room. Staff stored medicines on this ward in a locked drugs trolley and wall mounted secure cabinet in the nurses' station. The assessment ward had a clinic room.

Both wards had a pay phone. The pay phone on the assessment ward did not have a hood. This did not promote patients' privacy. However, all patients had access to their own mobile phones. Patients had an individual risk assessment in place to identify any potential risks involved in this. The wards also had access to tablet computers with internet access. Staff had a device agreement in place with patients which stated that they agreed to take phone calls in the privacy of their own bedrooms, not to take photographs, not to take audio or video recordings whilst on the wards.

Are services responsive to people's needs?

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

Access to outside space was available on both wards at any time. Staff supervised patients using the outside space on the assessment ward.

The patient led assessment of care environments for food score was 89%. The wards had a four week rolling food menu in place. Patients told us that they ordered their meal choice on the day a few hours before the meal time. Where patients had expected to be on leave and plans had changed they could inform staff who would arrange for them to receive the meal of their choice.

In addition, up to two times per week patients could self-fund and order a takeaway to be delivered to the ward. Occupational therapy assistants also ran self-catering groups. This involved shopping for ingredients and cooking activities where patients could be supported with cooking meals of their own choice

Patients on the rehabilitation ward could make hot drinks and snacks at any time of the day or night. Patients on the assessment ward told us that they could only access hot drinks from the tea pantry by asking staff. We also observed this during the inspection. One patient told us that they could access snacks on the assessment ward every hour and a half throughout the day and night.

All patients had a key to their own bedrooms and to a personal locker to store items. Patients could personalise their bedrooms with items of their choice.

Patients told us that the wards provided activities including: pool, snooker, clay work, painting, drawing, cooking, walking group, play station, table tennis and gym. They told us that they had themed nights that included Halloween, Caribbean night and that staff were planning a Christmas evening with them. According to activity timetables, activities available included: breakfast groups, art including pottery, baking, aromatherapy, exercise, table tennis, social group, lunch club, walking group, allotment group, gardening, reading group, drama group, cycling group, football group and music group. However, one timetable that we saw contained activities mainly between Monday and Fridays with activities on weekends described as subject to staffing availability. This timetable was dated as August 2016 and a copy of this was displayed on the assessment ward during our inspection. Three patients told us that they felt bored and one patient told us that this was especially at weekends. One patient described their experience of the ward as "like groundhog day".

Meeting the needs of all people who use the service

Forest Lodge had ramp access to the main entrance. The wards were situated on the ground floor level. Both wards had accessible bathrooms with an assistance system fitted for use in the event of patients requiring assistance from staff. Staff could obtain information for patients in a range of languages and easy read format when required from the trust. The trust accessed interpreters for patients when required. During our inspection we observed an interpreter working with a patient.

Staff provided an information pack to patients about local services on admission in the service information pack. Staff informed patients informed of their rights at regular intervals under the Mental Health Act. All patients told us that if they wanted to make a complaint they could do this by using a 'fast track' form. This related to the trust's procedure for making low level complaints. Three patients told us that they had used the fast track form to make a complaint. One patient told us that they had made three complaints but they had not received a response about them. All patients told us that they could provide feedback or raise issues in patient community meetings which took place monthly.

Patients and staff told us that different food options were available for patients to order to meet any specific dietary requirements of religious and ethnic groups. Menus showed that vegetarian options were available on each meal time.

Staff facilitated visits from the hospital chaplain and imam to meet with patients. Patients told us that staff supported them to celebrate Eid. The wards did not have access to dedicated space for patients to practice their religious beliefs. Two patients told us that they wanted a dedicated space to practice their religious beliefs. One patient used another communal area and another used their bedroom to practice their religion. One patient told us that the imam did not speak or understand their spoken language.

Listening to and learning from concerns and complaints

The trust had two ways to raise concerns and complaints. Anyone who wanted to make a complaint could raise a formal complaint or use a fast track complaint to raise low level complaints. Between 01 September 2015 and 31 August 2016 the trust reported that they received two complaints in relation to forensic inpatient and secure

Are services responsive to people's needs?

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

wards. One of these complaints was in relation to the assessment ward and one complaint was in relation to the rehabilitation ward. The trust reported that they received five compliments in the same time period for the assessment and rehabilitation wards. After investigation the trust did not uphold any complaints received and no complaints were referred to the ombudsman.

Between 01 September 2015 and 31 August 2016, the trust received eight fast track complaints submitted for the assessment ward and two fast track complaints for the rehabilitation ward. Four compliments submitted related to the assessment ward and one compliment related to the rehabilitation ward.

Noticeboards contained information about how patients could make a complaint. All patients told us that if they wanted to make a complaint they could do this by using a 'fast track' form. Three patients told us that they had used the fast track form to make a complaint. One patient told us that they had made three complaints but they had not received a response about them.

Are services well-led?

Good

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

Our findings

Vision and values

The trust had a vision statement and organisational values. The vision was:

"For Sheffield Health and Social Care NHS Foundation Trust to be recognised nationally as a leading provider for high quality health and social care services and recognised as world class in terms of co-production, safety, improved outcomes, experience and social inclusion."

The trust values were: respect, compassion, partnership, accountability, fairness and ambition. Staff told us about the trust's values and could relate these to their roles in practice. During our inspection we saw that staff displayed these values in practice.

Staff knew who senior managers were. Forest Lodge had posters displayed to show who senior figures within the trust were and information to explain their roles. Staff told us that senior managers regularly spent time on the wards. A senior figure from within the trust led a patient reading group.

Good governance

Systems in place ensured that staff received regular supervision and appraisal. However, systems did not ensure that all staff received regular mandatory training. The overall training compliance rate was 57%. Information provided by the trust showed that the trust used bank staff to try to meet staffing level requirements. However, the assessment and rehabilitation wards had a number of shifts not covered by bank or agency staff. This meant that some shifts did not have the number of staff required to provide care and treatment to patients.

Staff prioritised tasks on shift to deliver direct care activities. The wards had access to sufficient administrative support. Staff completed a range of clinical audits regularly to assess the performance of the ward against expected standards.

Staff received feedback from patients through community meetings, complaints and compliments. Where serious incidents occurred the trust investigated these and changes to practice were implemented accordingly following the findings. All staff knew of the outcome of the investigation into a serious incident that occurred.

Procedures in safeguarding and the Mental Capacity Act were embedded into staff practice. The Mental Health Act and code of practice was mostly followed. However, the wards had a blanket restriction and the seclusion room did not enable a continuous line of sight for patients in the toilet area which did not comply with the requirements of the code of practice.

Wards had key performance indicators set by the service commissioners. Each quarter of the year the trust reported on the wards performance against these performance targets. We reviewed performance returns submitted by the trust. The trust reported one performance indicator lower than the target rate. This was the amount of patients that had received a dental check up in the last 12 months. However, patients on the wards had access to services from a local dentist.

Managers told us that they felt they had sufficient authority to complete their roles and enough support from their managers and colleagues when needed. Staff including managers could raise issues to be considered for the risk register for Forest Lodge and for escalation to the trust risk register.

Leadership, morale and staff engagement

The average sickness rate was 5%. The trust did not provide the amount of bullying and harassment cases in relation to forensic inpatient and secure services. All staff knew how to raise concerns. Staff told us that if they had a concern they would initially raise this with their managers. They told us that they felt confident that they would be able to do this. The trust had a policy on whistleblowing called 'speaking up'. Staff told us that they could access the trust policy using the intranet and would follow this when needed. If something went wrong staff told us that they would ensure that they were open and transparent with patients.

All staff that we spoke with were enthusiastic and showed a commitment to their work with patients. Staff told us that teams worked together and colleagues provided each other with mutual support and team work. Staff told us that they could raise any issues and give feedback on the services including ideas at their team meetings and in supervision.

Commitment to quality improvement and innovation

At the time of our inspection, the trust was participating in the completion of commissioning for quality and

Are services well-led?

Good

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innovation goals for forensic inpatient and secure services for: supporting service users in secure services to stop smoking, the development of a recovery college and reducing restrictive interventions. In addition, staff had contributed to published literature on Mental Health Law.

Staff from forensic inpatient and secure wards designed a survey on the role of novel psychoactive substances (also known as, legal highs) in referrals to secure care. At the time of our inspection the trust had agreement from the commissioners and the trust had submitted an ethics application locally and to the Ministry of Justice.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment How the regulation was not met: The seclusion room did not allow staff to see patients in the toilet area of the suite. The door to the toilet could be used by to conceal themselves behind or used to injure themselves or others. Ligature points were present throughout the wards. A business case was put forward to reduce and replace items however, there was no timescale for this work as it had not been agreed. The ligature risk assessment was basic on the ward it did not identify the exact location of ligature points were and management place contained basic information. Copies sent electronically by the trust contained more detail than assessments in use on the ward. These were not in place on the ward at the time of the inspection. Regulation 12 (2) (a) (b)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment How the regulation was not met: Forest Lodge had a blanket approach to searching all patients on return from unescorted leave. Staff asked all patients to show items in their possession and used a wand metal detector. Patients' care and treatment records did not contain an individual risk assessment to

This section is primarily information for the provider

Requirement notices

justify this practice in relation to individual patient risk. Care and treatment records contained standard blanket statements which outlined that Forest Lodge had a blanket approach to searching all patients on return from unescorted leave.

Regulation 13 (4) (b)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983	Regulation 18 HSCA (RA) Regulations 2014 Staffing How the regulation was not met: Staff did not receive mandatory training. The overall compliance rate for training was 57%. There were 13 out of 22 mandatory training courses with a completion rate below the trust target of 75%. Regulation 18 (2) (a)