

**Requires improvement**


# Nottinghamshire Healthcare NHS Foundation Trust

## High secure hospitals

### Quality Report

Rampton Hospital  
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Retford  
Nottinghamshire  
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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)
RHA04	Rampton Hospital	Aintree	DN22 0PD
RHA04	Rampton Hospital	Cheltenham	DN22 0PD
RHA04	Rampton Hospital	Kempton	DN22 0PD
RHA04	Rampton Hospital	Newmarket	DN22 0PD
RHA04	Rampton Hospital	Adwick	DN22 0PD
RHA04	Rampton Hospital	Alford	DN22 0PD
RHA04	Rampton Hospital	Anston	DN22 0PD
RHA04	Rampton Hospital	Blake	DN22 0PD
RHA04	Rampton Hospital	Bonnard	DN22 0PD
RHA04	Rampton Hospital	Burne	DN22 0PD
RHA04	Rampton Hospital	Cambridge	DN22 0PD
RHA04	Rampton Hospital	Canterbury	DN22 0PD

# Summary of findings

RHA04	Rampton Hospital	Grampian	DN22 0PD
RHA04	Rampton Hospital	Eden	DN22 0PD
RHA04	Rampton Hospital	Erskine	DN22 0PD
RHA04	Rampton Hospital	Evans	DN22 0PD
RHA04	Rampton Hospital	Brecon	DN22 0PD
RHA04	Rampton Hospital	Cheviot	DN22 0PD
RHA04	Rampton Hospital	Cotswold	DN22 0PD
RHA04	Rampton Hospital	Hambleton	DN22 0PD
RHA04	Rampton Hospital	Malvern	DN22 0PD
RHA04	Rampton Hospital	Quantock	DN22 0PD
RHA04	Rampton Hospital	Emerald	DN22 0PD
RHA04	Rampton Hospital	Jade	DN22 0PD
RHA04	Rampton Hospital	Ruby	DN22 0PD
RHA04	Rampton Hospital	Topaz	DN22 0PD

This report describes our judgement of the quality of care provided within this core service by Nottinghamshire Healthcare 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 Nottinghamshire Healthcare NHS Foundation Trust and these are brought together to inform our overall judgement of Nottinghamshire Healthcare 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

Requires improvement



Are services safe?

Requires improvement



Are services effective?

Requires improvement



Are services caring?

Good



Are services responsive?

Requires improvement



Are services well-led?

Inadequate



### 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 Rampton Hospital as requires improvement because:

- Low staffing levels meant that safety to both patients and staff was at times compromised. Because of low staffing on some shifts, staff were having to undertake unsafe practice that breached trust policy by working alone on wards.
- Although the trust had a recruitment strategy in place, the whole time equivalent vacancy rate for qualified nurses was 10.4% in February 2017.
- Staff did not follow the requirements of the Mental Health Act Code of Practice consistently with respect to reviewing patients in long term segregation or seclusion. The trust had not addressed the concern that we had raised at a previous inspection regarding staff passing food through an observation hatch above a toilet. Staff did not ensure that patients in long term segregation had had regular access to fresh air.
- Staff were not consistent in recording the reasons that they had decided to monitor patients' mail. Also, they did not always explain to patients what the patient had to do to satisfy staff that it was safe for them to stop monitoring the patient's mail.
- Staff across all groups reported low morale and a distinct lack of feedback or involvement from trust leadership. Staff also reported feeling unconfident in raising concerns for fear of reprisal.
- Ward staff reported a lack of opportunity to progress or to be able to feedback on service developments.
- Full information about our regulatory response to the concerns we have described in this report will be added to a final version of this report we will publish in due course.

# Summary of findings

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

### Are services safe?

We rated safe as requires improvement because:

- In February 2017, there were 39 whole time equivalent qualified nurse vacancies which was a 10.4% vacancy rate. As a result of the staffing shortage, between September 2016 and February 2017, there were 120 instances where there was just one member of staff working on a ward at night.
- Staffing levels meant that on several shifts, staff were often deployed to other areas in order to cover shortfalls and on occasions, qualified staff were working alone at night to cover wards.
- The annual turnover rate for qualified staff in 2016 was 9.6%.
- Not all staff adhered to the infection prevention control or dress code policies.
- In some of the care records, there was no evidence staff had completed weekly reviews for patients in long-term segregation in line with the Code of Practice and the trust had not addressed concerns raised at a previous inspection around passing food through a hatch that was over a toilet.
- Staff did not always carry out searches on patients in line with the Code of Practice.

However:

- All ward areas were visibly clean and the furnishings were well maintained.
- There were up to date environmental risk assessments for the wards and staff reviewed these regularly.
- Ward managers had completed ligature risk assessments for their wards and these assessments were up to date.
- Each of the wards had a fully equipped clinic room. Staff checked that medication was in date and that it was stored securely.
- Staff received basic life support session on induction training and a full day intermediate life support training.

**Requires improvement**



### Are services effective?

We rated effective as requires improvement because:

- The Mental Health Act Code of Practice states that letters informing patients of the reason for their mail being withheld should give a specific reason why it is being withheld. In the letters we looked at, staff had stated the reason mail was withheld was because it was the law, rather than giving a

**Requires improvement**



# Summary of findings

specific reason relevant to the individual patient. In 50% of patient records reviewed, staff had not notified patients of a decision to withhold their mail within the allowed seven days under Section 134 of the Mental Health Act.

- We found variability in the quality of care plans that we looked at in that not all were person centred and recovery focused.
- All patient information was stored securely and was available to deliver care. However, each ward had their own system of where they stored information in the electronic or paper records. This meant staff unfamiliar with that ward may not easily find information regarding patients care and risk.

However:

- Teams included a full multidisciplinary range of staff.
- Staff used a range of recognised rating scales to assess and monitor patients' health.
- The hospital had a physical healthcare centre with a GP in attendance.

## Are services caring?

We rated caring as good because:

- Staff were observed giving patient centred care.
- Physical healthcare staff provided care that promoted dignity of the patients whilst having physical health assessments by using screens.
- We observed staff obtain consent before treatment by explaining procedures and giving full explanations and where needed diagrams and pictures were used.
- All of the patients we spoke with told us that staff go the 'extra mile' even though they were short staffed.
- The hospital 2016 patient led assessments of the care environment score for privacy, dignity and well-being was 94%. This was higher than the national average of 90%.
- The majority of the patients we spoke to felt involved in their care planning and risk assessment and were offered copies of their care plans.

However:

- The patients told us their regular staff on their wards and their named nurses had a good understanding of their needs. However, the staff were regularly moved around across wards and this meant there was not always a regular member of staff on the ward that knew the patients as well.

**Good**



# Summary of findings

## Are services responsive to people's needs?

We rated responsive as requires improvement because:

- Staffing issues had an impact upon patient activities and 1:1 time spent with patients.
- The bedrooms in the mental health service were not en-suite however, they had a toilet and sink. The bathrooms on those wards had a curtain on the outside of the observation windows that anyone could open which meant that patients' dignity could be compromised.
- The main reception did not have access for hearing aid users.
- Not all staff were aware or familiar with the complaints procedure.
- The hospital had a full range of rooms and equipment to support treatment and care, including; a fully equipped gym, swimming pool, woodwork room and a range of therapy rooms. There was also access to outside space across the hospital and bicycles that patients could use.

However:

- There was a visitor centre for families to stay in if they had travelled far; most wards facilitated visits in specific areas on the ward.
- The hospital site could accommodate wheelchair users and there was a specific room for specialised medical treatment.
- A British sign language interpreter always accompanied patients with hearing impairments to appointments in the physical healthcare centre.
- The 2016 patient led assessments of the care environment score survey score for disability access was 85%; this was above the national average of 82%.
- The patients we spoke to knew how to raise a complaint and felt well supported by the staff.

**Requires improvement**



## Are services well-led?

We rated well led as inadequate because:

- The trust had not addressed a number of concerns raised at the previous inspections, which included; ensuring sufficient staffing to maintain a safe environment, clocks on the wards should show the same and correct times and staff on night shift should get breaks from continuous observations.
- Every staff member we interviewed reported that morale was low among the staff at the hospital.
- Staff reported that they did not feel confident in raising concerns or whistleblowing despite being aware of the policy. Staff reported fear of victimisation if issues were raised.

**Inadequate**





# Summary of findings

- A large proportion of staff were unaware of and as such unfamiliar with the organisation's values.
- Staff reported that they felt a lack of engagement from the trust senior managers and told us that they rarely visited the wards.
- Some staff reported a lack of feedback from senior managers following incident reporting. Some staff were not able to describe any learning from incidents or subsequent changes in practice.
- Unqualified staff felt there was little opportunity for career development.
- Staff felt they were not offered sufficient opportunity to give feedback and input into service development.
- The majority of staff did not know what was on the hospital risk register or how to submit an item.

However:

- Mandatory training levels, including safeguarding and the Mental Health Act and the Mental Capacity Act were above the target the trust had set.
- Rampton hospital collaborated with the other high secure hospitals around the development of guidance for the use of long term segregation.

# Summary of findings

## Information about the service

Rampton Hospital is one of three high secure hospitals in England. It has 357 commissioned beds and at the time of inspection, there were 315 patients. The hospital has 26 wards divided into five services.

### **National Women's Service with 50 beds;**

- Emerald (learning disability and intensive care).
- Jade (mental illness).
- Ruby (personality disorder).
- Topaz (personality disorder admission ward).

### **National learning Disability Service with 54 beds for men;**

- Aintree (positive behaviour therapy ward).
- Cheltenham (assessment and admission ward).
- Kempton (physical healthcare/positive behaviour therapy ward).
- Newmarket (therapeutic community).

### **National deaf Service with 10 beds for men;**

- Grampian ward.

### **Mental Health Service with 128 beds for men;**

- Adwick (intensive care).
- Alford (continuing care and treatment).
- Anston (admission and treatment).
- Blake (admission and treatment).
- Bonnard (admission and treatment).
- Burne (admission and treatment).
- Cambridge (pre discharge and physical healthcare).

- Canterbury (rehabilitation and pre discharge).

### **Regional Personality Disorder service including the Peaks unit for people with enduring and severe Personality Disorders with 115 beds for men;**

- Eden (treatment).
- Erskine (low risk/discharge preparation).
- Evans (treatment).
- Brecon (high dependency)
- Cheviot (assessment).
- Cotswold (admission and assessment).
- Hambleton (treatment).
- Malvern (treatment).
- Quantock (treatment).

The number of beds for people with enduring and severe personality disorder was due to reduce from 115 to 98 on 1 April 2017.

NHS England is responsible for commissioning all high secure hospitals. Patients are only admitted to Rampton hospital if they are referred by a health professional and assessed by the hospital as meeting the criteria for admission. All patients admitted to the hospital are detained under the Mental Health Act 1983 and classified as having a learning disability, or mental illness and/or a psychopathic disorder.

The hospital follows the High Secure Hospital Directions (2013) and Guidance from the Secretary of State for Health. The providers must comply with certain aspects of the Directions and have discretion about others aspects such as night time confinement.

## Our inspection team

The team that inspected this core service consisted of three CQC inspection managers; 10 CQC inspectors; two CQC assistant inspectors; 30 specialist advisors including; psychiatrists; mental health nurses; social workers; occupational therapist; advisors with specific knowledge

around safeguarding and information governance; two experts by experience (an expert by experience is someone who has personal experience of using or

# Summary of findings

supporting someone using a mental health service); a CQC pharmacist; four Mental Health Act reviewers, a CQC complaints manager and the CQC's National Professional Advisor for forensic mental health services.

## Why we carried out this inspection

We inspected this core service as part of a plan to inspect all high secure hospitals by April 2017.

CQC undertook a comprehensive review of Nottingham Healthcare NHS Foundation Trust in May 2014. The forensic service, of which Rampton was part, was rated as good overall and as good in all domains; safe, effective, caring, responsive and well led.

CQC undertook a focused inspection of four wards at Rampton Hospital in March and April 2016 following concerns raised around staff not carrying out observations of patients correctly. These wards were; Emerald, Ruby, Jade and Alford. Following that inspection, we issued a warning notice.

CQC carried out a follow up inspection in August 2016 and found that the hospital had made improvements. The trust had reviewed its observation policy in June 2016 and, by the time of the inspection in August 2016; staff across the hospital were carrying out general observations every 30 minutes.

However, the report that followed the August 2016 inspection stated that:

- The trust should ensure all staff use the same codes indicated on the observation policy and that all records are fully completed with codes.
- The trust should ensure that all clocks on the wards show the same and correct times.
- The trust should ensure that all staff on night shift should get breaks from continuous observations.

- The trust should review their baseline numbers of staff to determine the adequate numbers required to maintain safe staffing and staffing to meet therapeutic care and treatment.
- The trust should ensure that there are proper arrangements in place to ensure that staffing levels are always adequate in summer time to maintain high therapeutic levels of activities.

There had been 10 Mental Health Act review visits in the 12 months prior to inspection.

The last Mental Health Act (MHA) visit to assess seclusion and long-term segregation was carried out in December 2015. Mental Health Act reviewers found the staff passed food and drink through an observation hatch directly above a toilet. They also found that patients in long term segregation were not getting sufficient access to fresh air. These issues remained a concern at the time of this inspection.

CQC carried out its most recent visit under Section 134 of the MHA to assess monitoring of patients' mail and of their use of the telephone in 2013. At that visit, we found that staff sometimes notified patients that mail was being withheld later than the seven-day time period expected. Records did not show that staff informed patients of what they needed to do to be taken off monitoring. Also staff were not recording or reviewing these practices consistently.

## 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.

During the announced inspection visit, the inspection team:

- Visited all 26 of the wards and looked at the quality of the ward environment and observed how staff were caring for patients.
- Carried out a specific check of the physical healthcare centre.
- Visited the day centre and various workshops within the therapies and education department.
- Visited the visitor and family centre.
- Spoke with 108 patients and received feedback from 152 patient comment cards.
- Spoke with seven carers via telephone interviews.
- Interviewed the executive director of forensic services and deputy director with responsibility for the hospital.
- Interviewed 14 members of the management team.
- Spoke with 203 other staff members; including doctors, modern matrons and deputy matrons, ward managers, nurses, occupational therapists, social workers and site liaison managers.
- Attended and observed three hand-over meetings and 29 multi-disciplinary meetings and five community meetings.
- Held 13 focus groups for a range of staff including nurses, doctors, GPs and advocacy and one for carers.
- Looked at 135 treatment records of patients.
- Carried out a specific check of the clinic room on all of the wards.
- Carried out a specific check on the medicines management throughout the hospital.
- Looked at 204 prescription charts.
- The Mental Health Act reviewers completed a thematic review focusing on the use of seclusion and long-term segregation and section 134 mail and telephone monitoring.
- Looked at a range of policies, procedures and other documents relating to the running of the service.
- Carried out an unannounced night-time visit.
- Carried out an additional visit on 24 March 2017 to specifically review further evidence on mechanical restraint.

## What people who use the provider's services say

We spoke with 108 patients and they spoke very highly of the staff on the wards and the ward managers. They said the staff were caring and had a good understanding of their needs. They said the food was of a good standard, but there was a four week rolling menu that had been in place for five years so the food choice had become boring.

They said their activities were often cancelled due to short staffing. However, the staff on the ward tried their best to ensure there was some kind of alternative activity. Shop staff were friendly and helpful. However patients felt the shop was overpriced, we saw all items marked up above the recommended retail price..

In total, we received 152 comment cards from patients over 14 wards; 75 provided negative feedback, 60 were

positive and 17 were unrelated or not legible. The main concerns raised related to low staffing levels with the consequence being that patients do not get to see regular staff as they were being moved around other wards. However, this group of patients commented that the staff worked very hard and the patients felt safe and felt they were treated with dignity and respect despite the staffing shortages. This was in contrast to the feedback received during face to face interviews where the patients generally stated that they did not feel safe when there was a shortage of staff.

We spoke with seven carers via the telephone and three carers in a focus group; all said the staff were respectful and clearly cared about the wellbeing of patients and carers. One carer advised that the security to ward processes were very professional and quick. Carers also

# Summary of findings

noted that all areas of the hospital were always clean, tidy and well maintained. They felt their relatives and their possessions were safe despite the shortage of staff. One carer felt their relative was receiving good physical health care and needed regular trips outside the hospital for outpatient appointments, which were mostly facilitated. Another carer commented they had had good experience of using the family centre with children.

Carers were aware of short staffing and felt this had a negative impact on their relative's well-being but that the

ward staff "tried their best". A carer felt that her son was institutionalised due to the time he had spent in prison and hospital and thought this was partly due to the shortage of staff available for groups and activities. Carers felt mostly involved in their relatives' care and all would feel comfortable raising a complaint, except one carer who felt this may have a negative impact on their relative's care and treatment.

## Good practice

- Rampton had begun to train staff in the harnessing opportunities, protective enhancement system (HOPE(s) model). This is a framework, developed by another high secure hospital, which supports the multi-disciplinary team help patients move beyond long term segregation.
- The physical health centre screening programmes were patient centred and responsive to their needs. The staff did not stop offering an appointment the first time a patient declined. They tried to engage the patient and kept offering appointments.
- There were early signs that the violence reduction manual, which was created in collaboration with the other two high secure hospitals, was resulting in a reduction in violence.
- The speech and language team contributed to the violence reduction programme by helping staff communicate more effectively with patients. This helps staff de-escalate situations that might otherwise end in violence.

## Areas for improvement

### Action the provider **MUST** take to improve

- The provider must ensure that sufficient staff are deployed across the hospital at night to avoid lone working.
- The provider must ensure that there are sufficient staff deployed across the hospital during the day so that activities are not cancelled due to staffing needs.
- The provider must ensure that all staff adheres to the infection, prevention and control policy and dress code policy.
- The provider must ensure that all National Early Warning Scores are calculated and entered into the electronic records system.
- The provider must ensure that all fire doors are kept shut at all times in line with fire regulations.
- The provider must ensure that the major incident trolley is checked regularly.
- The provider must ensure that all staff are aware of lessons learned from incidents and complaints.
- The provider must ensure adherence to the Code of Practice regarding seclusion and long- term segregation practices.
- The provider must ensure adherence to the Code of Practice regarding Section 134 mail monitoring.
- The provider must review whether the staffing situation is contributing to staff using more restrictive interventions than would otherwise be required.

### Action the provider **SHOULD** take to improve

- The provider should ensure that staff engagement is increased.

# Summary of findings

- The provider should ensure that doctors have time to see their patients outside of multi-disciplinary meetings.
- The provider should ensure that weekly reviews take place of patients in long-term segregation and these are recorded clearly.
- The provider should ensure there is regular access to fresh air for those patients in long-term segregation.
- The provider should review the process for ordering stock medication to ensure medication charts are not off the ward for lengthy periods of time.
- The provider should ensure there is a more consistent approach to record keeping across the hospital.
- The provider should ensure all care plans are recovery focused and reflect the patients' voice.
- The provider should ensure that therapists are able to attend multi-disciplinary team meetings on a regular basis.
- The provider should ensure there is multi-disciplinary discussion around mail and phone monitoring and the records on the ward are accurate and reflect the Mental Health Act Code of Practice.
- The provider should ensure that capacity to consent is assessed and recorded consistently in the patients' notes across the hospital.
- The provider should ensure the menu choices are reviewed on a regular basis.
- The provider should ensure food and drink is not passed through observation hatches above toilets.
- The provider should ensure all the clocks show the same and correct time.
- The provider should ensure staff receive breaks from continuous observations.
- The provider should ensure that all staff receives regular clinical supervision.

# Nottinghamshire Healthcare NHS Foundation Trust

## High secure hospitals

### Detailed findings

#### Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Rampton Hospital	Aintree
Rampton Hospital	Cheltenham
Rampton Hospital	Kempton
Rampton Hospital	Newmarket
Rampton Hospital	Adwick
Rampton Hospital	Alford
Rampton Hospital	Anston
Rampton Hospital	Blake
Rampton Hospital	Bonnard
Rampton Hospital	Burne
Rampton Hospital	Cambridge
Rampton Hospital	Canterbury
Rampton Hospital	Grampian
Rampton Hospital	Eden
Rampton Hospital	Erksine
Rampton Hospital	Evans
Rampton Hospital	Brecon
Rampton Hospital	Cheviot
Rampton Hospital	Cotswold

# Detailed findings

Rampton Hospital	Hambleton
Rampton Hospital	Malvern
Rampton Hospital	Quantock
Rampton Hospital	Emerald
Rampton Hospital	Jade
Rampton Hospital	Ruby
Rampton Hospital	Topaz

## 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.

- A non-executive director chaired the Mental Health Act legislative committee that oversaw the implementation of the Mental Health Act. The committee implemented and monitored a range of audits, including the mail monitoring audit which was completed in 2015.
- At the time of inspection, 90% of staff had completed and were up to date with their Mental Health Act training.
- Staff were able to explain the Mental Health Act and its guiding principles and knew where they could access support in all aspects of the Mental Health Act.
- The Mental Health Act administration team ensured all of the paperwork was completed correctly and scanned onto the electronic system before storing them securely.
- Consent to treatment cards were stored with the prescription charts.
- Associate hospital managers held hospital managers meetings and patients accessed Mental Health Act review tribunals.
- During the inspection, the Mental Health Act reviewers completed a thematic review focusing on the use of seclusion and long-term segregation and section 134 mail monitoring. These reviews found several instances in which the Code of Practice was not adhered to.
- Between April 2016 and March 2017, there were 14 Section 134 mail monitoring appeals made by patients under the Mental Health Act to CQC. Some of these were made by the same patient.

## Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff throughout the hospital had a good understanding of the Mental Capacity Act and how it related to the work that they carried out.
- At the time of inspection 90% of staff had completed and were up to date with their Mental Capacity Act training. The staff we spoke with were able to give us examples of how they had ensured that they worked to the principles of the Mental Capacity Act with patients through the hospital.



# Detailed findings

- Records on Grampian showed capacity to consent assessments were done on a decision by decision basis and was recorded correctly. However, the records reviewed in the women's service did not contain detailed assessments of capacity to consent.
- Physical healthcare records showed consent was sought in line with the Mental Capacity Act.

# 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

- The hospital had a head of security that reported directly to the trust board. A site and security liaison team implemented the in maintaining safety and security.
- The ground access committee reviewed each patient's access to the grounds as per the High Security Directions. This was to ensure that the safety and security of patients, staff and the site were maintained.
- Rampton Hospital consisted of a number of buildings which ranged from older buildings to newer facilities such as the Peaks Unit which was built in 2004. This meant the condition of facilities varied depending on the building in which the wards were housed. There was a refurbishment plan in place to ensure the estate was kept safe and secure and to accommodate the decommissioning of personality disorder beds.
- All ward areas were visibly clean and the furnishings were well maintained. There were housekeepers on the majority of the wards and we saw evidence to demonstrate that there was regular cleaning taking place. Some of the patients were able to clean their own rooms if they wished. The 2016 patient led assessments of the care environment survey score for cleanliness was 97%, which was just below the national average of 98% and for condition, appearance and maintenance it was 93% and this was just below the national average of 95%.
- All wards were compliant with guidance on same sex accommodation.
- Ward managers had completed ligature risk assessments which were up to date.
- Within all wards, there were staff placed in all areas of the ward and CCTV in all communal areas in order to mitigate against any blind spots. When staffing levels fell below establishment numbers, we saw that wards had to close off key areas in order to maintain safe observations.
- There was a fully equipped clinic room in each of the wards; the medication we checked was in date and stored securely. We saw records to show that fridge and room temperatures were recorded daily.
- There were two types of emergency bags across the hospital. Bag one included a defibrillator and oxygen and bag two held emergency drugs and dressings. Not every ward had both bags; some wards had bag one, some had bag two and some had neither. There was a member of staff assigned to an emergency bag each day and they responded to emergencies accordingly. We saw records to show the bags were checked regularly to ensure the equipment was working and within date.
- Practice drills for emergency resuscitation scenarios took place at least twice a year. Staff described having attended drills relating to a scenario involving an unconscious patient. Records of these drills showed that it took staff about three minutes to take emergency bags to a ward that did not have them. There were no incidents recorded in staff responding to the emergencies. However, there was a risk posed by lone working which may affect response time.
- The emergency major incident trolley had not been checked. This was because a ward moved across from another building and the trolley was placed near the physical health centre. The ward presumed that the physical health centre was checking it and vice versa. This was escalated on inspection and the physical health centre took immediate action to check it and ensure that regular checks occurred in the future.
- Environmental risk assessments for the wards were up to date and reviewed regularly.
- Seclusion rooms in the women's service, the mental health wards and Cheltenham ward in the learning disability met the requirements of the Code of Practice. On Adwick ward, when segregation was used, the hatch to one bedroom was situated in the en-suite area so staff would have to pass food and drink through the hatch over the toilet. On Emerald ward, there was no way of communicating with the patient locked in seclusion other than through a hatch in the door, which was below waist height. Staff stated

# Are services safe?

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

discomfort observing through this hatch. The seclusion suite on Topaz ward was decommissioned due to necessary repairs required. Therefore, the ward had to share with the adjoining ward. The window was located high up. Therefore the patient in seclusion had no real view of the outside. In the Peaks unit, the hatches in the seclusion rooms posed a potential hygiene risk as food was passed through on paper plates. The plates had to be folded in order to fit through the hatch. Brecon ward had three designated seclusion rooms of which one had been de-commissioned. One room was located in the secure area accessed through doors from the bedroom corridor or entrance corridor. The other two seclusion rooms were located some distance from the ward area, beyond offices and meeting rooms. One of those was awaiting repairs. Both rooms had en-suite bathrooms. There was a small sitting room in the area that was used when the area was used for long-term segregation. The room in use at the time of the inspection had a drawer hatch above waist height, which was used for passing food and medication. Staff observing in that area had to use the telephone to contact the ward area.

- All of the staff carried an alarm and there were nurse call systems in each of the bedrooms.
- All of the electrical equipment was tested and was in date.
- There was an infection prevention control strategy that was reviewed annually. There was not a specific infection control team for the hospital. One member of staff was allocated a large portfolio of which the hospital was one of 12 locations. The trust responded by informing us that infection control was part of the matrons' responsibilities. One patient on Kempton ward contracted diarrhoea and vomiting on 2 March 2017. This increased to three patients and this was not reported to infection control until 8 March 2017. The inspection team raised concerns with the trust and also found that despite the obvious infection control risk, activities and movements had not been factored or restricted. Not all staff adhered to the infection prevention control policy or dress code policy. Staff were observed to be wearing full sleeves (rather than bare below the elbow), jewellery and nail varnish which meant there was an increased risk of spread of infection.

- We observed staff using hand sanitiser and these were available at the entrance of every ward and to the hospital. We saw there were posters in some of the staff and patient toilets demonstrating good handwashing techniques.

## Safe staffing

- Following the inspection in August 2016, we told the trust that it should review the baseline numbers of staff to determine the adequate numbers required to maintain safe staffing and to meet therapeutic care and treatment. The trust had since reviewed their staffing levels and we were advised that the establishment would be increased on some wards within the women's service and mental health service from 1st April 2017. The trust told us they would be able to fulfil this due to the closure of Eden ward and also due to ongoing staff recruitment. However, shortage of staff had resulted in activities being cancelled during the day and lone working at night.
- At the time of inspection there were 341 full time equivalent qualified nurses in post and the establishment was 380. There were 398 full time equivalent nursing assistants in post and the establishment was 353. The vacancy rate for qualified nurses as of February 2017 was 10.4%.
- The sickness rate had gradually risen from 9% in January 2016 to 11% in December 2016; this rate was higher than the NHS national average of 4.5%. The trust had proactively been addressing the sickness rate and Rampton Hospital had recorded its lowest sickness rate in five years for January 2017 at 6.7%.
- The annual qualified staff turnover in 2016 was 9.6%. Between January 2016 and December 2016, bank staff covered approximately 2% of shifts for qualified nurses and the same percentage for nursing assistants. Rampton Hospital did not use agency staff.
- The hospital, under direction 35 of the High Security Psychiatric Services (Arrangements for Safety and Security) Directions 2013, operated a policy where the patients were confined to their rooms at night in order to manage staffing issues. If there were any risks that required the patient to be excluded from this, the doctor would complete a form explaining the reasons and a care plan would be implemented.

# Are services safe?

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- Between September 2016 and February 2017, there were 120 instances where there was just one member of staff working on a ward at night. According to the briefing given to CQC dated 8th March 2017 and the trust policy, there should be a minimum of two members of staff on duty at night (one qualified and one other). In the same paper, it was stated that in order to enter a patients' bedroom, a minimum of three staff were required. Lone working or reduced staffing increased the risk of staff members not being able to respond in time in the event of an emergency. Added to the risk was that the emergency bags were kept in designated wards and some wards with emergency bags were stood down as responders when there was a lone worker. We found that Cambridge ward had a lone worker during a night shift in the period prior to the inspection when there were patients being cared for with unstable diabetes. We were also advised by night staff that when short staffed, fire doors were left open in the women's service so that the lone worker could move freely to maintain observations. The staff and patients we spoke to said shortage of staff was very common and even on days when a ward had a full establishment, staff were often moved off the ward mid-shift and this could be unsettling for patients and meant there was not always the opportunity to have 1:1 time with their named nurse.
- Records showed that between October 2016 to December 2016 the average rate of activities cancelled due to staffing issues were; mental health service 5.3%, deaf service 2.9%, learning disability service 4.2%, women's service 8.2%, the peaks unit 1.3% and the personality disorder wards 4%. The trust said these figures do not show whether the patient took part in a replacement activity instead. Records showed between December 2016 and February 2017, 12 psychological groups were cancelled and 26 individual sessions were cancelled due to insufficient staffing but the trust were unable to tell us what proportion this was.
- We heard from patients across the hospital but in particular from the women's service, the Peaks and the learning disability wards that staffing levels felt dangerous and put staff and patients at risk of harm. This was because patients told us cancellation of their activities led to them feeling very frustrated and felt like their needs were being ignored. This could lead to an increase in incidents. Medical consultants commented that patient safety was a serious concern at times due to staffing levels and work load. During the week of inspection, we became aware that a planned patient visit to a step down unit as part of their discharge process agreed by the Ministry of Justice was cancelled due to there not being sufficient staff.
- The trust had recently required the consultants to increase their caseloads from 20 to 25 and they expressed concerns over this. Each consultant had patients over a number of wards and this made it more difficult for them to liaise with the multi-disciplinary team and it also meant they had to attend more ward rounds than they did previously. This impacted on one to one time with patients outside of ward rounds.
- Staff said they could contact a doctor quickly when needed. However unless it was an emergency, some of the wards felt they only saw a doctor during ward rounds and multi-disciplinary meetings. On Anston ward, staff expressed concern that the responsible clinicians met with patients infrequently. We looked at the ward round timetable; face to face meeting with the responsible clinicians varied from up to six, four and three weeks. Therefore, some patients may not see their responsible clinicians for up to six weeks. One patient told us he only saw the responsible clinicians when an incident occurred. The patient was concerned the responsible clinicians could not make a fair assessment of his mental health as he rarely saw him. However, staff on Burne ward explained the responsible clinicians visited the ward up to three times a week and made a real effort to engage with patients.
- The ward manager completed the staffing rota for their ward approximately four weeks in advance and the matrons authorised this. Any day to day changes or requests were made through the central resource office and the security liaison managers who were in charge of deploying staff to wards. The central resource offices' core function was to book additional staff in response to the changes in the clinical needs of the patients. The staff we spoke with reported the staffing issues had become worse since the deployment of staff was centralised and said completing a full shift on the same ward with sufficient staff was a rarity rather than the norm.

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- The ward managers were responsible for ensuring their staff completed their mandatory training and they had a score card highlighting the areas where improvement was needed. Compliance rates for all mandatory training were above the trust target of 85%.

## Assessing and managing risk to patients and staff

- Staff used a recognised risk assessment tools for mental and physical health. We looked at 135 treatment records. All of the records, except for one or two, contained an up to date risk assessment. The risk assessment tool used covered a wide range of risks including harm to self, risk of aggression and risk to children.
- The seclusion and long term segregation policy had been ratified on 30 January 2017 and staff told us that it would take time to embed into practice. Staff explained what behaviours and risks would indicate the use of long term segregation or seclusion and told us that they would use these interventions as a last resort following unsuccessful de-escalation attempts. However, a minority of staff told us that they believed that there had been an increased use in these practices due to staffing shortages.
- Records showed in 2016, the number of seclusion episodes each month had decreased from 51 episodes involving 34 patients in January 2016 to 22 episodes involving 18 patients in December 2016.
- We looked at 25 records of seclusion. These showed that medical reviews for seclusion were not being completed in line with the Mental Health Act Code of Practice. This was because some responsible clinicians were not undertaking reviews in person at the weekends and staff were not undertaking independent multi-disciplinary team reviews after eight consecutive hours of seclusion. We were told the on call consultant phoned the onsite duty manager and discussed the patients in seclusion and long term segregation. These discussions were not documented in the patients' notes; therefore we did not see evidence they had taken place. We observed a nursing review of a secluded patient on Brecon ward. Only one nurse undertook the review which was not in line with the Code of Practice
- Only one of the files we looked at contained a debrief for the patient at the end of seclusion.
- Staff on Anston, Burne and Cheltenham wards said that patients were searched before entering seclusion rooms but staff had not recorded these searches in line with the Code of Practice.
- The number of incidents of long term segregation was 38 in January 2016 and had increased to 64 in December 2016. The trust explained the increase in long term segregation was because there was an emphasis in the Code of Practice on seclusion being for a shorter period of time. The trust have been working with the other high secure hospitals around the development of best practice guidance in respect of long term segregation and have noticed early signs of the use of long term segregation reducing. For example, at the time of the inspection (March 2017) there were 32 patients subject to long term segregation. The four patients who had been in long term segregation for the longest time were: a patient on Cheltenham ward, had been in long term segregation since 5 August 2015; a patient on Anston ward since 8 December 2015; one patient on Adwick since 17 April 2013 and another on Adwick ward since 6 August 2015.
- The senior management team reviewed all 32 patients that were subject to long term segregation on 9 March 2017 and found that all except one patient were appropriate to be in long term segregation. Staff compiled monthly reports for each patient subject to long term segregation and the reports were discussed at ward round and with the multi-disciplinary team. All patients on long term segregation were also discussed each Monday in the senior managers' morning meeting.
- The three high secure hospitals worked together to provide external reviews for long term segregation. At the beginning of March, an external review of patients in long term segregation had been undertaken. Those undertaking the reviews concluded that long term segregation was appropriate for all of the patients to whom it applied except for three for whom they recommended that the trust considers ending the long term segregation.
- The Mental Health Act Code of Practice states that an approved clinician should formally review a patient in long term segregation at least once in any 24 hour period and there should be weekly reviews by the multi-disciplinary team. The records reviewed showed these

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reviews were not taking place on a consistent basis. In one file on Anston ward we found that, for the month of February 2017, there had been no weekly reviews of the patient.

- Between January 2016 and December 2016, there were 1,510 incidents of restraint across the service involving 213 patients. Brecon ward had the highest number of incidents of restraint with 321. The staff received management of violence and aggression training which included de-escalation techniques. Staff gave examples of when they would use these techniques in order to prevent restraint from being used. Between January 2016 and December 2016, there were 309 incidents of prone restraint across the service. Emerald ward had the highest number of incidents of prone restraint with 71. The majority of prone restraints were for the shortest period while administering intra muscular medication. Under the trust wide Sign up to Safety campaign, the hospital was required to look at reducing restraint. Rampton followed the Safe Wards model, which identifies what affects the conflict and containment rates.
- Rampton used mechanical restraint, which is any restrictive device that is used to restrict a person's free movement, most commonly used in emergencies to protect the patient from significant self-harming or to prevent the patient attacking others. In 2016, mechanical restraint was used 162 times to prevent life threatening self-injury and 91 times for violence and aggression. The staff who worked in the services where this was used, had a good understanding of when and how to use mechanical restraint and their training was up to date. Their mechanical restraint items had all been independently risk assessed and sourced from recognised providers. The decision when to use mechanical restraint was made by the ward team, the on call manager and a site and security liaison manager and if possible the on call doctor and this was in line with their mechanical restraint policy. Every Monday, senior managers reviewed every patient who was in mechanical restraint. Episodes of mechanical restraint were recorded in either the electronic patient records or paper records. Trained staff applied and checked mechanical restraints. On Emerald ward, six out of 30 staff had been trained its use. This meant that not every shift had someone trained and therefore staff from other wards assisted.
- We looked at seven care plans for the use of mechanical restraint and found the reasons and the discussion was documented in six out of seven. We looked at the records for a patient who had been secluded on Cheltenham ward. Staff had applied mechanical restraint in the form of an emergency response belt because the patient refused to walk to the seclusion room. The notes did not state at what time staff removed the belt and we were unable to locate a care plan for the use of mechanical restraint for this patient.
- The hospital also used strong clothing and bedding in order to prevent self-harm and this was in line with their self-harm policy. At the time of the inspection, staff required one patient to wear a strong all in one suit in order to prevent the patient self-harming.
- There were several blanket restrictions in place in line with the High Security Psychiatric Services Directions 2013; these were mostly around contraband items. Each ward risk assessed the individual patients with regards to what was safe for them to have in their rooms including CDs and magazines and on some wards patients were able to have open access to hot water and a kitchen in order to make themselves drinks and snacks.
- All of the staff were able to explain the observation policy and the search policy. There was a folder on each of the wards that contained 13 essential policies and the staff had signed to say they had read them. Following the warning notice that CQC issued on 23 March 2016 due to concerns around staff observing patients, the managers had revised the observation procedure and all staff had undertaken training to ensure observation practice would be safe and consistent across the hospital. However, the training was not consistent with the procedure around the way observations were recorded. We raised this as a concern and the trust corrected it immediately.
- Staff used rub down searches for patients leaving and returning to the ward. These were done within the communal areas. Staff assumed the patient gave consent as they lifted their arms in order to allow the search to take place. It was not always recorded that the search had been completed or the patient's consent had been sought. The high secure hospital directions state that a record should be made of consent to searches.



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- All of the staff were trained in safeguarding adults and had undertaken level 3 training in safeguarding children. The staff that we interviewed had a good understanding of safeguarding and knew how to raise any concerns to the ward manager. We saw good examples of individual safeguarding risk assessments in place on E block in relation to children visiting the patient. There was a family centre where children visited and we saw records to show there were robust procedures in place in order to safeguard the child. When safeguarding concerns between patients were identified on the wards then the staff were able to tell us how they would manage the situation and the process they would follow.
- There was good medicines management in place across the hospital. The pharmacy at Rampton provided a supply service and clinical service and also had some responsibilities for clinical service and contracted dispensing service to other hospitals within the trust. Records reviewed showed that the pharmacist had one to one discussions with patients. However, when stock was needed in between the fortnightly stock issues, the wards completed an order form which was taken to the pharmacy together with the treatment charts which included that medicine so the quantities could be checked. Nursing staff told us that sometimes they had to leave the charts at pharmacy and collect later. For staff from the Peaks unit, this was a considerable distance from pharmacy and meant a long time off the ward. Having the charts off the ward was a risk when 'as required' medicines were needed. Ward staff would call the pharmacy and ask the pharmacist to give a verbal instruction from the treatment chart. Two nurses would listen to the verbal instruction and administer the dose and then they would sign the chart when it was returned to the ward. We saw records to show that this had happened six times in the six months prior to the inspection on Brecon ward. We shared our concerns with the trust at the time of inspection and they confirmed that an immediate review of practice would be implemented. Out of hours, staff obtained medicines against a valid prescription chart from a 'supplementary medicines cupboard' on Alford ward. We observed the administration of physical health medications to patients. Prescriptions were legible, signed and dated. Staff recorded allergies and applied a stamp to indicate that discontinued drugs had been cancelled. Changes of medication were monitored by increased observations

and stickers were used in the patient notes to highlight they were on medication that required enhanced observations. For new patients, the prescribing doctor wrote the prescription chart based on the chart from the patient's previous placement. The pharmacy team were involved in the clozapine monitoring service and in supplying medicines in line with the blood test results.

## Track record on safety

- There had been 21 serious incidents in this service between January 2016 and December 2016.
- We reviewed five serious incident records and found that in each case, the recording and reporting followed the correct procedure.
- There have been two patient deaths in the same service within the hospital. The first was in August 2015 and the second was in February 2016. The review of the second death found several care and service delivery problems that were identical to those in relation to the death in August 2015. This showed lessons learnt had not been implemented. The main issues were around the observation policy, procedure, practices and governance arrangements were insufficient. Subsequently, the trust had learnt lessons and improved the observation policy and procedures in observing patients.
- There were 53 incidences between January 2016 and February 2017 that required reporting under the reporting of injuries, diseases, and dangerous occurrences regulations 2013 (RIDDOR). The most common incident reported was staff injury.

## Reporting incidents and learning from when things go wrong

- All of the staff we spoke with knew what an incident was and how to report it.
- Ward managers told us they received formal lessons learnt documents from the Clinical Incident Review Learning Environment group and they would disseminate to their staff. During inspection there was a lessons learnt workshop being held. The majority of the staff said they received feedback via ward rounds, handover and were emailed monthly updates by the modern matron. However, a few staff felt they did not

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receive any feedback and often thought there was no point in raising an incident, for example completing an incident form for lone working, as they reported that no action was taken.

- Staff told us that it was variable as to whether staff received a debrief every time following an incident.
- The staff had a good understanding of Duty of Candour and demonstrated this by being open and transparent and explained to patients when things went wrong. We saw examples of incidents when Duty of Candour was applied in a timely manner.
- The medicine safety officer reviewed medicine related incidents and the subsequent action plans. We saw

records that showed these were reviewed at the medicines safety group and medicines optimisation meetings. However, ward staff were not able to describe any examples of learning from such incidents.

- We looked at the trust's exception reports for January and February 2017 and found there were 399 reported incidents to do with staffing issues, 282 were regarding activities being cancelled or restricted and these were deemed by the trust to have had some impact on patient care. The trust had rated 117 incidents as having no impact on patient care as the staffing issues were at night time and the patients were in night time confinement.



# Are services effective?

Requires improvement 

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## Our findings

### Assessment of needs and planning of care

- We looked at 135 treatment records across the hospital. All of the records contained a comprehensive and timely assessment of the patients' needs at the point of admission.
- We saw evidence that a physical examination had been undertaken and there was good ongoing monitoring for physical health problems. All of the patients across the hospital received screening appropriate to their physical health needs. Records showed that each patient was offered an annual physical health assessment. This included an ECG to assess cardiac function and if any concerns identified, drug treatment regimens were assessed immediately. Staff used the Lester tool to assess cardiac and metabolic health for mental health patients. Records showed that staff had screened all patients on admission and then monthly for malnutrition using the malnutrition universal screening tool. In addition, staff offered health screening to appropriate patients; for example breast for cervical, testicular, bowel and prostate cancer. All screening was offered on site and a portable mammography unit visited the hospital to allow the women over 50 years old to access screening. We looked at nine records of patients with a raised body mass index. Staff had documented a clear care plan that included positive interventions such as healthy diet, explanation of risks of obesity and exercise plans. However, patients could only achieve their exercise plans if staffing allowed. We saw evidence to show that patients diagnosed with diabetes received the correct monitoring of their condition during the day to maintain their safety. Staff documented observations of blood sugars and gave medication as prescribed.
- Each ward had an electronic patient dashboard which highlighted physical health conditions.
- Records showed variability across the wards as to how person centred the care plans were. The care plans in the personality disorder service were recovery focused despite the patients being inpatients for several years. Also, it was evident that the patients had been involved in their care planning. The care plans in the deaf service were holistic and the patient voice was clear. Two of the

patients we spoke to in the deaf service said they would like to have their care plan in British Sign Language format rather than a paper copy as this would meet their needs better. In the women's service, it was noted that some of the care plans used language that was not recovery focused and offered little hope but there had been some involvement in their care. The care plans in the learning disability service were not holistic and it was unclear whether patients received a copy. The care plans in the mental health service were not specific and robust and it was unclear how much involvement the patient had in their care.

- We reviewed patient records which contained physical health care plans and referrals to the GP when required. For example, a patient who vomited after eating was referred for a GP review.
- Information was stored electronically and also printed out and stored in paper files which staff stored securely. Staff did not consistently record information in the same place within the care record across the wards. Staff on the wards knew where to find information upon request. However, this may pose a risk that staff do not know where to find information if they were moved to unfamiliar wards. The physical healthcare centre patient electronic record system was different to that used by wards. The physical health centre staff copied consultations into the ward system to mitigate the risk of running two systems. The ward manager of the physical healthcare centre told us they updated the care plans by reading the consultation notes.

### Best practice in treatment and care

- We looked at 204 prescription charts. There was low use of rapid tranquilisation and limited use of high dose anti psychotics.
- Records showed staff monitored the physical health of patients after restraint and use of rapid tranquilisation.
- We saw minutes to show the physical healthcare team operational group met every six weeks and was attended by registrars, staff grade doctors, ward nurses and physical healthcare staff where National Institute for Health and Care Excellence guidance was reviewed and they discussed different ways of doing things.
- There was a range of both individual and group psychological therapies recommended by national

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institute for health and care excellence offered across the hospital including; trauma schema, eye movement desensitisation and reprocessing therapy, dialectical behavioural therapy, violent reduction programme, problem solving group and reflective groups. The psychologists mostly worked with the patients and offered little training to staff which could prevent ward staff from being able to recognise certain behaviours and respond consistently.

- Staff used a range of recognised rating scales to assess and monitor patients' health and well-being. These included; health of the nation outcome scales to measure the health and social functioning of patients. The malnutrition universal screening tool to assess patients nutritional and hydration needs. All ward staff had received training in the use of the national early warning score instrument. This is a system used to monitor changes to physical health. However, on Emerald ward, we reviewed eight charts and out of 31 sets of observations staff had only completed two fully. The staff were not conforming to the guidelines of the use of NEWS because they were not calculating the scores or recording them correctly in the electronic notes system. This meant that they could not use the score to determine whether the patients' physical health was deteriorating. For two of the women, if they had not had the safety net of the eating policy, then the deterioration in their physical health might have gone unnoticed. We raised this concern with the trust and they immediately undertook an audit of the NEWS charts but the audit did not check if the calculation had been completed.
- There was a minor surgery clinic to prevent patients from attending outside providers. For example, removal of objects and suturing of self-harm incidents. This was a cost reduction for the trust because it prevented transferring patients to outside providers and reduces stress to patients who feel safer being treated in their own environment. Records showed speciality staff visited patients with physical health needs within the hospital. For example, a neurologist and diabetic specialist nurse visited to assess the patients' treatment care plans. The trust had introduced a sepsis pathway that staff could follow. This indicated when staff should transfer patients to a local hospital for treatment.

- Records showed the hospital had a clinical audit programme for 2016/2017. This included consent to treatment, clinical records and safe and secure handling of medicines. Physical health audits included infection control, use of antibiotics, the use of the malnutrition universal screening tool, blood pressure checks, body mass index, cardiovascular risk assessment and annual health screening. We found that no hand-washing audits were collated and published. The Clinical Effectiveness Sub Committee and the Infection Control Sub Committee monitored the audit programme and the actions plans to ensure learning was consolidated.
- The Ministry of Justice carried out an internal audit and assurance of Rampton hospital in February 2016. The hospital received a rating of good for searching, control of possessions, information technology and patient communications, patient movement, risk assessments, escorting of patients, visits, the patients' shop, management of intelligence and perimeter security. Further to the audit, an action plan was put in place to address and monitor minor improvements required.
- The therapy service team ran the healthy life style service and worked with the physical healthcare team to encourage patients to exercise and make healthy food choices.

## **Skilled staff to deliver care**

- There was a range of disciplines working across the hospital including; mental health nurses, learning disability nurses, psychologists, social workers, occupational therapists, speech and language therapist, dietician, nursing assistants and pharmacists. There were also the staff in the physical healthcare centre; they were all registered general nurses and they all had appropriate training for their role. A GP covering the women's ward had attended a women's health conference to update his skills to provide care and treatment to women within the service.
- The physical healthcare centre staff had delivered a variety of training to the ward staff to ensure care was continued when the physical healthcare centre was not available. For example, they have trained staff in wound management.
- The majority of the staff we spoke with had received the necessary specialist training for their role. For example, there was training provided around self-harm and

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ensuring boundaries when working with patients. The hospital had 120 highly trained staff to manage potential riots or dangerous incidents, and their own hostage negotiators.

- On Adwick ward, the ward manager had completed training in the harnessing opportunities, protective enhancement system (HOPE(s) model). And on Brecon ward a member of staff was a HOPE trainer. This is a framework, developed by another high secure hospital, which supports the multi-disciplinary team help patients move beyond long term segregation. Staff said there was an away day planned to cascade the HOPE training. All of the staff were very positive about this training and believed it will change attitudes across the hospital and reduce the use of seclusion and long term segregation.
- Staff were nursing one patient with autism in the long term segregation annex. However, none of the staff on duty were trained in autism spectrum disorder. There were twenty members of staff across the hospital that had received autism awareness training.
- Some of the nursing assistants we spoke to were on the bottom of band 2 and felt there was little or no career progression. The trust had seconded a small percentage of band 3 nursing assistants to complete their nurse training and there were plans to increase the number of band 3s.
- The nursing staff across the hospital said they did not always get formal supervision in a timely manner but they were aware of whom to discuss any concerns with. The supervision rate was 83% against a target of 80%. The overall appraisal rate for non-medical staff between January 2016 and December 2016 was 88%. Eden ward had the highest appraisal rate, 97% and Anston ward had the lowest appraisal rate at 70%. The overall appraisal rate for permanent medical staff was 92%.
- Twenty of the 23 medical staff had completed their revalidation at the time of inspection. The revalidation of two doctors had been deferred because of insufficient evidence and one was off sick.
- Senior managers told us they addressed poor staff performance promptly and effectively and they felt this

had contributed to the reduction in sickness levels. At the time of inspection, there were three whistle-blowers', nine grievances and 31 disciplinary procedures in process.

- General Practitioners (GP) were employed by an agency and were not permanent members of staff. This meant that there was an uncertainty around finding doctors to staff the physical health centre.
- We were told by staff the clinical pharmacist specialists make a valuable contribution to some of the multidisciplinary teams. On Brecon ward, they advised doctors how to switch between different antipsychotic medications to maintain effectiveness. The pharmacists also had discussions with patients about the benefits and possible side effects of their medication. However, the pharmacy team had to prioritise which wards received this level of service.
- There was a therapies and education department, which provided occupational therapy, art therapy, chaplaincy and spiritual care, speech and language therapy, education and hairdressing.

## Multidisciplinary and inter-agency team work

- All of the wards had regular multidisciplinary meetings and we observed 29 multi-disciplinary team meetings across the hospital. The ward round we observed on the personality disorder wards had good representations from the members of the multi-disciplinary team and included the patient in the discussion. However, a lack of leadership was observed which may have contributed to the lengthiness of the ward round. This led to detailed discussions around patients' care which was confusing. Therapists did not always attend the multi-disciplinary team meetings due to conflicting appointments.
- The speech and language team had been involved in the reduction of violence and aggression programme, which the staff had found beneficial as it helped communication with patients.
- We observed three handovers between shifts across the hospital and they included all relevant patient information including risk and safeguarding issues, diary appointments and staffing issues affecting any planned care.

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- There was good joint working between ward nursing staff and the physical healthcare team. Records showed the ward staff provided information to the physical health team to be submitted for key performance indicators for example monthly height and weight monitoring. The ward named nurse for the patient was responsible for the physical health care plan. They named nurse wrote the plan jointly with the physical health staff. Joint working was available between an end of life care team working within the trust and the service to care for patients in the last days of life. The trust had a suite to accommodate patients who requested their end of life care within the hospital.
  - Physical healthcare staff told us that handovers were effective between them and the ward nursing staff, but they said responsible clinicians did not always follow policy as they were meant to discuss referrals with the physical healthcare team but often sent them via email instead.
  - Records showed good joint working during pre-admission and admission between Rampton and the staff working in the placements where the patients came from. The social worker told us they had good working relationships with the local authority.
  - Records showed that staff communicated effectively with other hospitals around supporting the patient in attending their appointments outside of the hospital.
  - Rampton collaborated with the other secure hospitals around practice in respect of long term segregation and this resulted in the implementation of new procedures for the use of seclusion and long term segregation. The managers told us they communicated regularly with their counterparts at the other hospitals. NHS England specialist commissioner case managers attended patient reviews and held regular meetings with Rampton hospital and they reported positive working relationships.
- around the Act and to access legal advice. The Mental Health Act paperwork was stored in the administration office and not on the wards but it was scanned onto the electronic system so it was accessible for all staff to see.
- The ward staff had a good understanding of the Act and the Code of Practice. At the time of the inspection, 90% of staff had completed and were up to date with their Mental Health Act training.
  - We saw consent to treatment cards were correctly attached to medication charts. This shows the staff whether the patient has capacity and if they have consented to their treatment or not.
  - Records showed patients had their rights read to them on admission and on a regular basis afterwards.
  - There was good access to independent mental health advocacy across the hospital.
  - We spoke with five patients and five staff and looked at 38 records between March 2016 and December 2016 in order to review Mental Health Act Section 134, withholding patients' mail. Staff inserted colour coded inserts into open mail to assist patients with a learning disability know why their mail had been opened. Packages were taken straight to the ward area after x-ray and opened by staff and patients together. All of the records reviewed showed that staff informed patients of their right to contact CQC and to appeal the decision. Staff assessed the need for monitoring for each patient upon admission. Evidence showed the hospital were thinking about being less intrusive and had been advising the responsible clinicians to use partial monitoring. However, records reviewed were not in line with the Code of Practice because they did not include a statement of the content of the discussion concerning mail and phone monitoring in ward rounds. Staff only recorded yes or no to monitoring. Staff had not recorded whether patients knew what they had to achieve in order to come off telephone and mail monitoring. Letters informing patients of the reason for their mail being withheld stated that this was the law but did not give a specific reason why it applied to the item withheld as is stated in the Code of Practice. In 50% of records reviewed, patients had not been notified of a decision to withhold mail within the allowed seven days. The delay appeared to be with the responsible clinician. This was also not in line with the Mental Health

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

- There was a Mental Health Act administration team which examined Mental Health Act paperwork on admission. All of the staff we spoke to knew they could access this team for support in relation to any questions

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Act Code of Practice. We found some instances where records stated that that staff were monitoring a patient's mail when this was not the case and vice versa. There had been 14 appeals made to CQC between April 2016 and March 2017.

## Good practice in applying the Mental Capacity Act

- At the time of inspection, 90% of staff had completed and were up to date with Mental Capacity Act training.
- Staff were able to give us examples of how they had ensured they worked to the principles of the Mental Capacity Act with patients throughout the hospital.
- Records showed that staff supported patients to make their own decisions where appropriate and staff recognised the importance of the person's wishes, feelings and culture. However, the information recorded in the majority of records was insufficient to determine whether staff always assessed capacity to consent. Records on Grampian ward showed staff assessed capacity to consent on a decision by decision basis and recorded this correctly. Records in the physical healthcare centre showed that staff considered capacity to consent in relation to physical health conditions.
- There was an up to date Mental Capacity Act policy including information about Deprivation of Liberty Safeguards that staff were aware of and could refer to. There were no Deprivation of Liberty Safeguards applications made at the time of inspection.
- Staff could access advice from the Mental Health Act administration team regarding the Mental Capacity Act and they monitored compliance to the Mental Capacity Act within the trust.



# 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

- Staff interacted with patients in a supportive and caring way. We saw staff were responsive to patients' needs despite staffing pressures and provided practical and emotional support when required. We saw one example of staffing levels reduced to four mid-shift and they had to close off areas of the ward in order to maintain observations. The remaining staff continued to interact with the patients and managed the difficult situation well. We observed positive interactions between staff and patients and observed sensitive and non-judgemental supportive care in the physical healthcare centre and within ward areas.
- Physical healthcare staff provided care that promoted dignity of the patients whilst having physical health assessments. Staff used screens to reduce the number of staff observing the consultation.
- There were some concerns on the mental health wards that dignity could be compromised because the covers over the observation windows for the bathrooms along the main corridors could be pulled open by anyone walking down the corridor. We raised this as a concern and the trust responded immediately by ensuring staff were deployed in the corridor to prevent inadvertent access by other patients and they said they would install internal privacy curtains by 31 March 2017.
- We observed staff providing holistic care to patients in a gentle, respectful manner by the staff in the physical health care centre. This meant physical healthcare staff also considered the mental health needs and the patients' current mood and feelings.
- Patients told us that staff go the 'extra mile' even though they were short staffed. The patients said that when their wards were short staffed or there was a lone worker at night then there were occasions when they would not press their nurse call button unless necessary as they were conscious the staff were busy. This sometimes meant the patient waiting longer for a drink or for someone to talk to.
- The patients told us their regular staff on their wards and their named nurses had a good understanding of

their needs. However, the staff was regularly moved between wards and this meant there was not always a regular member of staff on the ward that knew the patients as well.

- On the ward for patients who were deaf, dignity staff respected patients' dignity by flashing the light outside the room to notify the patients that they were outside to talk to them.
- However, some male patients told us that female staff had been assigned to observe them while they were in the bathroom because of a shortage of male staff members on the ward.
- The hospital 2016 patient led assessments of the care environment score for privacy, dignity and well-being was 94%. This was above the national average of 90%.

### The involvement of people in the care they receive

- The patients we spoke to told us that when they were admitted they were shown around the ward and were given information leaflets about hospital and what was available. Patients told us the interpreters in the deaf service worked closely with staff to ensure they had understood hospital policies and the staff's expectations.
- Two thirds of the patients we spoke to felt involved in their care planning and risk assessment and were offered copies of their care plans. They felt the staff and the treatment programmes tried to encourage and support recovery and independence but, because staff sometimes cancelled activities, this could delay their recovery.
- There was an advocacy service and all of the patients we spoke with knew how to access this. There were information leaflets on the wards to promote the service. We observed a monthly patient council meeting, which was supported by the advocacy service. A patient representative attended from each ward. They were responsible for bringing issues from fellow patients to the meeting and disseminating information on their return. Advocates and patients reported this system worked well. Patients contributed freely throughout the meeting. A deaf patient chaired the meeting; a signer was present throughout.

# Are services caring?

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

- The patient council had developed a traffic light system for their feedback log to track the progress of issues raised via the patient council. Patients raised the issue of low staffing numbers but did not elaborate on the impact or frequency.
- We held a carers' focus group which was attended by three carers, one person from the befriending service and two employees from the family support service. Carers spoke positively about Rampton carers' forum which the carers found very supportive. The trust supported the forum. Although the trust said that they imposed no condition on who could attend, the carers reported that the trust had imposed some conditions. Carers reported some difficulties in getting information about their relatives' care and treatment either due to poor practice in information sharing, or staff respect for patient confidentiality. The carers said the named nurses were not often available to talk with carers. We saw evidence in the learning disability service that there was good joint working with the carers. Rampton had "Carers' Champions" to promote staff understanding of the need to involve carers as part of the "Triangle of Care" approach. However, carers did not understand the scope of their role, and thought these Champions were primarily their point of contact on the ward. Carers were concerned that their relatives were prosecuted following serious incidents and they felt this was inappropriate. The trust had raised and discussed this at carers forum. The visiting facilities on Canterbury ward were cramped, this was compounded by the requirement that all visits were supervised by a member of staff. Two carers told us they found it awkward when a staff member was sitting close to them as they felt they should involve them in the conversation. One carer showed us an envelope she received in the post with "Rampton" entered as the return address. She felt this breached her confidentiality. All of the carers we spoke to said staff were caring and supportive and they also valued the Family Support team who run carers' events throughout the year. There was also a befriending service at the hospital to support patients who do not have carers.
- We observed five community meetings during the inspection and saw that patients set the agenda, were able to give feedback about the hospital and their ward and raise concerns. Minutes were kept of these meetings and were accessible for all patients. The ward representative could then feed issues into the patient council.
- Staff and patients told us they were involved in the recruitment of staff but at the time of inspection, this was not done as collaboratively with staff as they would like and there were plans to change this.

# Are services responsive to people's needs?

Requires improvement 

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

## Our findings

### Access and discharge

- Staff from Rampton made a pre-assessment visit to ensure that each newly referred patient required treatment under conditions within a high secure environment, and met the criteria of posing a grave and immediate danger to themselves or the public. People were admitted via the criminal justice system; court or prison. Those patients who had not committed a criminal offence were civil admissions under Part II of the Mental Health Act and usually admitted from a lower level security hospital setting.
- The average length of stay was five years, with a very small number of patients who would remain at Rampton hospital for a significantly longer period of time due to their own individual needs or circumstances.
- The bed occupancy on 31 January 2017 was 88%. The bed occupancy on the learning disability service was 85%; personality disorder wards were 67%; the Peaks unit was 82%; the deaf service was 90%; mental health service was 97% and the women's was 100%.
- At the time of inspection, 18 patients were awaiting admission. Six of these people were waiting for a bed in the women's service; with the longest wait being nine months. The clinical director for the service had invited the commissioners to a bed management meeting in order to discuss a way forward. Managers told us that, due to the high occupancy, four patients were waiting to be transferred to medium or low secure services. However, staff told us that the shortage of medium secure beds could make it difficult to identify where someone could move on to.
- If a patient required more intensive care then the risk and clinical acuity would be reviewed and a decision made whether it was needed to transfer them to a different ward. Usually, the staff would manage the patient through increased observations or he or she may require to be nursed in seclusion or segregation.
- There was a full range of rooms and equipment to support treatment and care throughout the hospital, including; a fully equipped gym, swimming pool, woodwork room and a range of therapy rooms.
- There was a visitor centre for families to stay in if they had travelled far; most wards facilitated visits in specific visiting areas or rooms. If there were children visiting, this took place in the family centre. The family centre was a short walk from the hospital and was fully equipped for children.
- The majority of patients across the hospital had en-suite shower and toilet facilities in their rooms, except for those on the generic mental health wards where they only had a toilet and sink. The bathrooms on those wards had a curtain on the outside of the observation windows that anyone could open; this could compromise the dignity of the patients. We raised this issue with the trust and they responded by ensuring a staff member would be placed in the corridor to ensure dignity was maintained and have said that internal curtains would be installed by the end of March 2017. There were phones on all of the wards. These were within communal areas but they had a hood over them to help maintain privacy. Some of the patients told us the phones do not always work but the staff ensured that they help to facilitate the call if they can. On Grampian ward, the quiet room was used for phone calls that needed to be interpreted. Three of the patients felt there were privacy issues when they made a call in this way due to a member of staff needing to be with the interpreter. There were no skype facilities so the patients could communicate with their family directly.
- There was access to outside space across the hospital and there were bikes patients could use. However, general access to fresh air was not always possible due to staffing.
- Patients were able to make snacks and hot drinks during the day shifts. At night time, patients were risk assessed in order to have snacks, cold drinks and flasks of hot drinks in their room as they were unable to make them during the night due to the night time confinement policy. Staff could make hot drinks for patients if required but this would require either drinks to be passed through observation hatches or three staff to unlock the door.

### The facilities promote recovery, comfort, dignity and confidentiality



# Are services responsive to people's needs?

Requires improvement



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

- The patients did not complain about the quality of the food but they all said they were bored of the four-week rolling menu that had been in place for five years.
- Records showed, the hospital offered 25 hours a week therapeutic activity. However, the average number of hours of activity attended by the patients did not achieve the 25-hour target. The main reason for the activity not going ahead was that the patient chose not to attend. Records showed that between October 2016 to December 2016 the average rate of activities cancelled due to staffing issues were; mental health service 5.3%, deaf service 2.9%, learning disability service 4.2%, women's service 8.2%, the peaks unit 1.3% and the personality disorder wards 4%. The trust said these figures do not show whether the patient took part in a replacement activity instead.
- There was a range of physical exercise choices for patients including swimming, the gym, badminton, tennis, cricket and football. However, patients could only use these facilities when there was a sufficient number of staff on duty. Patient activities were cancelled regularly due to poor staffing levels.
- Some wards had their own gym equipment but this could only be accessed if a member of staff on the ward had completed their gym observer training and was able to be present, otherwise it could not be used.
- Some security doors throughout the hospital were solid or had a small glass window in. This meant that it was difficult at times for deaf people to sign through them. The main reception did not have a loop system for hearing aids user but there was a loop system in the learning development centre. In the main reception, there were information leaflets for visitors but they were not in British Sign Language and the staff in the reception were not trained in British Sign language. Patients with hearing impairment were always accompanied by a British sign language interpreter to appointments in the physical healthcare centre.
- A list of training courses for patients with diabetes was displayed in ward areas. Patients were given information about their physical health needs. Easy read leaflets were available for patients who had difficulties reading. There were also leaflets in the wards about advocacy and patients' rights.
- The 2016 patient led assessments of the care environment survey score for disability access was 85%, which was above the national average of 82%. The hospital site could accommodate wheelchair users and there was a specific room for specialised medical treatment.

## Listening to and learning from concerns and complaints

### Meeting the needs of all people who use the service

- There were 16 chaplains who were available for staff and patients throughout the hospital and they felt they were an integral part of the patients' recovery programme. The chaplaincy team saw approximately 60 people per week from a wide range of religions and cultures. Any patient or staff member could self-refer or they held weekly drop in sessions. They told us the trust responded positively to the barriers caused by night time confinement in being able to meet specific religious practices and also in supporting patients being able to pray. We were told patients and staff can pray together. There was a spirituality and well-being practitioner who catered for non-religious patients and practised therapy such as Reiki.
- Staff told us that an interpreter for a patient whose first language was not English could be arranged for all medical consultations and treatments and leaflets could be sourced in different languages.
- Rampton had a dedicated complaints team. Complaints were received via advocacy or letters directly from patients. We were told there were two types of action taken when complaints were received, either a full investigation was conducted or there was a local resolution.
- Between February 2016 and January 2017, patients made 306 complaints. The majority of the complaints were dealt with within the agreed timescales. However, in April 2016 there were 11 complaints that were not resolved within 25 working days and in December 2016 there were nine complaints outside of the agreed timescale. The hospital acknowledged staff had not always dealt with complaints within the specified time scale. However, there was some evidence of improvement in the months leading up to the inspection. In January 2017, they received 24 complaints and only four fell outside of the agreed timescale. In February 2017, they received 31 complaints and 30 of them were acknowledged within the

# Are services responsive to people's needs?

Requires improvement 

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timescale of three days and responded to within 25 days. There were two cases referred to the parliamentary health service ombudsman between February 2016 and January 2017. One case was not upheld and the outcome of the second is not known. We looked at five complaint files and saw evidence to show they had been investigated and the correspondence was sent out to the complainant.

- The patients we spoke to knew how to raise a complaint and felt well supported by the staff but felt the issue regarding cancellation of activities had not been resolved and was a continuous complaint from patients. These were managed by updating the patients' timetable the week before with all planned cancellations.
- Records showed an example of lessons being learnt and action taken following a complaint from a patient who had completed a claim for pension benefits which had

taken a long time; working processes within the finance department had been amended and procedures updated to include what to do in the event of a new claim.

- Not all staff that we spoke to understood the complaints procedure. Complaints awareness training was not compulsory and we were told that except for half an hour on the initial induction staff under band 6 were not offered anything. The staff that had received the training knew how to handle complaints appropriately and they said they received feedback on the outcome of any investigations. The other staff were less sure but said they would direct the patient to advocacy or the nurse in charge. The complaints liaison team told us they did not go on wards that often and complaints were often directed to advocacy as they were present in the patient areas more.

# Are services well-led?

Inadequate 

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 majority of the staff we spoke to were aware of the 'positive tick' logo but more than half of the staff we spoke to could not tell us what 'positive' stood for and could not talk about the organisation's values.
- Ward managers and matrons mostly knew who the senior managers were but nursing staff and nursing assistants did not know who was above their ward manager. They said that sometimes they were aware that senior staff visited the ward but they generally did not speak to them or know who they were. However, we saw a time-table of planned visits to wards by senior trust managers.

### Good governance

- We raised concerns at the previous inspection that remained a concern at this inspection. These were; staff were not getting breaks from continuous observations, ward clocks were not set at the same and correct times, activities were cancelled due to staffing issues, and there were breaches of the Code of Practice with regard to seclusion, long term segregation and the monitoring of mail.
- Recruitment and retention of staff was an ongoing issue. The trust's recruitment strategy during the 18 months prior to inspection involved several open days, attendance at job fairs and an open advertisement for qualified staff and nursing assistants. Due to the difficulty in recruiting sufficient qualified nurses, the trust had over recruited to nursing assistant posts.
- Mandatory training levels were 92%; which was above the 85% target the trust had set. The ward managers had good oversight of who had completed mandatory training. The staff had a good understanding of the Mental Health Act, Mental Capacity Act and Safeguarding and there were procedures and policies in place to support them in applying the principles. Ward managers, deputy matrons and matrons were involved in audit but other staff members had little awareness of the audit programme. Due to the staffing issues, all ward staff we spoke to told us they had little 1:1 time with patients and it was difficult to organise activities safely without the required numbers of staff.

- The qualified staff and other members of the multi-disciplinary team knew who their supervisor was but the unqualified members of staff commented they did not receive regular clinical supervision.
- There was a trust wide information governance structure in place at the time of inspection. There were no separate arrangements for Rampton because the hospital operated within trust agreements. This was under review; with a proposal for a new framework to be presented to the board in May/June 2017. There were dedicated forensic information governance meetings which reported into a trust wide group and were chaired by the executive director who led on high secure reported to the board quality committee.
- A serious incident review group met weekly to ensure that the serious incident process was followed correctly. This group included members of the senior leadership team. The group produced a root cause analysis of the incident and presented it at the forensic circle group to sign off. The forensic circle group then fed in to the trust circle group and they discussed any action plans that had to be taken back to the hospital and completed and communicated across the hospital via email or lessons learnt bulletins. The physical healthcare team had a weekly clinical meeting to discuss complex cases, incidents and lessons learnt from any investigations. We saw records showed a lesson learnt bulletin was produced by the physical healthcare team and reviewed at the service quality governance meeting.
- The majority of the wards did not have regular staff meetings. Staff said they would informally raise any issues with their ward manager who would escalate their concerns.
- There was a mixed response from the ward managers to the question of whether they had enough authority to do their job. Some reported that they were just told what to do and which member of staff they would be having on their ward. Ward managers felt that the staffing issues had become worse since it moved to the central resource office. They generally felt they had enough administration support to do their job but often felt that due to staff shortages they were needed on the ward and this prevented them from being able to do their job as ward manager as effectively.

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- Ward managers were unable to tell us which items were highlighted on the hospital risk register.
- The complaints team reported monthly to the managers and the trust board and reports its key performance indicators on a quarterly basis which feeds into the wider trust complaints and PALS activity.
- There were key performance indicators in place to reduce violence and aggression but no specific indicators to gauge the performance of the team.
- We reviewed the personnel files of two directors (who were responsible for Rampton) for the fit and proper person test. There were good recruitment processes and checks made. Directors signed declarations relating to the fit and proper person test. However, we did not see competency based interview forms in the personnel files, or formal sign off by the chair that the fit and proper person test had been met.
- We looked at six personnel files and saw that they followed the correct recruitment process and included relevant information.

## Leadership, morale and staff engagement

- All of the clinical staff groups we spoke to said they felt staff morale was low. The nursing staff told us they did not feel valued and that the pace of change had been too fast. They felt that decisions were made by matrons with no opportunity to give their opinion. Most ward staff said shifts could not be changed or swapped at short notice at a local level to cover for personal appointments or family commitments, stating this was due to rotas being overseen by a central resource team. Newly qualified nursing staff received less pay than nursing assistants who received psychiatric lead and this made them feel frustrated. The nursing assistants we spoke with felt the hospital was top heavy with managers and they were unhappy with the difference between pay for staff who received the psychiatric lead and for those who do not. They said it made them think of their future and other options outside of the hospital. The staff grade and junior doctors felt their consultants were supportive. However, the consultant psychiatrists generally felt when they tried to express concerns around patient care or safety; they did not get any response or a hostile response from senior management. They felt there was reluctance amongst the doctors to raise concerns due to fear around having pay cuts or being investigated and suspended. They said they felt marginalised and disempowered. The senior managers reported they were aware they needed to improve engagement with the doctors and they had planned a specific engagement programme between the Medical Director and chair of the hospital medical staff committee. Allied health professionals, including occupational therapists, art therapists and psychologists, mostly felt that they were given opportunities for training but were unable to take them up due to high workload. They said they felt able to raise concerns without fear of victimisation. They felt support from management had decreased, for example, they had gone from 1:1 supervision to group supervision.
- Within the past 12 to 18 months prior to inspection, there had been significant changes within Rampton involving the creation of new posts and the changing role of a central resource office where the decisions were made about the deployment of staff. The trust had recently appointed an executive director for high secure hospitals and a non-executive director to lead on Rampton. The senior management team for Rampton were also relatively new in post. There had been the creation of the site security liaison team who were all senior nurses and their role was to maintain the security of the hospital. Alongside this team there were matrons and deputy matrons. Their role appeared less clear and the staff said they were not sure who was in charge of the hospital during the day time.
- The senior management team acknowledged that they had led the hospital top down during the past twelve months. They felt this had been the best way to implement change, in particular, embedding the revised observation policy. However, they said they wanted to move away from that type of management style and to try and increase staff engagement. They had held an away day for ward managers, matrons, deputy matrons and security liaison managers. They had met every three months. Its aim was to help start building relationships and clarify roles in order to improve collaborative working. The feedback regarding the day was positive.
- There were some opportunities for leadership development for senior managers but ward staff felt they did not get any opportunities for development. The ward staff team as a whole were very supportive of one another and showed good team working. Staff felt like

# Are services well-led?

Inadequate 

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there was little opportunity to give feedback about services and service development but the management team were aware of this and had started to hold away days for groups of staff and planned to hold more later on in the year. There had been a small staff group that had contributed to the observation policy and training.

- We saw minutes of meetings that showed senior managers met with staff side representatives.
- General managers said despite the improvement in sickness rates, lone working continued, which had a negative impact on staff morale.
- The staff we spoke with were aware of the whistleblowing policy but they talked about a blame culture and they said they felt their career or job would be negatively affected if they raised an issue or whistle blew.

- The trust acknowledged there was a need for improved staff engagement and told us they had reviewed and launched its people and culture strategy in February 2017. This programme aimed to develop culture and embed approaches in order to hear staff's voice regarding service improvement and delivery. They also planned to hold away days for each ward and another away day for ward managers, deputy matrons, matrons and security liaison team.

## **Commitment to quality improvement and innovation**

- The hospital had collaborated with the other high secure hospitals to produce a violence reduction manual.

This section is primarily information for the provider

## Requirement notices

### Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment <b>Staff were not calculating the National Early Warning Scores and recording them correctly. The trust audit did not address this issue.</b>  This was a breach of regulation 12(1)(2)(a)
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 <b>Staff were not adhering to the infection prevention control and dress code policy as we observed staff wearing, rings, nail varnish and full sleeves.</b>  This was a breach of regulation 12(1)(2)(h)
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 <b>The emergency major incident trolley had not been checked.</b>  This was a breach of regulation 12(1)(2)(e)
Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment <b>Fire doors were left open overnight on the women's wards to facilitate observations.</b>

This section is primarily information for the provider

## Requirement notices

This was a breach of regulation 15(1)(d)

### Regulated activity

### Regulation

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

Treatment of disease, disorder or injury

Regulation 17 HSCA (RA) Regulations 2014 Good governance

**The trust did not have effective systems in place to ensure the staff were engaged and were able to give feedback without fear of victimisation.**

This was because staff did not feel adequately engaged and reported feeling demoralised and so further improvements in communication were needed.

This was a breach of regulation 17(1)(2)(a)(b)(e)(f)

### Regulated activity

### Regulation

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

Treatment of disease, disorder or injury

Regulation 18 HSCA (RA) Regulations 2014 Staffing

**The trust was not ensuring that there were sufficient numbers of suitably qualified, competent, skilled and experienced staff to meet the needs of the patients.**

There was regular lone working at night.

This was a breach of regulation 18(1)