

# St Magnus Hospital & Rosemary Park Nursing Home

## Quality Report

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Date of inspection visit: 26th November 2019  
Date of publication: 16/03/2020

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

### Ratings

Overall rating for this location	Outstanding	☆
Are services safe?	Good	●
Are services effective?	Outstanding	☆
Are services caring?	Outstanding	☆
Are services responsive?	Good	●
Are services well-led?	Good	●

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

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

# Summary of findings

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

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

## Overall summary

This service was inspected using CQC's methodology for inspecting both mental health and adult social care services. The report has been structured to provide an overall rating for the whole location and includes our rating for the low secure wards at St Magnus and older peoples services at both St Magnus and Rosemary Park Nursing Home..

We rated the St Magnus and Rosemary Park as Outstanding overall because:

- There was a truly holistic approach to assessing, planning and delivering care and treatment to all patients who used services. This included addressing, mental health and physical health care needs along with their nutrition, hydration and well-being needs. All care plans were personalised, holistic and recovery focused. It was clear from the content of the care plans that patients and their carers had been involved in developing the plans. All patients were risk assessed on admission and had up to date risk assessments which were linked to their care plans
  - Staff used safe, innovative and pioneering approaches to care. There were individual and group psychological therapies such as cognitive behavioural therapy and dialectical behavioural therapy available to assess and provide treatment and there was a dedicated psychologist in post to ensure psychological evaluation was happening
  - Staff across both services used an “all about me” document which was kept in the patient bedrooms for patients who had cognitive difficulties to help inform staff of patients’ likes and dislikes. This document was detailed and informative and gave all staff an opportunity to engage with patients in areas of interest
  - The majority of patients were detained under the Mental Health Act 1983 (MHA) and understood and were empowered to exercise their rights under the Act.
- The provider supported staff to understand and meet the standards in the MHA Code of Practice. The service had developed a system for ensuring patients supported on a Deprivation of Liberty Safeguards (DOLS) applications were fully tracked and they had their rights and entitlements explained to them and recorded regularly.
- Practices around consent and records were actively monitored and reviewed to improve how patients were involved in making decisions about their care and treatment.
  - Staff were clear about their safeguarding responsibilities to ensure they kept patients safe and knew how to identify and make a safeguarding referral within office hours and during the evening and weekend.
  - The services supported health care assistants to complete the care certificate standards and senior healthcare workers were offered the opportunity to complete their Nurse Associate training funded by the hospital.
  - Feedback from patients and their carers and stakeholders was overwhelmingly positive about the way staff treated patients. NHS England commissioners reported witnessing a high level of compassion and understanding when they attended the hospital and reported that the clinical teams took a great deal of time and effort to ensure that the patients were involved in the process as fully as possible. Carers told us that they felt patients were safe, cared for and well looked after by staff. Staff attitude was described as caring, motivated and patients and carers told us that staff went the extra mile to ensure patients’ needs were met.
  - All staff across the service were observed to be exceptionally and consistently caring and respectful to

# Summary of findings

all patients. Staff used thoughtful, appropriate and considerate language and adapted their style of communication to the patients' level of understanding. We saw staff always responded quickly to patient requests for additional support such as personal care. Staff were passionate about their work and it was clear they genuinely cared about the emotional wellbeing of their patients and wanted them to feel cared for.

- All staff were actively engaged in activities to monitor and improve quality and outcomes. Opportunities to participate in benchmarking and peer review were proactively pursued, including participation in approved accreditation schemes. High performance had been recognised as St Magnus Hospital is a member of the Quality Network for Forensic Mental Health Services (Royal College of Psychiatrists). St Magnus Low secure unit was found to have fully met 92% of standards, putting it in the top ten low secure units in the network.
- Managers, with support from the security lead, completed ligature audits to identify ligature points throughout the wards and gardens. In addition, daily walk-around checks and a weekly environmental check on each ward ensured a regular systematic approach to maintaining a safe environment.
- The ward and unit environments at both St Magnus and Rosemary Park were clean and well maintained. Staff followed good infection control procedures and monitored the cleanliness of the environment regularly through conducting audits. The design, layout, and furnishings of the ward/service supported patients' treatment, privacy and dignity. In St Magnus hospital each patient had their own bedroom with an en-suite bathroom and could keep their personal belongings safe. Across the whole service there were quiet areas for privacy. The bedrooms had been personalised. Carers had supported staff to personalise bedrooms on the wards for patients with dementia.
- The food was of an excellent quality and patients could make hot drinks and snacks at any time. The patients were complimentary regarding the kitchen's ability to meet their individual food choices
- Staffing levels and skill mix were planned, implemented and reviewed to keep patients safe at all

times. Any staff shortages were responded to quickly and adequately. Registered nurses were visible on the wards and able to spend time with patients on the wards and 1:1 sessions were taking place. At Rosemary Park we observed staff were busy but not rushed, and patients told us call bells were answered quickly when pressed.

- Training was managed with the support of the hospitals own dedicated education department in the hospital. Staff were up to date with all their mandatory training and could also access specialist training to support them to deliver good quality care. Support staff were supported to undertake nurse training if they wished.
- Use of rapid tranquilisation was low across all wards at St Magnus and staff were using verbal de-escalation skills to ensure that patients' distress was managed before it required additional medicine
- Both St Magnus and Rosemary Park were able to meet the needs of all patients who used the service – including those with a protected characteristic. Staff helped patients with communication, advocacy and cultural and spiritual support.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team and the wider service. Patients told us that they did not have a need to complain. However, they were confident that if they did they would be listened to and the matter dealt with. Families confirmed that there was little need to complain about anything. Staff confirmed that they received feedback from incidents and complaints and that lessons learnt from other wards was shared with them at team meetings, via emails and within supervision and team days.
- Leaders had the skills, knowledge and experience to perform their roles, had a good understanding of the services they managed, and were visible in the service and approachable for patients and staff. Staff consistently reported that managers were supportive and would listen and act on any concerns they raised. Staff felt that the management team were more of a family and nurtured and supported the staff to progress within their roles.

# Summary of findings

- Staff knew and understood the provider's vision and values and how they were applied in the work of their team. Staff felt respected, supported and valued. They felt able to raise concerns without fear of retribution. Staff morale was high, and staff told us they were happy in their roles. We observed supportive and cohesive team working and the atmosphere appeared relaxed and encouraging.
- Not all staff at St Magnus had access to the electronic patient record. Junior support workers did not have access to the electronic record and could only view them if a member of staff with access login for them. This meant there was a paper copy of care plans and an electronic copy which required updating every time a care plan was reviewed which could lead to confusion within the staff team.

**However:**

# Summary of findings

## Our judgements about each of the main services

### Service

#### Forensic inpatient or secure wards

### Rating Summary of each main service

Good



- The service provided safe care. The ward environments were safe and clean. The wards had enough nurses and doctors. Staff assessed and managed risk well. They minimised the use of restrictive practices, managed medicines safely and followed good practice with respect to safeguarding.
- Staff developed holistic, recovery-oriented care plans informed by a comprehensive assessment. They provided a range of treatments suitable to the needs of the patients and in line with national guidance about best practice. Staff engaged in clinical audit to evaluate the quality of care they provided.
- The ward teams included or had access to the full range of specialists required to meet the needs of patients on the wards. Managers ensured that these staff received training, supervision and appraisal. The ward staff worked well together as a multidisciplinary team.
- High performance had been recognised as St Magnus Hospital is a member of the Quality Network for Forensic Mental Health Services (Royal College of Psychiatrists). St Magnus Low secure unit was found to have fully met 92% of standards, putting it in the top ten low secure units in the network.
- Staff understood and discharged their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, and understood the individual needs of patients. They actively involved patients and families and carers in care decisions.
- The service was well-led and the governance processes ensured that ward procedures ran smoothly.

However:

# Summary of findings

- A small number of staff were allowed to work excessive hours without taking regular days off
- Handovers did not take place during regular working hours
- The patient bedroom window restrictors were not included in the ligature point audit
- A small amount of equipment was out of date in the clinic room.

## Wards for older people with mental health problems

Outstanding



- The ward environment was clean and infection control was well managed. The wards had cleaning schedules and regular audits for cleanliness were undertaken by the housekeeping department.
- We saw clear evidence that all patients were risk assessed on admission and had up to date risk assessments which were linked to their care plans. The staff were exceptional at ensuring that all care plans were personalised, holistic and recovery focused. It was clear from the content of the document that patients and their carers had been involved in developing the plan.
- Use of rapid tranquilisation was low across all wards and staff were using verbal de-escalation skills to ensure that patients' distress was managed before it required additional medicine
- Staff were clear about their safeguarding responsibilities and knew how to identify and make a safeguarding referral within office hours and during the evening and weekend.
- There were individual and group psychological therapies available to assess and provide treatment in line with national guidance. There was a dedicated psychologist in post to ensure all diagnostic formulation work was happening
- The service invested heavily in trained health care assistants by supporting them to complete the care certificate standards and senior healthcare workers were offered the opportunity to complete their Nurse Associate training funded by the hospital.
- All staff across the service were observed to be exceptionally and consistently caring and respectful to all patients. Staff used thoughtful, appropriate and considerate language and adapted their style of communication to the patients' level of understanding.

# Summary of findings

- Carers reported that they felt patients were safe, cared for and well looked after by staff. Staff attitude was described as caring and motivated and carers felt staff went above and beyond to support their loved ones.
- Staff could give multiple examples of the type of person-centred support that individual patients needed and how they met their needs. Staff were very passionate about their work and it was clear they genuinely cared about the emotional wellbeing of their patients and wanted them to feel cared for. Staff consistently used their in-depth knowledge of the patients to engage with them whilst recognising personal choice.
- The design, layout, and furnishings of the ward/ service supported patients' treatment, privacy and dignity. Each patient had their own bedroom with an en-suite bathroom and could keep their personal belongings safe.
- The food was of an excellent quality with multiple healthy choices. and patients could make hot drinks and snacks at any time. The patients were complimentary regarding the kitchen's ability to meet their individual food choices
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team and the wider service.
- Leaders had the skills, knowledge and experience to perform their roles, had a good understanding of the services they managed, and were visible in the service and approachable for patients and staff.
- Staff felt respected, supported and valued. They reported that the provider promoted equality and diversity in its day-to-day work and in providing opportunities for career progression. They felt able to raise concerns without fear of retribution. Staff reported high morale and were happy in their roles. We observed supportive and cohesive team working and the atmosphere appeared relaxed and encouraging.
- Governance processes operated effectively at ward level and that performance and risk were managed extremely well. All board assurance reports, safety reports and policies were scrutinised by and authorised by the SMT.

# Summary of findings

- Staff reported multiple opportunities for professional development and that training was appropriate to their needs. This was echoed by the large training department who had already arranged opportunities for mandatory and patient specific training in the next year. Staff reported many opportunity to progress within the service. The culture of developing their own nurses was evident within several of the wards where support workers were being developed to undertake their nurse training.
- Staff confirmed that they received feedback from incidents and complaints and that lessons learnt from other wards was shared with them at team meetings, via emails and within supervision and team days.

However:

- Not all staff had access to the electronic patient record. Junior support workers did not have access to the electronic record and could only view them if a member of staff with access login for them. This meant there was a paper copy of care plans and an electronic copy which required updating every time a care plan was reviewed.
- We found a small number of missed medicine doses that staff had not signed as being given.



# Summary of findings

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Outstanding



# St Magnus Hospital and Rosemary Park Nursing Home

**Services we looked at:**

**Forensic inpatient or secure wards, Wards for older people with mental health problems**

# Summary of this inspection

## Background to St Magnus Hospital & Rosemary Park Nursing Home

St Magnus Hospital is an independent mental health hospital run by Oldercare (Haslemere) Limited. The hospital provides a highly specialist, national service to predominantly older age men with behavioural and psychological symptoms of dementia, cognitive impairment and/or enduring mental illness. The average age of patients was 68 years. There are two core services at the hospital, a low secure/forensic service, and locked wards for older people with mental health problems and high dependency needs.

The hospital shares a site with Rosemary Park, a 66-bed nursing home, and is registered as a single location. At the same time as we inspected the hospital, an adult social care inspection team inspected Rosemary Park Nursing Home; their findings are included in the detailed findings of this report.

There are 86 beds across seven wards in St Magnus Hospital; 82 beds were in use during our inspection. Seventy-nine patients were detained under the Mental Health Act (MHA) and three patients were subject to Deprivation of Liberty Safeguards (DoLS) as part of the Mental Capacity Act (MCA).

There are three units at Rosemary Park Nursing Home which provide care for elderly and / or frail individuals, we inspected all three units.

There are seven wards at St Magnus Hospital, three low secure/forensic wards and four locked wards for older people with mental health problems.

We inspected all seven wards:

- Sycamore Ward nine beds for men, low secure, admission and assessment
- Willow Ward nine beds for men, low secure, continuing care

- Oak Ward 15 beds for men, low secure, continuing care
- Cowdray Ward eight beds for men, locked admission/high dependency ward
- Petworth Ward 15 beds for men, locked, continuing care
- Park House 18 beds for men, locked, continuing care, progressive dementia
- Goodwood Ward 12 beds for men, locked, continuing care, enduring mental illness

St Magnus Hospital and Rosemary Park Nursing Home are registered to provide the following regulated activities:

- Assessment or medical treatment for persons detained under the Mental Health Act 1983
- Diagnostic and screening procedures
- Treatment of disease, disorder or injury
- Accommodation for persons who require nursing or personal care.

The location had managers registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

We have inspected the services provided at St Magnus Hospital and Rosemary Park Nursing Home five times since 2011. At the time of the last inspection in November 2017, St Magnus Hospital was rated as Outstanding, there were no requirement notices.

This inspection was unannounced.

# Summary of this inspection

## Our inspection team

The team that inspected St Magnus Hospital comprised of two inspection managers, four inspectors, two registered mental health nurses and one expert by experience (a person that has experience of mental health services as a patient or carer).

The team that inspected Rosemary Park Nursing Home comprised of three CQC inspectors and specialist elderly care nurse and an expert by experience.

## Why we carried out this inspection

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

## How we carried out this inspection

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

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

Before the inspection visit, we reviewed information that we held about the location, asked a range of other organisations for information and sought feedback from Mental Health Act Reviewers inspections that had been completed in the preceding year.

During the inspection of Rosemary Park Nursing Home the inspection team:

- visited all three units at the nursing home, looked at the quality of the environment and observed how staff were caring for people;
- spoke with seven people who were using the service and one relative;
- spoke with the registered manager, the deputy manager and 10 staff members;
- spoke with the visiting GP;
- attended and observed an art and music therapy session;
- Looked at 10 care plans:

- carried out a specific check of the medication management; and
- looked at a range of policies, procedures and other documents relating to the running of the service

During the inspection of St Magnus, the inspection team:

- visited all seven wards at the hospital, we looked at the quality of the environments and observed how staff were caring for patients;
- spoke with 10 patients who were using the service;
- spoke with the registered manager and managers or acting managers for each of the wards;
- spoke with 29 other staff members; including doctors, nurses, occupational therapist, speech and language therapist, Medical Director and social worker;
- received feedback about the service from 4 commissioners;
- spoke with an independent advocate;
- attended and observed two hand-over meetings and two multi-disciplinary meetings;
- Looked at 39 care and treatment records of patients:
- carried out a specific check of the medication management on all wards;
- looked at a range of policies, procedures and other documents relating to the running of the service

# Summary of this inspection

## What people who use the service say

We spoke with 17 patients and four relatives across the whole of St Magnus Hospital and Rosemary Park Nursing Home.

Patients that were able to communicate with us told us they knew their named nurse, key worker, care staff and the hospital managers. All said they had been involved in planning their care and were supported by staff to understand their care plans and were offered copies of their care plans. Patients described having their rights under the Mental Health Act explained to them regularly.

The carers expressed unreserved satisfaction and spoke highly of all staff and services provided. Comments included, "I am so grateful to everyone, St Magnus is brilliant and fantastic", "I would unreservedly recommend the hospital to others", "It's absolutely gorgeous. Extremely good" and "Having had experience of other hospitals I have been astonished at the standards at St Magnus."

# Detailed findings from this inspection

## Mental Health Act responsibilities

- Mental Health Act paperwork was examined by appropriate qualified and experienced staff upon admission in accordance with the Code of Practice.
- Staff told us that they would contact the Mental Health administrator on site if they needed any specific guidance.
- Leave forms were in place where required. Those we examined were signed and in date. The training for this core service was 85% staff compliance with Mental Health Act Training. Staff received training every 3 years as part of their mandatory training. Staff generally understood the MHA and their responsibilities under the act.
- Staff completed appropriate Mental Health Act paperwork upon admission. We saw evidence of this in case records.
- Consent to treatment forms were completed upon admission for every patient. We reviewed 15 sets of care records and patients had these in place.
- Consent to treatment forms and current medication forms were kept together so staff could check patients' consent for medicines.
- Staff read patients their Section 132 rights on admission and routinely thereafter.
- The Hospital provided administrative support and legal advice on implementation of the MHA and code of practice when required. The onsite Mental Health Act administrative support was effective and well organised, so all files were identically ordered, and information was easily accessible for medical and nursing staff.
- Detention paperwork was filled out correctly, was up to date and stored appropriately.
- The hospital carried out regular audits to ensure that the Mental Health Act was applied correctly.
- Staff reported that patients had access to Independent Mental Health Advocacy (IMHA) services. We saw evidence in case records of this taking place. There were posters on all wards providing information about this service. Managers reported regular advocacy visits to the ward and during the inspection we were able to interview a visiting advocate who was positive about the support the hospital had given them to ensure that patients access to advocacy was well maintained.
- There was information available on the notice boards on the wards regarding the relevant sections of the Mental Health Act (MHA) that applied to the particular patient group and how to complain to the CQC in relation to their detention and treatment.
- There was also information relating to what should happen if a patient were to be discharged from the MHA whilst they stayed at the hospital in relation to their rights to leave the ward. This was information was available on a notice board next to the door, so patients could see it if they wanted to leave the ward.

## Mental Capacity Act and Deprivation of Liberty Safeguards

- Overall, 96 % of staff had completed Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DOLS) training. The hospital defined this as mandatory training.
- The service had made 4 Deprivation of Liberty Safeguards applications for this core service within the last 12 months. When we discussed the process for applying for and receiving standard authorisations for a deprivation of liberty we could see that there was a backlog from the local authority. The hospital had recorded their attempts to arrange the Deprivation of Liberty Safeguards applications and documented that they had regularly discussed the applications and the what this means to the patients.

# Detailed findings from this inspection






- The organisation ensured that they were trying to help patients to understand were their rights and entitlements under the Mental Capacity Act.
- Most staff had general understanding of the Mental Capacity Act and the five statutory principles.
- Staff discussed mental capacity in clinical reviews and recorded this throughout care and treatment records. Staff were aware when mental capacity assessments had taken place and where to locate them.

## Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Forensic inpatient or secure wards	Good	Good	Good	Good	Good	Good
Wards for older people with mental health problems	Good	Outstanding 	Outstanding 	Good	Good	Outstanding 
Overall	Good	Outstanding 	Outstanding 	Good	Good	Outstanding 

# Forensic inpatient or secure wards

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

## Are forensic inpatient or secure wards safe?

Good 

### Safe staffing

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

We were told that the hospital service manager worked out the staff numbers based on patient need. The ward managers could adjust the staffing levels according to any additional patient needs. For example, when patients required higher levels of nursing observation or for leave outside the hospital additional staff were brought in for this.

Staff worked day and night shifts, shifts were from 8am to 8pm and 8pm to 8am. We reviewed three months of rotas for all the forensic secure wards at the hospital. Wards had enough staff with the right skills on duty. All shifts had the agreed number of registered nurses on duty.

However, we saw that some staff were working long hours and did not have regular days off. For example, in October 2019 eight staff worked 300 or more hours and in November 2019 five staff worked 300 or more hours. We discussed this with a senior manager who explained they currently had staff going through the induction process that would mean this would no longer happen.

At the time of our visit we were told there were no vacancies on Sycamore or Willow wards and one vacancy for a registered nurse and a support worker on Oak Ward.

The service had low usage rates of bank and agency nurses.

The service had low usage rates for bank and agency support workers.

Managers made sure all bank and agency staff had a full induction and understood the service before starting their shift.

In the 12 months between August 2018 and July 2019 38% of staff had left the service. We discussed this with ward managers at the time of the inspection and they told us staff had left for promotions, to attend university and to return to their home country.

Levels of sickness were low. The sickness rate for the forensic services was 2.6% between August 2018 and July 2019.

The ward manager could adjust staffing levels according to the needs of the patients.

Patients had regular one to one sessions with their named nurse.

Patients rarely had their escorted leave or activities cancelled, even when the service was short staffed.

The service had enough staff on each shift to carry out any physical interventions safely.

Staff shared key information to keep patients safe when handing over their care to others. However, there was no handover period built into the hospitals shift pattern. We discussed this with the ward managers and they told us that staff came in before the official shift start time or stayed after the official shift end time to make sure handover took place. We were told staff would be paid for this additional time.



# Forensic inpatient or secure wards

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

Staff had completed and kept up-to-date with their mandatory training. The hospital reported mandatory hospital wide rather than at a core service level. Of the 16 courses identified as being mandatory only two were below 80% completion rates, Relational security 78% and physical security 70%. However, we were told that this was because the hospital had just increased the number of staff who needed to complete this training and extra sessions have been planned to address this.

The mandatory training programme was comprehensive and met the needs of patients and staff.

Managers monitored mandatory training and alerted staff when they needed to update their training. Managers and staff told us that there was sufficient access to mandatory training. Managers encouraged staff to book on to training and would also remind staff via email and during supervision.

## Assessing and managing risk to patients and staff

Staff assessed and managed risks to patients and themselves well. They achieved the right balance between maintaining safety and providing the least restrictive environment possible to support patients' recovery. Staff had the skills to develop and implement good positive behaviour support plans and followed best practice in anticipating, de-escalating and managing challenging behaviour. As a result, they used restraint and seclusion only after attempts at de-escalation had failed.

Staff completed risk assessments for each patient on admission using a recognised tool, and reviewed this regularly, including after any incident. We reviewed 24 sets of care notes across the hospital and saw that all patients had an up to date risk assessment in place. Staff used a recognised risk assessment tool. For example, staff always completed the risk assessment that was embedded in the electronic record system. Where appropriate staff would complete specialised risk assessments such as the Historical Clinical Risk Management-20 for the assessment and management of violence.

Staff knew about any risks to each patient and acted to prevent or reduce risks. Staff we spoke to could tell us about individual patients risks and how they worked with the patient to reduce the risk.

Staff identified and responded to any changes in risks to, or posed by, patients. We reviewed records and saw that staff had up dated risk assessments and care plans after any change to a patients' risk.

Staff followed procedures to minimise risks where they could not easily observe patients.

The hospital had policies and procedures for staff to follow when they needed to search patients or their bedrooms to keep them safe from harm.

Levels of restrictive interventions were low. In the six months between February 2019 and July 2019 there had been four restraints across all three wards. The provider was actively working to reduce the number of physical interventions used. For example, they had changed the physical intervention training they provided.

Staff made every attempt to avoid using restraint by using de-escalation techniques and restrained patients only when these failed and when necessary to keep the patient or others safe. We saw staff using distraction and engagement techniques with patients to help reduce the need for physical interventions.

At the time of the inspection the hospital had started to work with staff around restrictive practices not related to physical interventions.

## Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Staff received training on how to recognise and report abuse, appropriate for their role. All staff we spoke to could explain what they would report as a safeguarding issue and the process for reporting it.

Staff were kept up-to-date with their safeguarding training. The hospital did not provide training details at a core service level. At the time of the inspection 98% of staff were up to date with their safeguarding training.

# Forensic inpatient or secure wards

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

Staff knew how to recognise adults and children at risk of or suffering harm and worked with other agencies to protect them. The hospital had a safeguarding lead and all the staff we spoke to knew who they were.

Staff followed clear procedures to keep children visiting the ward safe. Once it is agreed a child can visit a patient, visits take place in the family room and all wards are advised a child is in the hospital.

## Staff access to essential information

Most staff had easy access to clinical information and it was easy for them to maintain high quality clinical records – whether paper-based or electronic.

We reviewed 24 sets of patient notes and saw they were comprehensive. However, not all staff had access to the electronic patient record. Junior support workers did not have access to the electronic record and could only view them if a member of staff with access login for them. There was a paper record that all staff could access. This included risk assessments and care plans, staff made sure they were up-to-date and complete.

When patients transferred to a new ward, there were no delays in staff accessing their records.

Records were stored securely. The service used a secure electronic computer system. Staff kept paper records in locked offices.

## Medicines management

The service used systems and processes to safely prescribe, administer, record and store medicines. Staff regularly reviewed the effects of medications on each patient's mental and physical health.

Staff followed systems and processes when safely prescribing, administering, recording and storing medicines.

Staff reviewed patients' medicines regularly and provided specific advice to patients about their medicines.

Staff stored and managed medicines and prescribing documents in line with the provider's policy. Mental Health Act paper work needed to legally administer medicines was kept with patients' prescription cards and we saw staff check them before giving medication to patients.

Staff followed current national practice to check patients had the correct medicines.

The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely. The provider had an agreement with a national pharmacy to provide services to the hospital, this included weekly audits of the medicines and training.

Decision making processes were in place to ensure people's behaviour was not controlled by excessive and inappropriate use of medicines. Patients receiving high doses of antipsychotic medication were identified and the medication was reviewed regularly. Patients had care plans in place to help reduce the use of "as required" medication.

Staff reviewed the effects of each patient's medication on their physical health according to National Institute for Health and Care Excellence guidance.

## Track record on safety

The service had a good track record on safety.

Between January 2019 and August 2019, the provider reported three serious incidents relating to unexpected deaths. However, they were all regraded as deaths by natural causes.

Reporting incidents and learning from when things go wrong

The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

Staff knew what incidents to report and how to report them. The service used an electronic incident recording system. Not all staff had access to the system. However, all staff we spoke to knew what to report and told us they would report incidents to someone who could access the system.

# Forensic inpatient or secure wards

Staff raised concerns and reported incidents and near misses in line with the provider's policy.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong. Staff could give us examples of when they would apologise to a patient.

Managers debriefed and supported staff after any serious incident. All staff were offered debriefs following an incident, at team meetings and in supervision sessions.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations. Ward managers would investigate minor incidents, more serious incidents were investigated by the service manager.

Staff received feedback from investigation of incidents, both internal and external to the service. Learning from incidents was shared via incident form feedback, at handovers, in team meetings and a lessons learnt poster was circulated to the wards.

Staff met to discuss the feedback and look at improvements to patient care.

There was evidence that changes had been made as a result of feedback. For example, the staff were reminded to lock away laundry tablets after a patient attempted to swallow one.

## Are forensic inpatient or secure wards effective?

(for example, treatment is effective)

Good 

### Assessment of needs and planning of care

We reviewed 24 sets of case records and saw that staff assessed the physical and mental health of all patients on admission. They developed individual care plans which were reviewed regularly through multidisciplinary discussions and updated as needed. Care plans reflected patients' assessed needs, and were personalised, holistic and recovery-oriented. They included specific safety and security arrangements and a positive behavioural support plan.

Staff completed a comprehensive mental health assessment of each patient either on admission or soon after.

All patients had their physical health assessed soon after admission and regularly reviewed during their time on the ward. A local GP visited weekly and the hospital employed registered adult nurses as well as mental health nurses.

Staff developed a comprehensive care plan for each patient that met their mental and physical health needs.

Staff regularly reviewed and updated care plans when patients' needs changed. All care plans we reviewed were up to date and had been reviewed in line with the providers policy. When a care plan was changed this was reported in the ward handover and we saw this in the handover records we reviewed. A ward manager told us they only replaced the care plans in the paper file if a change was made to the care plan, rather than at every review. We reviewed the paper files and saw that they were the most up to date care plans.

Care plans were personalised, holistic and recovery-orientated.

### Best practice in treatment and care

Staff provided a range of treatment and care for patients based on national guidance and best practice. They ensured that patients had good access to physical healthcare and supported them to live healthier lives. Staff used recognised rating scales to assess and record severity and outcomes. They also participated in clinical audit, benchmarking and quality improvement initiatives.

Staff provided a range of care and treatment suitable for the patients in the service. The service employed occupational therapists, drama therapists, music therapists, activities co-ordinators and a fitness instructor. They ran groups and led one to one sessions on the wards and in the communal therapeutic areas. We observed two group sessions on the ward and a one to one session and saw that staff engaged well with patients.

Staff delivered care in line with best practice and national guidance. For example, "My Shared Pathway" which is a collaborative approach to supporting and developing care which keeps the patient's perspective the focus of the care.

Staff identified patients' physical health needs and recorded them in their care plans.

# Forensic inpatient or secure wards

Staff made sure patients had access to physical health care, including specialists as required. The service supported patients to attend health appointments and provided one to one support for patients admitted to an acute hospital.

Staff met patients' dietary needs and assessed those needing specialist care for nutrition and hydration. The kitchen team were able to meet all the dietary needs of the patients, including softer meals when needed to avoid choking. This was done with the support of the hospital speech and language therapist. However, there was not a dietician employed at the hospital.

Staff helped patients live healthier lives by supporting them to take part in programmes or giving advice.

Staff used recognised rating scales to assess and record the severity of patients' conditions and care and treatment outcomes. The wards used the Health of the Nation Outcome (Elderly) scale, as this was considered the most appropriate for the patient group, to measure patients progress.

Staff took part in clinical audits, benchmarking and quality improvement initiatives. Managers used results from audits to make improvements. For example, the hospital was part of the Quality Network for Forensic Mental Health Services which was a quality improvement network for low and medium secure inpatient forensic mental health services, organised by the Royal College of Psychiatrists. The wards had an action plan for improvement relating to a recent peer review.

## Skilled staff to deliver care

The ward teams included or had access to the full range of specialists required to meet the needs of patients on the wards. Managers made sure they had staff with the range of skills needed to provide high quality care. They supported staff with appraisals, supervision and opportunities to update and further develop their skills. Managers provided an induction programme for new staff.

Managers ensured staff had the right skills, qualifications and experience to meet the needs of the patients in their care, including bank and agency staff.

Managers gave each new member of staff a full induction to the service. The staff induction programme took place over the first three months of their employment. All staff received an induction before working on the ward that include essential training such as safeguarding.

Managers supported staff through regular, constructive appraisals of their work. Staff had regular supervisions and appraisals. We saw that records were kept of supervisions and appraisals and staff told us that they felt well supported by their managers. At the time of the inspection the appraisal rates on the forensic wards was 94%. Only two staff had not received an appraisal and both were currently not at work.

Managers made sure staff attended regular team meetings or gave information from those they could not attend.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. The provider funded staff to complete associate nurse training and registered nurses training.

Managers made sure staff received any specialist training for their role. Staff we spoke to told us they were encouraged to attend specialist training courses. For example, courses in dementia.

Managers recognised poor performance, could identify the reasons and dealt with these. The ward managers we spoke to were not currently performance managing any staff. They were able to explain the process they would follow and where they could get support if needed.

## Multi-disciplinary and inter-agency team work

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

Staff held regular multidisciplinary meetings to discuss patients and improve their care. Multidisciplinary meetings were held weekly and each patient was discussed at least once a month.

Staff made sure they shared clear information about patients and any changes in their care, including during handover meetings. We reviewed handover records and saw that key information including changes to patients care plans was included in the handover. However, the hospital did not use a clear structure for handovers.

Ward teams had effective working relationships with other teams in the organisation.

## Adherence to the MHA and the MHA Code of Practice

# Forensic inpatient or secure wards

Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice and discharged these well. Managers made sure that staff could explain patients' rights to them.

Staff received, and kept up-to-date, with training on the Mental Health Act and the Mental Health Act Code of Practice and could describe the Code of Practice guiding principles. At the time of our inspection 89% of staff were up to date with the providers Mental Health Act training.

Staff had access to support and advice on implementing the Mental Health Act and its Code of Practice.

Staff knew who their Mental Health Act administrators were and when to ask them for support.

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

Patients had easy access to information about independent mental health advocacy and patients who lacked capacity were automatically referred to the service. Mental Health Act advocates were invited to multidisciplinary meetings when needed.

Staff explained to each patient their rights under the Mental Health Act in a way that they could understand, repeated as necessary and recorded it clearly in the patient's notes each time. We saw that staff explained patients their rights monthly.

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

Staff requested an opinion from a Second Opinion Appointed Doctor (SOAD) when they needed to.

Staff stored copies of patients' detention papers and associated records correctly and staff could access them when needed.

Managers and staff made sure the service applied the Mental Health Act correctly by completing audits and discussing the findings.

## Good practice in applying the MCA

Staff supported patients to make decisions on their care for themselves. They understood the hospitals policy on the Mental Capacity Act 2005 and assessed and recorded capacity clearly for patients who might have impaired mental capacity.

Staff received, and were consistently up-to-date, with training in the Mental Capacity Act and had a good understanding of at least the five principles. At the time of our inspection 97% of staff were up to date with the providers Mental Capacity Act training.

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

Staff knew where to get accurate advice on the Mental Capacity Act and deprivation of liberty safeguards.

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

We saw excellent capacity decision other than treatment with the involvement of Independent Mental Capacity Act (IMCA) and family especially related to future wishes at end of life.

Staff assessed and recorded capacity to consent clearly each time a patient needed to make an important decision. We saw examples in patients records where capacity had been considered. The hospital took a multidisciplinary team approach and clearly recorded any decisions and the reasons why they felt a patient did or did not have capacity to make a decision.

When staff assessed patients as not having capacity, they made decisions in the best interest of patients and considered the patient's wishes, feelings, culture and history.

The service monitored how well it followed the Mental Capacity Act and made changes to practice when necessary.

Staff audited how they applied the Mental Capacity Act and identified and acted when they needed to make changes to improve.

**Are forensic inpatient or secure wards caring?**

# Forensic inpatient or secure wards

Good 

## Kindness, privacy, dignity, respect, compassion and support

Staff treated patients with compassion and kindness. They respected patients' privacy and dignity. They understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition.

Staff were discreet, respectful, and responsive when caring for patients. All interactions we saw between staff and patients were caring and respectful.

Staff gave patients help, emotional support and advice when they needed it. Patients told us that they could speak to staff for advice and that staff were available when needed.

Staff supported patients to understand and manage their own care treatment or condition.

Staff directed patients to other services and supported them to access those services if they needed help. Staff supported patients to access any other services they need. For example, the staff supported patients admitted to other hospitals.

Patients said staff treated them well and behaved kindly. Patients we spoke to told us that staff treated them with respect.

Staff understood and respected the individual needs of each patient. Staff were able to explain patients' needs. For example, they understood patient dynamics and made sure patients were not left with others they did not get on with.

Staff felt that they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards patients. All staff we spoke to told us they could raise concerns with the ward managers. Staff also told us they could raise concerns with senior managers if they felt an issue had not been dealt with.

Staff followed policy to keep patient information confidential.

## Involvement in care

Staff involved patients in care planning and risk assessment and actively sought their feedback on the quality of care provided. They ensured that patients had easy access to independent advocates.

Staff introduced patients to the ward and the services as part of their admission. There was a folder in the patients' bedroom that explain how the ward worked. For example, meal and laundry times and how to raise a concern with the staff team.

Staff involved patients and gave them access to their care planning and risk assessments. We reviewed 24 sets of care records and saw that staff had involved patients in planning their care. Patients were given an up to date copy of their care plans to keep in their room.

Staff made sure patients understood their care and treatment and found ways to communicate with patients who had communication difficulties.

Staff involved patients in decisions about the service, when appropriate. There was a patients' community meeting for patients to put forward their ideas about the service. All the wards had a representative at the community meeting. In addition to the community meetings there were six weekly hospitality meeting where patients could discuss catering and housekeeping services.

Patients could give feedback on the service and their treatment and staff supported them to do this.

Staff made sure patients could access advocacy services.

Staff supported, informed and involved families or carers. Staff would involve families and carers in the patients care when appropriate and with the patient's permission. Staff would attempt to make contact with families when the patient did not have family members involved in their care, unless they were told not to. The hospital had a carers group to offer support to families and carers.

Staff helped families to give feedback on the service.

# Forensic inpatient or secure wards

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

Good 

## Access and discharge

Staff planned and managed discharge well. They liaised well with services that would provide aftercare and were assertive in managing care pathways for patients who were making the transition to another inpatient service.

Managers regularly reviewed length of stay for patients to ensure they did not stay longer than they needed to. At the time of the inspection the average length of stay for patients in the low secure service was 758 days. The length of stay was affected because the patient group were complex and finding placements for them could be difficult.

Managers and staff worked to make sure they did not discharge patients before they were ready.

When patients went on leave there was always a bed available when they returned. The service did not fill the beds of patients on leave.

Patients were moved between wards only when there were clear clinical reasons or it was in the best interest of the patient.

Staff did not move or discharge patients at night or very early in the morning. All moves and discharges were planned and took place at an appropriate time of the day.

Managers monitored the number of delayed discharges. At the time of the inspection we were told there were six delayed discharges. Patient discharges were sometimes delayed because when patients were discharged commissioning arrangements changed from NHS England to a Care Commissioning Group (CCG). This meant that it was a new cost to the CCG.

Staff carefully planned patients' discharge and worked with care managers and coordinators to make sure this went well.

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

The design, layout, and furnishings of the ward supported patients' treatment, privacy and dignity. Each patient had their own bedroom with an en-suite bathroom and could keep their personal belongings safe. There were quiet areas for privacy. The food was of good quality and patients could make hot drinks and snacks at any time.

Each patient had their own bedroom, which they could personalise. We saw that patients could have their own belongings including photos and stereos in their bedrooms.

Patients had a secure place to store personal possessions. Each patient had a lockable cupboard in their bedroom.

The service had a full range of rooms and equipment to support treatment and care. Staff and patients could access the rooms. The wards had dining rooms and lounges available to patients and there were therapy rooms on the ground floor.

The service had quiet areas and a room where patients could meet with visitors in private. Patients could access quite areas on Oak ward and there were visitors' rooms on the ground floor.

Patients could make phone calls in private.

The service had an outside space that patients could access easily. The garden was on the ground floor and staff supported patients to access it. Staff told us they would encourage patients to access the garden.

Patients could make their own hot drinks and snacks and were not dependent on staff. The ward staff also had set drinks time when they would encourage all patients to have a drink.

The service offered a variety of excellent quality food. Patients told us the food was good.

## Patients' engagement with the wider community

Staff supported patients with activities outside the service including family relationships.

Staff made sure patients had access to opportunities to visit the local community. The hospital ran a bus that took patient to a local supermarket, so they could access the community.

Staff helped patients to stay in contact with families and carers. Staff also supported patients to regain contact with family members when it was appropriate.

# Forensic inpatient or secure wards

Staff encouraged patients to develop and maintain relationships both in the service and the wider community.

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

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

The service could support and make adjustments for disabled people and those with communication needs or other specific needs. The hospital had a lift to access the wards and accessible bathrooms on each ward.

Staff made sure patients could access information on treatment, local service, their rights and how to complain.

The service had information leaflets available in languages spoken by the patients and local community. The service could get information in different languages and an easy read format when needed.

Managers made sure staff and patients could get help from interpreters or signers when needed.

The service provided a variety of food to meet the dietary and cultural needs of individual patients.

Patients had access to spiritual, religious and cultural support. The service could access religious leaders when needed to support their patients. There was a multi-faith room available at the hospital and patients could be provided with religious equipment available to meet patients' spiritual needs.

## Listening to and learning from concerns and complaints

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team and wider service.

Patients knew how to complain or raise concerns. Staff gave patients information on how to complain when they were admitted. Patients told us they would speak to staff if they had a concern.

The service clearly displayed information about how to raise a concern in patient areas.

Staff understood the policy on complaints and knew how to handle them. Staff we spoke to told us what they would do if a patient complained to them.

Managers investigated complaints and identified themes.

The forensic wards received three complaints between November 2018 and August 2019. Two of these were upheld and one was not upheld. None were referred to the Ombudsman.

Staff protected patients who raised concerns or complaints from discrimination and harassment.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint.

Managers shared feedback from complaints with staff and learning was used to improve the service. Learning from complaints was shared in team meeting, handovers and via email.

The service used compliments to learn, celebrate success and improve the quality of care. This service received three compliments between November 2018 to August 2019.

## Are forensic inpatient or secure wards well-led?

Good 

### Leadership

Leaders had the integrity, skills and abilities to run the service. They understood the issues, priorities and challenges the service faced and managed them. They were visible in the service and supported staff to develop their skills and take on more senior roles.

We interviewed the two ward managers and saw that they had the skills and experience needed for their role. The ward managers were not included in the core nursing hours, so they had time to complete administrative tasks and they all told us that they felt supported. The ward managers covered shifts when the ward did not have enough registered nurses.

### Vision and strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action. Managers made sure staff understood and knew how to apply them.



# Forensic inpatient or secure wards

Staff knew and understood the provider's vision and values. The ward staff understood how their work contributed towards meeting the providers vision and values as the senior leadership team had communicated this to the frontline staff.

## Culture

Staff felt respected, supported and valued. They felt the service promoted equality and diversity and provided opportunities for career development. They could raise concerns without fear.

All staff we spoke to told us that senior managers were approachable. We saw that staff knew who senior managers were and were not surprised to see them on ward areas.

Staff told us they knew how to raise concerns and felt that they would be listened to and action would be taken if they did.

Staff told us there were opportunities for career development available to them through the provider, this included help to complete registered nurse and associate nurse training and for registered nurses to retrain in a different branch of nursing.

All staff we spoke to told us the hospital was a happy place to work.

## Governance

Leaders ensured there were structures, processes and systems of accountability for the performance of the service. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

The senior leadership team met once a week and shared the information from this meeting with the ward managers at a weekly ward manager meeting. The ward managers shared the information from this meeting with the ward team in handovers, team meetings and emails. However, we attended a meeting and reviewed meeting records and saw there was no set agenda or recording format used.

Staff undertook or participated in local clinical audits and acted on the results.

The hospital had a quarterly contract meeting with NHS England and reported on key performance indicators (KPIs) which included serious incidents, delayed discharges, completion of risk assessments and average length of stay.

## Management of risk, issues and performance

Leaders managed performance using systems to identify, understand, monitor, and reduce or eliminate risks. They ensured risks were dealt with at the appropriate level. Clinical staff contributed to decision-making on service changes to help avoid financial pressures compromising the quality of care.

The ward managers knew how to escalate issues so that they senior managers were aware of their concerns. The senior leadership team would decide if an issue needed to be placed on the hospital risk register.

The leadership team acted to address issues when they were identified.

## Information management

The service collected reliable information and analysed it to understand performance and to enable staff to make decisions and improvements. The information systems were integrated and secure.

The hospital used both electronic and paper records. Staff understood the systems and knew which was the main record. Staff kept patient records securely. However, not all staff had access to the electronic record and incident system.

## Engagement

The service engaged well with patients and staff, to plan and manage appropriate services.

The provider made sure that staff and patients had access to up to date information about their services. Patients and staff were given opportunities to give feedback on the service, the hospital managers had access to this feedback and could use it when planning service development.

The senior leadership team made themselves available to patients, staff and carers to hear feedback.

## Learning, continuous improvement and innovation






All staff were committed to continually improving services.

The hospital was part of the Quality Network for Forensic Mental Health Services, a quality improvement network for

## Forensic inpatient or secure wards

low and medium secure inpatient forensic mental health services, organised by the Royal College of Psychiatrists. The wards had received a peer review and were rated in the top 10 secure services in the country.

# Wards for older people with mental health problems

Safe	Good 
Effective	Outstanding 
Caring	Outstanding 
Responsive	Good 
Well-led	Good 

## Are wards for older people with mental health problems safe?

Good 

### In the older person wards at St Magnus:

#### Safe and clean environment

The layout of the ward enabled staff to observe most parts of the ward. Nursing stations gave good views of the wards. Blind spots had been identified and staff completed 15 minute checks of these areas to monitor patient safety. Communal areas were open plan and provided good observation points. There were convex mirrors used in all areas where full easy sight was not possible. Closed circuit television cameras (CCTV) were in use in communal areas of the wards, and recorded footage from these was reviewed when necessary as part of the incident review process. There were checks in place for staff to provide patient observations and this was well documented.

Ward Managers, with support from the security lead completed ligature audits to identify ligature points throughout the wards and gardens. This was done biannually using a tool developed by the hospital and specific to each ward. Ligature points had been identified in all ward areas and gardens across the service. A ligature is a place to which patients' intent on self-harm could tie something to harm themselves. Managers mitigated risk by robust risk assessments and nursing observations. In addition, daily walk-around checks and a weekly environmental checks on each ward ensured a regular

systematic approach to maintaining a safe environment. Issues such as the internal ensuite doors that had been picked up as missing in the last inspection had been rectified and the ligature tool was full and thorough.

The service was commissioned to provide care and treatment for men only, so was fully compliant with the Department of Health guidance on same sex accommodation.

Wards had accessible resuscitation equipment and emergency drugs. We saw evidence of regular checks of equipment, fridges and drugs taking place. Emergency medication was not held on each ward but was centrally available and all staff were aware of its location. The wards did not have clinic rooms and the medicine was managed from the large nursing offices. The areas in the office for the management of medicines were clean and well stocked with hand washing facilities available. Stock items were in date and facilities were available for safe disposal of sharps and waste. Medicines checks were carried by an external pharmacy provider who came in to the service and looked at prescribing and administration of medicines. They then provided detailed information to the governance team to ensure that any issues were identified and addressed.

There were no seclusion rooms within this core service. Wards used a low stimulus room or separate rooms where patients could spend time in a quieter environment.

All wards were clean, tidy, with appropriate furnishings. The wards were free from unpleasant odours and very well maintained with age specific paintings and murals on the walls to interest the patients. Carers and patients confirmed that the wards were clean and complimented the environment of the wards. The wards had cleaning



# Wards for older people with mental health problems

schedules and regular audits for cleanliness were undertaken by the housekeeping department. This meant that the ward environment was clean and infection control was well managed.

Staff adhered to infection control principles including hand washing. There were handwashing facilities across all wards and good hand hygiene by staff was observed.

Equipment across wards was well maintained. Clean and appropriate checks had taken place and were in date. We saw stickers on equipment that noted the dates last cleaned. Equipment to support the prevention of, and care of patients with pressure ulcers and a range of continence aids was available. Staff confirmed that specialist equipment can be obtained when required without delay by liaising with the General Manager.

Environmental risk assessments were completed as required and there was evidence of review and updating these across the service.

There was a robust system in place in the reception area to the main hospital using photo identification to ensure that staff and visitor identity was checked, and correct door access fobs given when people came in and out of the secure area airlock. In Park House and Goodwood wards staff entered through an air lock area however it felt homelier and less formal than the main hospital building but retained safe access to the wards.

Alarms were tested on a daily basis by the reception staff as part of their duties. In the previous inspection there was no record of alarms being tested by the reception staff, this had now been resolved and there was a document recording this had been completed.

We saw staff respond quickly when patients and staff used their alarm to call for support. Remote bed sensors were available when required for additional monitoring of patients who were at risk of falls.

## Safe staffing

The hospital used a system based on the National Quality Board for reviewing Nursing Hours Per Patient Day (NHpPD) This calculates nursing hours per patient per day. The hospital general manager reported to the clinical services meeting and senior management team about ward staffing levels across the hospital.

The information provided to us by St Magnus indicated that across the three four locked rehab wards there was one healthcare worker vacancy and one nurse vacancy. We reviewed the staff rotas on all wards and saw this to be the case. The Parkhouse and Goodwood wards were slightly over recruited to enable them to offer additional staff to cover the other forensic and locked rehab wards to minimise the use of adhoc agency staffing. This staffing resource covered annual leave training and sickness to maintain a consistent staff team across the whole service.

The overall leavers' rate for the service was 27% in the last 12 months up to July 2019, which was equivalent to 20 staff. When this was discussed with the General Manager this was related to staff uncertainty relating to Britain leaving the European economic union. The service had already identified the deficit and had recently carried out recruitment drives in Europe and Africa.

Sickness across the service was at 1% and was well managed with support of the HR administration staff.

There were set staffing levels on each ward. Managers reported that they were able to adjust staffing numbers as required to take account of case mix and additional observations. Managers considered skill mix of staff alongside the numbers of staff on duty. Patients confirmed there were adequate staff on shift to meet their needs.

To cover gaps in the rotas permanent staff were offered additional hours, bank and agency staff were used to ensure safe staffing. Between 1st May 2019 and 31st May 2019, 34 shifts were filled by bank or agency. In addition to the core numbers on the wards, the ward managers were supernumerary and were able to work as part of the team when necessary to ensure there were suitable numbers of trained staff.

Qualified nurses were visible on the wards and able to spend time with patients on the wards. We saw evidence in care records of 1:1 sessions taking place. The qualified nurse ratio could be increased if there was a clinical need, such as on ward round days.

Staff were available to carry out physical interventions. We saw that routine physical health observations including, weight and blood pressure monitoring was taking place. Patients confirmed that their physical health needs were met. We saw evidence in care records of doctors seeing patient upon admission and reviewing patients' physical health.



# Wards for older people with mental health problems

During office hours there was adequate cover for medical staff to attend the ward in an emergency. Out of normal office hours the consultants and senior managers operated an on-call rota, which was clearly visible on all the wards.

The hospital reported mandatory training hospital wide rather than at a core service level. This included safeguarding training for adults and children, information governance, physical intervention training, infection control, manual handling, health and safety, basic food hygiene, equality and diversity, first aid and use of the defibrillator, Mental Capacity Act and Deprivation of Liberty, dementia and mental health disorder training and training in relational security. Of the courses identified as being mandatory only two were below 80% completion rates, Relational security 78% and physical security 70%. However, we were told that this was because the hospital had just increased the number of staff who needed to complete this training and extra sessions have been planned to address this.

Training was managed with the support of the education department in the hospital. The education team consisted of qualified teachers and assessors able to offer face to face training not only in all mandatory training but also in specific training relevant to individual and service need. For example, nurses were supported to complete mental health focussed degree level training, staff were supported to become dual trained mental health and general. The education team had also developed a Nursing Associate program with the local university to enable experienced support workers to gain additional qualifications in nursing with a view to them becoming qualified nurses.

## Assessing and managing risk to patients and staff

There were no seclusions reported and the service had no seclusion rooms.

There were 11 incidents of restraint on three different patients in between 1st February 2019 and 31st July 2019. Petworth ward accounted for 9 of these incidents. There were no prone (face down restraints. Staff were trained in Non-Abusive Psychological and Physical Intervention (NAPPI) and used low level interventions when restraint was required.

We reviewed 15 care records. which were held electronically on a system called Care Notes. We saw clear evidence that all patients were risk assessed on admission

and had up to date risk assessments which were linked to their care plans. These were detailed assessments covering all aspects of mental and physical health needs and reflecting changes in risk behaviours.

Recognised risk assessment tools were used to assess risk including; nutritional screening, falls, and pressure areas screening. In addition to this where relevant, service used the detailed Historical Clinical Risk Management tool (HCR-20) which was updated regularly at ward meetings and CPA meetings. This meant that by looking at the past history of risk and patients' current behaviour, risk was being regularly reviewed and care plans were put in place with the patient to minimise the risk happening again.

There were blanket restrictions in place, but these were mostly clinically appropriate for the secure services environment. These were kept under review by the clinical governance team and the hospital had already started additional training to the ward staff on recognising and understanding the impact of restrictive practices and blanket restrictions. The hospital had a working group for restrictive practice reduction led by the Clinical Director and were currently developing a strategy for Restrictive Practice reduction. The Clinical Director was the nominated Director responsible for monitoring and reporting on the use of restrictive practices and for the creation and implementation of a reduction strategy.

There were policies and procedures for the use of observation and searching patients. Due to blind spots, ward areas were checked at regular intervals to maintain patient safety. Staff reported that patients would not be searched unless risk assessment indicated a need. Patients were nursed on enhanced observations appropriately.

Medicine cards showed that use of rapid tranquilisation was low across all wards and staff were using verbal de-escalation skills to ensure that patients' distress was managed before it required additional medicine.

The ward had a comprehensive process for the management of restricted items. These were items which may affect the safety on the ward, for example, razors and illicit substances. There was an information pack available for patients when they were first admitted onto the wards and this clearly detailed which items were restricted. In addition to this, all visitors to the service were asked to



# Wards for older people with mental health problems

read and sign a document which clearly identified all items not able to be brought onto the wards, to raise awareness of restricted items. This process was managed by the staff allocated to the 24-hour reception airlock area.

The hospital had a room in the reception area that could be used to support safely children visiting patients and there was a visible policy and procedure in place to ensure that staff knew how to manage this process. All visits with children were carefully arranged by the social work team and the whole unit hospital were aware if a visit was happening to ensure all visitors remained safe.

## Safeguarding

Overall 98.4% of staff had received safeguarding training.

Staff could describe the safeguarding process, and immediate safeguards they could put in place to protect patients. Staff were aware of specific risk factors for older adults and of current safeguarding plans in place at the time of inspection. Staff were clear about their safeguarding responsibilities and knew how to identify and make a safeguarding referral within office hours and during the evening and weekend. The hospital had a senior social worker who was the designated safeguarding lead and Staff knew how to seek support from them if they needed it.

## Staff access to essential information

The hospital used an electronic system for managing patient records. However, not all staff had access to the electronic patient record. Junior support workers did not have access to the electronic record and could only view them if a member of staff with access login for them. This system was backed up by the wards printing off the most recent care plans and keeping them in a file in the office to ensure that all staff were able to read and review.

## Medicines management

We reviewed 9 prescription charts across three wards and saw good management of medicines.

Medicine was prescribed within recommended guidance and documentation was present and in date.

We found a small number of missed medicine doses. These records were then unable to show that patients were receiving their medicines when they needed them. Medicine errors were not always reported using the incident reporting system, there was not incident reporting

of patients having missed administration doses. These included medicines which were considered to be critical to the patient. When we highlighted this issue to the ward managers they immediately completed incident report using the electronic system.

The wards were supported by regular pharmacy audits which meant that incidents were recorded and analysed, with actions set, so that staff could minimise the risk of reoccurrence. However, this would not pick up immediate administration errors as described above.

## Track record on safety

There was one serious incidents reported for the older person mental health wards in the past 12 months, this was recorded as a death by natural causes. The ward managers were aware of recent incidents that had happened elsewhere in the hospital that had affected patient care and had fed this back through the staff team meetings. This ensured that all staff were aware of issues that were affecting other inpatient sites in the hospital.

## Reporting incidents and learning from when things go wrong

Staff we spoke with knew how to report incidents using the electronic reporting system.

We saw evidence of staff discussion with patients and family members appropriately following incidents or concerns.

Staff confirmed that they received feedback following serious concerns and were able to describe incidents from other wards. All staff told us they were aware of recent examples and changes to practice following incidents of safeguarding and incidents of falls. Staff attended monthly staff meetings where incidents were discussed, and learning was shared.

Staff confirmed that de-briefs and support was provided following incidents. Nursing staff attended regular group supervision where reflective practice was facilitated.

Managers told us that incidents were discussed at their weekly meetings and lessons learnt were shared across the service and changes in practice implemented where appropriate. All staff we spoke with could give examples of recent safeguarding and falls that had occurred within the service.



# Wards for older people with mental health problems

## In the older person wards at Rosemary Park Nursing Home:

Staff were aware of their responsibility to protect people from harm and abuse. Thorough internal investigations had taken place where required. As a result of this, people told us they felt safe living at Rosemary Park. One person said, "I feel safe as I am being looked after very well."

Risks to people were appropriately recorded and managed. Staff were aware of triggers that could upset people and de-escalation techniques to prevent this. People were encouraged to take positive risks in order to encourage their freedom and autonomy. For example, we observed some people wearing padded caps and hip protectors. A nurse told us, "They're at risk of falls but we also don't want to stop their freedom from walking around the building. With the protectors on, we are safely giving them freedom to do this while lowering the risk."

There were sufficient staffing levels to meet the needs of people at the service. We observed staff were busy but not rushed, and people told us call bells were answered quickly when pressed.

Medicine recording, administration and storage practices were safe. Medicines were securely stored and 'as and when required' medicine (PRN) was only used after all de-escalation techniques had been tried without success. Staff ensured people took all of their prescribed medicines and medicine administration records (MARs) confirmed this as there were no gaps.

People were cared for by staff who adhered to safe infection control practices to prevent the spread of infection. We observed staff wearing aprons when serving food and personal protective equipment (PPE) was available for staff to wear when delivering personal care. The registered manager told us, "Staff remember to wear PPE and they get pulled if they don't."

Accidents and incidents were recorded and action taken to prevent reoccurrence. For example, the fire alarm had been triggered during works taking place at the service. The registered manager had asked the work area operatives to limit the amount of dust during the works to prevent reoccurrence.

Although medicine fridge and room temperatures were recorded daily, staff had not documented what action had been taken when the temperature had exceeded the

maximum recommended level. Impact to people was low as staff members were able to explain what actions they would take. We raised this with the registered manager who confirmed they would ensure staff recorded actions taken in future.

Incontinence pads were being stored outside of their packaging in a cupboard. This left them exposed to potential contamination and dirt. We advised the registered manager of this who confirmed they would ensure pads were stored within their packaging in future.

## Are wards for older people with mental health problems effective?

(for example, treatment is effective)

Outstanding



## In the older person wards at St Magnus:

### Assessment of needs and planning of care

We reviewed 15 care records. Staff completed comprehensive assessments for all patients' following admission.

Care records showed that physical health examinations upon admission were completed by a speciality doctor and there was ongoing monitoring of physical health. Care plans were in place for specific physical health needs and were reviewed and updated regularly. Some wards had separate physical health folders for on-going monitoring of patient's health to ensure that physical healthcare appointments were recorded and future appointments were met. Patients confirmed that their physical health needs were met. The hospital had a weekly visit from a local GP who had worked within the service for many years and was familiar with all the patient's individual physical healthcare requirements. The GP was extremely happy with the level of support he received from the clinical team at the hospital and felt that any interventions he prescribed were followed up effectively by the nursing and medical team.

Care records contained up to date information. Care plans were holistic and were recovery focused. All care plans were personalised, and it was clear from the content of the document that patients and their carers had been involved in developing the plan.



# Wards for older people with mental health problems

Staff used an “all about me” document which was kept in the patient bedrooms for patients who had cognitive difficulties to help inform staff of patients’ likes and dislikes. This document was detailed and informative and gave all staff an opportunity to engage with patients in areas of interest. We saw psychology staff reviewing these documents in depth with support workers in Goodwood ward and had devised a quiz scheme which fostered an interest in learning as much as possible about the patient’s personal interests.

## Best practice in treatment and care

Staff followed National Institute for Health and Care Excellence guidance when prescribing medication across the service. Antipsychotic medication was prescribed within the British National Formulary limits and monitoring was in place. Medication audits were regularly carried out by an external pharmacist provider. Reports were regularly sent to the clinical governance team and individual ward managers.

There were individual and group psychological therapies available to assess and provide treatment and there was a dedicated psychologist in post to ensure all diagnostic formulation work was happening. Therapy was in place across the wards and staff confirmed there was an appropriate resource level allocated. Occupational therapist used a range of recognised assessment tools including to assess and shape individual patients care. The occupational health team were able to support patients with vocational and recreational activities and we saw all wards had an up to date timetable of activities available to the patients. Patients reported that they received the therapies and activities they need and were making progress.

There was good access to physical healthcare and patients were referred and attended specialist appointments. We saw evidence of speech and language therapy and dietitian input where required. Speech and language therapy was part of the therapeutic services department and Dieticians could be arranged on a referral basis. Staff confirmed that specialist input such as ophthalmology and tissue viability/wound care was available following referral. The Speech and language team had SALT assessments and there was clear guidance to staff about what level of intervention patients required to assist them with their diet and

swallowing needs. Staff tried lots of options with patients with dementia taking into consideration flavours and textures to support patients to try different options which encouraged them to take on food and fluids.

Staff completed assessments of nutrition and hydration and care plans were in place for specific patients.

Staff completed Health of the Nation Outcome Scales to assess and record severity and outcomes for patients.

Staff reported participating in clinical based audits on most aspects of care and treatment including; care plans and care records, security audits, deep cleaning audits, infection control audits, antipsychotic drug prescribing, process for covert administration of medicine, equipment, and nutritional assessments.

Positive behaviour support (PBS) plans have been implemented and were bedding in across the wards. Positive behaviour support plans are a way of shaping the care to the individual patient based on a range of strategies which not only focus on the challenging behaviour(s) but also include ways to ensure the person has access to things that are important to them and helps them find new ways to cope. A Psychologist specialising in dementia was taking the lead in this work Alongside the clinical team as well as family/carers to develop PBS plans for patients whose behaviours provided the most significant challenge.

The hospital had implemented ‘About me’ as an initiative involving detailed work from members of the MDT with knowledge and input from family/carers. Details about each patient were captured on a proforma A3 sheet. These aimed to bring the whole individual person with dementia (past and present) to life. The A3 sheet was laminated for display in the patient’s bedroom. These overlapped with PBS planning’ and included “Five things to know about me”, these are the five most important items for a member of staff to know about each person. This was used in clinical supervision from more senior staff and to encourage its use, quizzes were up and running to support meaningful learning for those providing day to day care.

Work on ‘dementia boxes’ which contained personal and meaningful items to each patient, were in development. This is to assist in engagement, maintaining interest, and supporting staff in caring for patients using objects/representations known to be of special significance to the





# Wards for older people with mental health problems

patient in the past. This was particularly useful with patients who were hard to engage because of the severity of their dementia and associated neuropsychiatric symptoms.

## Skilled staff to deliver care

Patients received care and treatment from a range of professionals including nurses, doctors, Speech and Language Therapists, physiotherapists, and a large occupational therapy team across the service. If required patients were referred to Dietitians. Pharmacy was also available and worked closely with the wards.

An induction program was in place for all permanent staff. We reviewed this induction process and could see that staff were provided with the necessary training from the point of starting to ensure they were safe to work with the patient group. This was in place to ensure that patients' safety was the priority while staff were booked into the more formal annual training plan. Managers ensured that bank and agency staff received induction to the wards. The hospital supported health care assistants to complete the care certificate standards and senior healthcare workers were offered the opportunity to complete their Nurse Associate training funded by the hospital.

Supervision for care staff was made up of individual 1:1 supervision with a line manager and a regular group supervision as part of the team meeting standard agenda.

In the 12 months prior to the inspection, 94% of the care staff in the older persons mental health wards had received their regular six weekly supervision and 100% of care staff had received their annual appraisal.

Managers addressed poor staff performance promptly. Managers told us of additional supervision, support and monitoring of staff where required. In the last 12 months here had been one staff suspension across the core service, this was fully investigated by the police and reported to the CQC.

We saw evidence that regular staff meetings were taking place across the service. Staff confirmed that they attended team meetings and other informal discussions and handovers.

Staff reported receiving the necessary training for their role and described the training as appropriate and useful.

## Multi-disciplinary and inter-agency team work

The multi-disciplinary team held twice weekly ward rounds where patients care and treatment were discussed. In the event that a patient's risk level had increased there was also the opportunity to hold an impromptu ward round where risk issues could be fully reviewed. The ward rounds gave every discipline the opportunity to feed back via a detailed report structure that had been developed within the hospital. This structure covered all aspects of care and concluded with a report of the patients progress and future plans.

Staff described good links with other agencies, for example, community teams to support patients during discharge. This process has been historically difficult but case managers from the South East New Care Model teams are involved in supporting this process.

NHS England commissioners reported witnessing a high level of compassion and understanding when they have attended the hospital and report that the clinical teams take a great deal of time and effort to ensure that the patients are involved in the process as fully as possible. Particularly for the patients with cognitive impairment.

Managers attended referrals meetings to discuss patients' movements through the service and patients who needed admission or discharge from the service.

Staff described supportive working relationships across the multidisciplinary team. Staff spoke very positively of the input from the occupational therapy and physiotherapy. Strong working relationship between nursing and medical staff was described.

Handovers were taking place twice a day across the service. Staff described these handovers as detailed and informative.

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## Adherence to the MHA and the MHA Code of Practice

Mental Health Act paperwork was examined by appropriate qualified and experienced staff upon admission in accordance with the Code of Practice.



# Wards for older people with mental health problems

Staff told us that they would contact the Mental Health administrator on site if they needed any specific guidance.

Leave forms were in place where required. Those we examined were signed and in date. The training for this core service was 85% staff compliance with Mental Health Act Training. Staff received training every 3 years as part of their mandatory training. Staff generally understood the MHA and their responsibilities under the act.

Staff completed appropriate Mental Health Act paperwork upon admission. We saw evidence of this in case records.

Consent to treatment forms were completed upon admission for every patient. We reviewed 15 sets of care records and patients had these in place.

Consent to treatment forms and current medication forms were kept together so staff could check patients' consent for medicines.

Patients were read their Section 132 rights on admission and routinely thereafter.

The Hospital provided administrative support and legal advice on implementation of the MHA and code of practice when required. The onsite Mental Health Act administrative support was effective and well organised, so all files were identically ordered, and information was easily accessible for medical and nursing staff.

Detention paperwork was filled out correctly, was up to date and stored appropriately.

The hospital carried out regular audits to ensure that the MHA was applied correctly.

Staff reported that patients had access to Independent Mental Health Advocacy (IMHA) services. We saw evidence in case records of this taking place. There were posters on all wards providing information about this service. Managers reported regular advocacy visits to the ward and during the inspection we were able to interview a visiting advocate who was positive about the support the hospital had given them to ensure that patients access to advocacy was well maintained.

There was information available on the notice boards on the wards regarding the relevant sections of the Mental Health Act (MHA) that applied to the particular patient group and how to complain to the CQC in relation to their detention and treatment.

There was also information relating to what should happen if a patient were to be discharged from the MHA whilst they stayed at the hospital in relation to their rights to leave the ward. This was information was available on a notice board next to the door, so patients could see it if they wanted to leave the ward.

## Good practice in applying the MCA

Overall, 96% of staff had completed Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DOLS) training. The hospital defined this as mandatory training.

The service had made 4 Deprivation of Liberty Safeguards applications for this core service within the last 12 months. When we discussed the process for applying for and receiving standard authorisations for a deprivation of liberty we could see that there was a backlog from the local authority. The hospital had recorded their attempts to arrange the Deprivation of Liberty Safeguards applications and documented that they had regularly discussed the applications and the what this means to the patients.

Most staff had general understanding of the Mental Capacity Act and the five statutory principle.

Staff discussed mental capacity in clinical reviews and recorded this throughout care and treatment records. Staff were aware when mental capacity assessments had taken place and where to locate them.

## In the older person wards at Rosemary Park Nursing Home:

The service used national standards and guidance when assessing people's needs. This included using the Waterlow scale which put up reminders for staff flu jabs and warmer winter guidance. The Medicines and Healthcare products Regulatory Agency (MHRA) send medicine guidance through, and the service received CQC newsletters.

Staff were up to date with mandatory training, as well as completing additional training relevant to their roles such as catheterisation. Nursing staff were

People's nutritional and hydration needs were appropriately managed. Fluid charts were completed for people who were at risk of dehydration, and those who required assistance with eating were provided with support during mealtimes. People's nutritional preferences were recorded in their care plans so staff were aware of these.



# Wards for older people with mental health problems

Daily handover meetings ensured staff were up to date with people's needs and what was going on within the service.

Staff completed referrals to healthcare professionals when appropriate. People were also supported to attend regular appointments with their GP, dentist and optician.

Despite being an old building, the environment had been adapted to meet people's needs. Doors between units had keypads to encourage people to stay in the units that had been assessed as best meeting their needs. People had key fobs to their own rooms. The registered manager told us, "We find it prevents a lot of conflict as well as being good in the privacy aspect."

## Ensuring consent to care and treatment in line with law and guidance

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the Mental Capacity Act. In care homes, and some hospitals, this is usually through Mental Capacity Act application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the Mental Capacity Act, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

Staff followed the principles of the Mental Capacity Act. Decision-specific capacity assessments had been completed for people for decisions such as the use of covert medicines and regular observations. These had been followed by best interest decisions, which had included those who were an integral part of people's care, such as their GP and next of kin. Appropriate Deprivation of Liberty Safeguards applications had been made which noted the restrictions in place for individual people.

The environment could be further improved for those with a cognitive impairment. For example, people's bedroom

doors were not always personalised and therefore could make it hard to identify. We raised this with the registered manager who said they would look in to ways to improve this.

## Are wards for older people with mental health problems caring?

Outstanding



### In the older person wards at St Magnus:

#### Kindness, privacy, dignity, respect, compassion and support

All staff across the service were observed to be exceptionally and consistently caring and respectful to all patients. We saw staff helped patients mobilise safely around the wards in a very supportive way, ensuring patients were caringly encouraged and guided. Staff were extremely warm in their interactions, spoke kindly to patients and consistently offered guidance and reassurance when patients became agitated or confused. We observed a distressed patient return from a meeting and became agitated toward the staff, the staff team were able to engage and de-escalate the patient safely with no physical management and enabled them to engage in a game of chess and calmly discuss their concerns about the meeting.

Staff used thoughtful, appropriate and considerate language and adapted their style of communication to the patients' level of understanding. Staff reassured patients and offered them support when needed. Interactions showed in depth knowledge of the patients' needs. We observed staff communicate effectively with individuals with communication issues and always offer kind reassurance in a respectful manner. We saw patients respond positively to staff.

We saw staff always responded quickly to patient requests for additional support such as personal care. Staff went the extra mile to ensure patients' needs were met. All staff were fully aware and showed an excellent understanding of patients' individual care and treatment plans and their preferences for receiving care from staff. The staff approach to care was truly person centred. Staff consistently used their in-depth knowledge of the patients to engage with them whilst recognising personal choice. We observed staff



# Wards for older people with mental health problems

encouraging patients with dementia to eat as they walked around the ward outside of meal times to ensure their dietary intake was maintained. On Park House we observed staff supporting patients and relatives to eat together in a visitor's room at lunch time. The carer reported that their relative had been cared for in numerous services previously, and that because of the staff at St Magnus hospital, this was by far the best environment for meeting their relatives' care needs.

Patients told us that they felt staff were always caring and treated them with respect, dignity and care. They reported that staff always made time to talk and spend time with them even if they were busy.

Carers reported that they felt patients were safe, cared for and well looked after by staff. Staff attitude was described as caring and motivated. They reported that staff ensured that the patients' needs were always met.

Staff could give examples of the type of person-centred support that individual patients needed and how they met their needs. Staff were passionate about their work and it was clear they genuinely cared about the emotional wellbeing of their patients and wanted them to feel cared for.

Mood music was played on the wards, more energetic music was played during times of activity and more relaxing music was played at meal times. Patients had their own music play lists that they used for calming purposes when agitated.

## **Involvement in care**

Wards had welcome packs and patients were orientated to the ward. Carers and patients confirmed this. Overall, patients felt supported upon admission and said that processes and procedures were explained as were their rights under the Mental Health Act.

Patients and carers were encouraged and supported to be involved in all aspects of their care. Carers were invited into ward round and to more formal reviews of care and treatment. Carers confirmed contact with nurses and doctors to discuss their relative's treatment and progress. Carers were encouraged to assist with creating memory boxes and 'this is me' documents on the wards for people patients with dementia.

A patient satisfaction survey was carried in March 2019 as part of the Quality Network Peer review process. Feedback

from the survey was that it was difficult for the patients to respond to the answers due to issues around cognitive impairment. 49% of the patients responded to the survey. Most patients surveyed reported that staff treated them with dignity and respect and were caring towards them. Of concern to the hospital were 7 out of 16 patients felt they were not involved in their care planning and 8 out of 16 patients felt it had not been explained why they had come to the hospital. The hospital had already addressed these issues as part of the quality review process and put things in place to address the issues.

The hospital had many examples of how patients and carers are involved in the running of the service such as;

Quarterly meetings were held with carers in a St Magnus and Rosemary Park Family support group, in the meeting Carers wanted access to Wi-Fi and radios when visiting loved ones. Service placed music systems in all visitor lounges and Guest Wi-Fi advertised and made accessible to visiting carers.

Hotel services held six weekly meetings with patients/residents in hotel services meetings. The Therapies Department chaired the meetings and catering, housekeeping, laundry and maintenance were represented. In one meeting the patients expressed that meals served were not hot enough- new food warmers were purchased, and the issue was resolved.

A patient representative was invited to attend the quarterly Clinical Governance meeting, for the 'Hospitality & Environment' section of the meeting, presented by the Director of Therapies. The patient had the opportunity to comment on the Director of Therapies report and to ask the committee any questions. The Medical Director had a separate interview with the patient representative after the meeting to check if he had anything to say away from the pressure of the meeting and to check that the patient didn't find the meeting attendance too stressful.

## **In the older person wards at Rosemary Park Nursing Home:**

People and relatives told us staff were kind and compassionate towards them. One person said, "Staff are considerate, they share our interests." Another person told us, "I'm extremely happy here. Staff are lovely." A relative



# Wards for older people with mental health problems

told us, "The most important is the quality of carers, they work very well as a team. They don't care only for my husband but for me, by informing me about things. They are there for me. They are very caring people."

The registered manager felt they had a kind and hard-working team. They told us, "The proof of the pudding is when there's a crisis. Like when there was a load of snow. Our backs were up against the wall. Staff couldn't get in or out. We just worked through it and organised breaks. When you have a situation like that, the staff are magnificent."

We observed staff comforting people when they were upset, and also sharing humour with people which in turn encouraged people to consent to care being provided to them.

People and their relatives were involved in decisions around their care. A relative told us, "I am very much involved. If his needs happened to change, I will be informed and I will make a relevant decision." Documents evidenced that people had been involved in reviews of their care where appropriate.

Staff treated people with dignity and respect. A staff member was quick to respond when a person became too hot and started removing clothing to make them more comfortable. They opened the window next to them, put their t-shirt back on them and fanned them until they had cooled down.

People were encouraged to be independent where safe to do so. This included helping them to eat independently and completing parts of their personal care they were able to do without assistance.

**Are wards for older people with mental health problems responsive to people's needs?**

(for example, to feedback?)

Good



## In the older person wards at St Magnus:

### Access and discharge

Between February 2019 and July 2019, the average bed occupancy rate across the wards for older people was 98%. The average length of stay of patients that had been

discharged in the 12 months prior to the inspection was in this service was 828 days. This high number reflects the difficulties in discharging the patients from the Hospital into suitable accommodation due to individual clinical presentations and the lack of suitable accommodation for the patient group.

Patients were not moved between wards during an admission for non-clinical reasons. When patients were moved, this occurred at an appropriate time of day. Staff told us that if a patient required intensive psychiatric nursing care, a bed could be located on a local NHS psychiatric intensive care unit ward.

We reviewed 15 care records and saw all had discharge care plans in place.

Staff described good links with other agencies, for example, community teams to support patients during discharge. Managers reported effective working relationships with teams outside of the organisation, for example, local authority social services.

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

A full range of rooms and equipment to support treatment and care were available across the service, with a variety of activity rooms and quiet lounges in the wards.

There were designated patient phones in the wards and the phones were situated in a private room for patients to use. In addition, Patients could be risk assessed to make private phone calls using their personal mobile phones.

Patients had access to outdoor space when they wished on all the wards. Due to the nature of the clients a blanket restriction had been put in place which indicated that most wards had garden doors closed and patients could access the garden when they wished but with staff support. Ward managers kept this under review based on the patients presentations on the ward. Garden doors were locked during the night. As well as the individual ward gardens the patients were also able to access a secure wildlife woodland garden, which meant that patients that may have been on more restrictive sections of the Mental Health Act were able to increase their independence and freedom to wander in a safe manner.

The hospital had an enclosed wildlife garden which could be accessed by all patients following a risk assessment. This area was landscaped and had nature trails and a large



# Wards for older people with mental health problems

variety of well kept lawns and trees. Because of the way the garden was designed, patients were able to wander freely in this area with minimal staff support. This was particularly important to patients that may have restrictions imposed on them by the Ministry Of Justice and unable to leave the hospital grounds. The wildlife garden had a summer house which could be used by patients to carry out activities, away from the wards, in a more relaxed and natural environment.

All of the patients were happy with the food cooked on site by the kitchen staff and all cultural and religious dietary requirements could be met. The patients were complimentary regarding the kitchen's ability to meet their individual food choices. In addition to serving kitchens the wards had access to skills kitchens where Occupational Therapy staff supported patients to cook as part of their recovery plans.

When the appropriate risk assessments have been carried out patients had access to an onsite gym

We saw up to date therapeutic timetables on each of the wards which detailed what activities and groups were available for patients across the week. However as per the previous inspection in 2018 we found an inconsistent response from the patients as to whether they had individual timetables. Some patients had individual timetables on the walls in their bedrooms, for three patients' staff were able to show us that some patients had individual timetables in their paper care plan files, but this was inconsistent.

The wards provided drinks and snacks throughout the day and night if needed. Patients also had their own snacks available and clearly labelled in the ward fridges.

The bedrooms we viewed had been personalised with individual paintings and pictures of patient's families. Some carers were supporting staff to personalise bedrooms on the wards for people with dementia. A risk assessment was completed to enable patients to have their own fob to enable them to go in and out of their room without staff assistance. Patients had lockable spaces on their bedrooms, so they could keep documentation safe if they chose, in addition each ward had secure lockable storage spaces on the wards for items that were not able to be brought on to the main ward.

The main living area on Park House ward had a large picture wall with over 100 pictures of historic events and

interesting pieces of artwork designed to stimulate the patients and prompt discussion, the patients commented on how they loved it and noticed a new thing every time they looked.

Activities over the weekend where nurse led sessions, as there was a reduced occupational therapy activity programme on the weekends. Patients told us they liked having some time to themselves at the weekends and did not feel they required additional activities to be planned for them. Patients reported an appropriate activity and therapy level across the week and confirmed that activities were not cancelled due to staffing issues.

## Patients' engagement with the wider community

Ward based activity schedules indicated that there were regular trips on to the community of patients leave arrangements enabled this.

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

There was access for wheelchairs and handrails to help those with restricted mobility and at risk of falling across the service. We observed staff provided additional support to those who required it to walk around the wards. All wards were suitable for older age adults.

Patients spoke positively about their regular contact with the chaplaincy service. The chaplain visited the service on a weekly basis or more frequently if required. The hospital had a multi-faith room with multiple religious texts available from reception. Contact details for representatives from different faiths were available. The chaplain facilitated this contact and the patients and staff all spoke highly of their input.

The service provided information leaflets on a variety of subjects including complaints, advocacy, and patients' rights, which were available in different languages.

The service catered for specific dietary requirements and we saw patients offered food and drinks outside of the main meal times. We observed a patients being supported to eat at meal times. Patients confirmed that they were happy with the choice, quality and quantity of food.

## Listening to and learning from concerns and complaints



# Wards for older people with mental health problems

The hospital reported that there were four complaints relating to this core service in the 12 months before this inspection. The wards received 27 compliments during the same period.

Staff and managers told us that they responded to any concerns raised immediately and often concerns were dealt with informally. Managers maintained contact with carers in order to address any concerns swiftly.

The majority of patients and family knew how to report complaints or raise concerns. Patients reported that they did not have a need to complain. However, they were confident that if they did they would be listened to and the matter dealt with. Families confirmed that there was little need to complain.

## In the older person wards at Rosemary Park Nursing Home:

People were able to take part in meaningful activities which provided them with a sense of achievement. One person told us, "I enjoy doing the art therapy as it means I can socialise with people. I won an art award last year for a painting called My Wheelchair which is hung up in the TV room. I won £20 for it and a certificate."

The staffing team conducted smaller activities which people visibly enjoyed. We observed a staff member playing skittles with a group of people. People were laughing and smiling and staff were really encouraging people to interact. This had helped create friendships between people which were clear on the day.

Staff were aware of people's communication needs and how to meet them. One person had limited verbal communication. However, when a staff member sang the line of a song the person would then finish the line themselves. The staff member said this was a way of encouraging the person to vocalise.

Staff knew people and their behaviours well. A staff member demonstrated they were aware that one person was displaying behaviour that was out of the ordinary for them on the day of our inspection, so sat with them to see if they were upset. The registered manager told us, "Staff know people well due to the length of time they've worked here. Their knowledge of the residents is in depth. They know their triggers, how to approach them in the right way. They know when to stand back."

Complaints were investigated and steps taken to achieve positive outcomes for those involved. A relative had complained about the presentation of the pureed diet provided. As a result of this, the registered manager and chef attended courses and researched presentation of pureed food to improve the experience for people who required this diet. The relative had been kept updated throughout this process.

The service had also received compliments which were recorded in a central file. One had been received from an agency worker who had written, "[People] are taken care of and showed love and care. They are eating good quality food in a clean and safe environment. The staff here are patient and well mannered. There is an atmosphere of coordination."

People were supported with end of life care where required. People's wishes around this time of their lives had been gathered prior to them reaching it, so staff were fully aware how they would want to be supported. The registered manager told us, "It's a part of our job I feel we do really well. We support the relatives too. We have a relatives' suite they can stay in whilst someone is in their last days."

## Are wards for older people with mental health problems well-led?

Good



## In the older person wards at St Magnus:

### Leadership

At the time of inspection, there were no reported cases of bullying and harassment. However, in the staff survey 30% of staff had identified issues relating to feelings of being bullied by the patients and residents due to the nature of their presentations.

Sickness across all the wards in this core service was low at 1%. Staff reported they felt that sickness was managed well, and they did not feel pressured to come to work if they felt ill.

Staff knew how to use the whistle-blowing process and felt able to raise concerns without fear of victimisation.



# Wards for older people with mental health problems

Staff consistently reported that managers were supportive and would listen and act on any concerns they raised.

The staff knew whom to contact if there was a particular issue with safeguarding, facilities or human resource issues. All of these roles were located on site, so staff were able to access freely.

The hospital general manager had a visible presence across the unit and the staff told us they felt that the hospital had a stable management structure. Staff felt that the management team were more of a family and nurtured and supported the staff to progress within their roles.

## Vision and strategy

Managers were aware of the services' visions and values however the majority of ward-based staff were unable to describe them in detail. Staff told us that the visions and values were incorporated into annual appraisals and were part of how they worked on the wards

There was a clear, flattened management structure consisting of ward managers and the general manager. Above that the staff were aware they could go the owner of the service who was also a visible presence at the Hospital. The staff continued to describe the staff team as "like a family" and felt nurtured in their roles and supported to develop when they and their line managers felt it was appropriate.

We found that staff were not fully aware of the developments within the location as a new ward was being designed within the Rosemary Park service. They were aware a new ward was being designed but did not know its remit or how it would work alongside the already existing services.

## Culture

Staff overwhelmingly reported high morale and were happy in their roles. We observed supportive and cohesive team working and the atmosphere appeared relaxed and encouraging. This was confirmed by staff.

Staff reported multiple opportunities for professional development and that training was appropriate to their needs. This was echoed by the large training department who had already arranged opportunities for mandatory and patient specific training in the next year. Staff reported

many opportunity to progress within the service. The culture of developing your own nurses was evident within several of the wards where support workers were being developed to undertake their nurse training.

## Governance

The education department kept a close review of all staff mandatory and statutory training and ensured that emails to individual staff members and their managers were sent when a staff member was required to attend training. This meant that all training for this core service were above 70%. The areas where they were lower were due to an influx of new starts still undertaking their induction training and this would be resolved within the next three months.

When we discussed Key Performance Information with each of the ward managers there was an inconsistent response. Some managers were aware that information regarding care plan audits was extracted from the care notes system. However, no managers were required to provide a weekly or monthly return on the staffing and sickness of their wards as this was collected by the HR department and fed back to the ward managers if required. All managers knew who staff members they were offering additional support to and the rationale, so this information was filtering to the managers effectively. This meant that managers were able to spend more time on clinical issues relating to the management of the ward.

We observed staff maximise shift-time on direct care activities as opposed to administrative tasks. Staff were engaged with patients and supporting them in daily activities. Patients and carers confirmed this.

The Senior Management Team (SMT) meets weekly and reviews all important matters for the safe and effective running of the hospital.

All board assurance reports, safety reports and policies were scrutinised by and authorised by the Senior Management Team. Membership of the Senior Management Team included the Registered Manager of the nursing home, the General Manager and Deputy General Manager who are the senior nurses for St Magnus. The General Manager also invited a ward manager from St Magnus to attend the meeting to enhance ward input into Team discussions and decision making. The Senior Social Worker, Director of Therapies, Medical Director (chair) and





# Wards for older people with mental health problems

Clinical Director were also members of the Senior Management Team ensuring the social workers, therapies and medical staff were involved in its decision making and assurance processes.

Managers attempted to staff shifts to the agreed safe level of nurses; they offered staff overtime and used bank staff to achieve this. At times, wards used agency staff to maintain safe staffing levels. Managers considered skill mix in additional to staffing numbers.

The managers reported sufficient authority to make decisions and adjust staffing levels when needed and felt supported by senior managers. Administration support was provided to the wards.

## Management of risk, issues and performance

Managers confirmed that they could submit items to the Hospital risk register and were able to give examples and describe the process involved.

Staff confirmed that they received feedback from incidents and complaints and that lessons learnt from other wards was shared with them at team meetings, via emails and within supervision and team days. All staff we spoke with could describe recent incidents on their wards and managers could describe lessons shared across the Hospital

## Information management

As discussed previously in the report the hospital used both electronic and paper records. Staff understood and could describe these systems and knew which the main record was. Staff kept patient records securely in the staff office. Not all staff had access to the electronic record and “Ulysses” the electronic incident reporting system.

## Engagement

The Hospital had developed a system for gathering patient and carer views when visits happened at the hospital. This involved a short question “flash” survey and a longer questionnaire used at the point when a patient was discharged from the service.

Staff had an annual survey, the results of which were shared with the staff team and senior management team through the clinical governance process.

## Learning, continuous improvement and innovation

The Hospital had implemented Positive behavioural support plans across the services. These were supporting the patients whose behaviour presented the most significant challenge and were being overseen by a psychologist specialising in dementia.

The hospital had implemented ‘About me’ as an initiative involving detailed work from members of the MDT with knowledge and input from family/carers. Details about each patient were captured on a proforma A3 sheet.

Work on ‘dementia boxes’ which contained personal and meaningful items to each patient, were in development.

## In the older person wards at Rosemary Park Nursing Home:

Staff felt supported by the registered manager and there was a positive culture within the service which focused around teamwork. One staff member said of the registered manager, “When I need her, she’s always there for me. She is really nice.” The registered manager told us, “We’re a cohesive team. It’s very inclusive despite us being a separate service. It’s what we’re all about. We’ll all help each other.”

Monthly audits identified any issues which were then resolved by the management team and staff. For an example, thorough care plan audits identified where dates were missing on assessments. This was highlighted to the person’s key worker to resolve. The care plan was then reviewed by the management team two weeks later to ensure the findings had been actioned by the key worker.

Feedback was sought from relatives and visitors. Relatives attended monthly meetings where they could raise concerns and also provide suggestions about the running of the service. Visitors were asked to complete a quality assurance form on their experience. The findings from this exercise had been consistently positive.

There were plans in place to decrease the size of the nursing home service to allow more space for an adjoining hospital within the building.

The service had strong working partnerships with outside agencies. This included community psychiatric nurses, and local churches.

# Outstanding practice and areas for improvement

## Outstanding practice

The hospital had implemented 'About me' as an initiative involving detailed work from members of the MDT with knowledge and input from family/carers. Details about each patient were captured on a proforma A3 sheet. These aimed to bring the whole individual person with dementia (past and present) to life. The A3 sheet was laminated for display in the patient's bedroom. These overlapped with PBS planning and included "Five things to know about me", these are the five most important items for a member of staff to know about each person. This was used in clinical supervision from more senior staff and to encourage its use, quizzes were up and running to support meaningful learning for those providing day to day care.

The hospital had an enclosed wildlife garden which could be accessed by all patients following a risk assessment. This area was landscaped and had nature trails and a large variety of well kept lawns and trees. Because of the way the garden was designed, patients were able to wander freely in this area with minimal staff support. This was particularly important to patients that may have restrictions imposed on them by the Ministry Of Justice and unable to leave the hospital grounds. The wildlife garden had a summer house which could be used by patients to carry out activities, away from the wards, in a more relaxed and natural environment.

## Areas for improvement

### Action the provider SHOULD take to improve

- The provider should ensure all staff have access to the electronic record keeping systems.
- The provider should ensure that staff do not work excessive hours and have enough days off.
- The provider should ensure that the ligature point assessment includes all ligature points.
- The provider should ensure all medicine errors are reported using the incident reporting system.

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.

This section is primarily information for the provider

## Enforcement actions

### Action we have told the provider to take

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