Cygnet NW Limited

Cygnet Bury Hudson

Inspection report

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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

Overall rating for this location	Inadequate
Are services safe?	Inadequate
Are services effective?	Good
Are services caring?	Inadequate
Are services responsive to people's needs?	Requires Improvement
Are services well-led?	Inadequate

Summary of findings

Overall summary

We rated the service as inadequate overall and decided to place it in special measures.

When an independent healthcare service is in special measures it is the provider's responsibility to improve it. We expect the provider to seek out appropriate support to improve the service from its own resources, and from other relevant organisations or oversight bodies or both.

We will inspect the service again within six months. If insufficient improvements have been made to justify a higher rating than inadequate overall or for any key question or core service, we will consider whether it is appropriate to extend special measures for a further six months, or whether to begin the process of preventing the provider from operating the service.

Special measures will give people who use the service the reassurance that the care they get should improve.

For more information about special measures for independent healthcare, see our *Guide to special measures: independent healthcare* on the CQC website.

We rated the service as inadequate overall because:

- Patients we spoke with said they were being bullied and abused by their peers and staff members and they did not feel safe on the wards. Staff were not always discreet, respectful or kind when caring for patients. Patients and one carer told us staff could be patronising, antagonistic, rude and made negative comments about patients. Safeguarding issues were not always recognised and managed effectively by staff and patients' needs were not always being put first. A security breach had led to a patient's index offence being disclosed to their peers and they had to be moved to another ward after receiving abuse.
- Staff did not always meet the communication needs of patients on the wards. A patient with a learning disability told us they were given information in a way they could not understand and information on noticeboards was in English and Welsh only.
- Staff did not always actively involve or inform families and carers about their loved ones progress.
- Staff turnover within the service was high. However, managers were taking steps to recruit more permanent staff and used bank and agency staff to cover staff shortages.
- Medicines were not always well managed, and we found medicines which were out of date. There was no poster in the clinic room on Upper West ward to inform staff who the first aiders were in the service.
- Staff did not always follow best practice in relation to the use of rapid tranquilisation. On Upper East ward, a doctor was aware that rapid tranquilisation medicine had been administered to a patient, but staff had not recorded this in the patient's care record.
- Staff had not informed a doctor that a patient had been placed in seclusion, so no medic review took place for this patient.
- The ward environments were not always comfortable for patients. A problem with the central heating system was causing the heating to come on even though it was warm which was making the temperature in the hospital uncomfortable for patients and staff.
- On East Hampton ward, patients' sleep was being disturbed by slamming doors and lights from a sensor shining into their bedroom.
- Staff found difficulty finding information we requested to see in care records which meant staff did not always have timely access to important information they needed to deliver appropriate care to patients.

Summary of findings

- Posters about advocacy were not specific in relation to the roles of Independent Mental Health advocates and Independent Mental Capacity advocates and not all of the staff we spoke with knew what the difference was between the two roles.
- Governance processes within the service did not always ensure that wards ran smoothly, and clinical audits were not always effective. We found issues in relation to safeguarding, complaint handling, responses to feedback, staff not being able to access patient information in a timely manner, medicines management, staff attitudes to patients and carers, blood monitoring machines not being calibrated, and communication needs not being met for a patient.

However:

- The ward environments were clean. The provider was taking steps to recruit more nursing staff to the service.
- Staff minimised the use of restrictive practices and used de-escalation techniques to minimise the use of restraint on the wards. Blanket restrictions were in accordance with identified risks on the wards and were reviewed regularly.
- Staff provided a range of treatments suitable to the needs of the patients and in line with national guidance about best practice.
- Staff planned and managed discharge well and liaised with services that would provide aftercare. As a result, discharge was rarely delayed for other than a clinical reason.
- 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 and with those outside the ward who would have a role in providing aftercare.
- Staff understood and discharged their roles and responsibilities under the Mental Health Act 1983.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Forensic inpatient or secure wards	Inadequate 	

Summary of findings

Contents

Summary of this inspection

Background to Cygnet Bury Hudson

Cygnet Bury Hudson hospital provides low and medium secure inpatient services for men and women:

There are six wards and 78 beds:

- Upper West Side ward –13 bed medium secure ward for females
- Lower East ward – 13 bed medium secure ward for males
- Madison ward – 13 bed medium secure ward for males with a personality disorder
- Columbus ward – 13 bed medium secure ward for males with a personality disorder
- Upper East ward – 13 bed low secure ward for males
- East Hampton ward – 13 bed low secure ward for males

The service has a registered manager. It has been registered with the Care Quality Commission since 30 April 2021 to carry out the following regulated activities:

- Diagnostic and screening procedures
- Assessment or medical treatment for persons detained under the Mental Health Act 1983
- Treatment of disease, disorder or injury

The hospital was last inspected in July 2020 when it was registered as Cygnet Hospital Bury. We identified regulatory breaches in relation to the running of the service, including the safeguarding of patients. The services at Bury are now registered under three separate locations which include Cygnet Bury Hudson.

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 service.

This was an unannounced comprehensive inspection which meant staff did not know we were coming.

Our inspection team comprised two CQC inspectors, a nurse and an occupational therapist working as specialist advisors to the CQC and an expert by experience with experience of forensic and secure services.

Summary of this inspection

During the inspection visit, the inspection team:

- spoke with the registered manager
- spoke with the clinical risk manager
- spoke with five ward managers
- spoke with 25 other staff members including nurses, healthcare assistants, occupational therapists, occupational therapist assistants, activities coordinators, a Mental Health Act administrator and a doctor
- spoke with 18 out the 67 patients who were using the service and four carers
- looked at 12 patients' care records
- looked at the ward environments, including the review of health and safety related documentation
- looked at the medicines management arrangements within the service
- observed a multidisciplinary team meeting
- observed how staff were interacting with patients and,
- looked at documents relating to the running of the service.

Areas for improvement

Action the provider MUST take to improve:

Regulation 13

- The provider must ensure that any complaints or concerns raised by patients, their families or carers, are logged, acknowledged, investigated, complainants are informed of the outcome in line with provider policy and lessons learned from investigating complaints are implemented and shared with staff within the service. The provider must ensure that patients have access to complaints forms on the wards at all times and that all carers are made aware of the complaints process.

Regulation 16

- The provider must ensure that systems and processes operate effectively to assess, monitor and improve the quality and safety of the services provided:

Regulation 17

- The provider must ensure that feedback from patients is recorded, looked into and responded to in a timely manner.

Regulation 17

- The provider must ensure there is an effective care records system in place to enable staff to access patient information in a timely manner.

Regulation 17

- The provider must ensure that audits are effective and appropriate action is taken in response to audit findings.

Regulation 17

Action the provider SHOULD take to improve:

Summary of this inspection

- The provider should continue with its recruitment of permanent staff to ensure there is sufficient cover at weekends, and reduce the cancellation of section 17 leave and patient activities on the wards.
- The provider should ensure that there are systems in place to ensure the communication needs for all patients within the service are met and information is provided in a way all patients currently on the wards can understand.
- The provider should ensure there is an effective process in place to enable patients to have regular access to the hospital's gymnasium without delays.
- The provider should ensure that posters about advocacy are specific in relation to the roles of independent mental health advocates and independent mental capacity advocates to allow patients and staff to request appropriate advocacy when needed.
- The provider should ensure that all staff know what the specific roles are in relation to independent mental health advocates and independent mental capacity advocates and have a good understanding of the duty of candour.
- The provider should ensure that all documentation in relation to the use of rapid tranquilisation medicines is up to date and correct.
- The provider should ensure that doctors' reviews always take place for patients placed in seclusion.
- The provider should ensure that there are posters in the clinic rooms on all the wards to inform staff who the first aiders are within the service.
- The provider should ensure that all equipment used in the delivery of care and treatment is calibrated.
- The provider should address the issues in relation to a sensor light shining into patients' bedrooms and the office door slamming on East Hampton ward so that patients' sleep is not disturbed.
- The provider should ensure that furnishings on all of the wards are in a good state of repair.
- The provider should ensure that the problem with the hospital's heating system is addressed so that the temperature is comfortable for both patients and staff.
- The provider should ensure that all medicines are in date and any expired medicines are appropriately disposed of.

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Forensic inpatient or secure wards	Inadequate	Good	Inadequate	Requires Improvement	Inadequate	Inadequate
Overall	Inadequate	Good	Inadequate	Requires Improvement	Inadequate	Inadequate

Inadequate

Forensic inpatient or secure wards

Safe	Inadequate
Effective	Good
Caring	Inadequate
Responsive	Requires Improvement
Well-led	Inadequate

Are Forensic inpatient or secure wards safe?

Inadequate

We rated safe as inadequate.

Safe and clean care environments
All wards were safe, clean well equipped, well furnished, well maintained and fit for purpose.

Safety of the ward layout
Staff completed and regularly updated risk assessments of all the ward areas and removed or reduced any risks they identified. Ligature audits were undertaken on an annual basis or when there had been an associated incident on the wards and other environmental risk assessments were completed each day.

Staff could observe patients in all parts of the wards. Blind spots were mitigated through the use of closed-circuit television on the wards.

The ward complied with guidance and there was no mixed sex accommodation.

Staff had easy access to alarms and patients had easy access to nurse call systems.

However, there was no poster in the clinic room on Upper West ward to inform staff who the first aiders were in the service.

Maintenance, cleanliness and infection control
Ward areas were clean, well maintained, fit for purpose and most were well-furnished.

Staff made sure cleaning records were up to date and the premises were clean.

Staff followed infection control policy, including handwashing. Staff wore masks and the wards were cleaned regularly to mitigate the risk of COVID-19 transmissions. We saw evidence that COVID-19 audits took place to ensure staff complied with national guidance around minimising the risk of infections.

Inadequate

Forensic inpatient or secure wards

Seclusion room

The seclusion rooms allowed clear observation and two-way communication. They had a toilet and a clock.

Clinic room and equipment

Clinic rooms were fully equipped, with accessible resuscitation equipment and emergency drugs that staff checked regularly.

Overall, staff checked, maintained, and cleaned equipment. However, blood monitor machines on Columbus and East Hampton wards had not been calibrated.

The service had enough nursing and medical staff, who knew the patients and received basic training to keep people safe from avoidable harm. Managers were taking steps to recruit additional staff to the service to ensure patients' needs were safely met.

Safe staffing

Nursing staff

Six staff members on East Hampton, Madison, Columbus and Upper East wards said staffing could be problematic. Three staff members said that staffing levels were a struggle at weekends on Columbus and Upper East wards and two staff members on Madison ward said there were staff shortages at least once a week and a staff member said there was not always enough staff on East Hampton ward. Ward managers had the authority to adjust staffing levels according to the needs of the patients and bring in bank and agency staff to fill any staff shortages.

The service had the following vacancy rates:

- 40.6 whole time equivalent healthcare assistants and,
- 1.4 whole time equivalent nurses

Managers were aware of staff shortages on the ward and were recruiting to these vacancies.

At the time of our inspection, 37 whole time equivalent healthcare assistants and six nurses were due to commence working for the service. An open day was planned for later in the month to assess and interview 60 candidates.

At the time of our inspection, the current staffing levels comprised:

- 114.4 whole time equivalent healthcare assistants
- 47.37 whole time equivalent nurses
- 26.7 whole time equivalent administrative staff
- 5.4 whole time equivalent catering staff
- 29.23 whole time equivalent multidisciplinary team staff and,
- 13 whole time equivalent estates and housekeeping staff.

1,882 shifts had been covered by agency staff and 1,042 shifts had been covered by bank staff in the previous 12 months. 56.25 shifts were not filled by bank and agency staff during this time.

In the previous 12 months, section 17 leave had been cancelled nine times and activities had been cancelled 45 times within the service.

Only two members of staff were awaiting updated Disclosure and Barring Service certificates. These two staff members had been risk assessed as being suitable to carry out regulated activity within the service.

Managers made sure all bank and agency staff had a full induction and understood the service before starting their shift. Managers had developed induction packs for agency and bank staff and a dedicated pack for international nurses.

The service had high staff turnover rates. The average turnover in the previous 12 months was 34.9%. The main reasons for staff leaving the service were pay and conditions, dismissal, ill-health and the role being unsuitable for the jobholder.

Managers supported staff who needed time off for ill health. Staff who spoke with us said managers wanted to make sure they were fully recovered before coming back to work and were not pressured into coming back to work too early.

The average staff sickness level within the service over the previous 12 months was eight per cent.

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

We saw evidence that staff shared key information to keep patients safe when handing over their care to others.

Medical staff

The service had enough day and night time medical cover and a doctor available to go to the ward quickly in an emergency. There were doctors onsite during the day who could quickly attend wards when needed and an out of hours service.

An acute hospital was nearby, and paramedics could attend the wards within five minutes in an emergency.

Mandatory training

Staff had completed most of their mandatory training. The overall compliance for mandatory training was 90% at the time of our inspection. Only one training element was below 75% compliance which was intermediate life support (69.3%) on the medium secure wards.

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

Mandatory training included:

- Safeguarding
- Equality and diversity
- Responding to emergencies
- Health and safety
- Information governance
- Infection control
- Medication management
- Clinical risk management
- Suicide and self-harm
- Observations and engagement
- Physical health
- Autism awareness
- Learning disabilities

- Personality disorder
- Mental Health Act awareness

Managers monitored mandatory training and alerted staff when they needed to update their training.

Assessing and managing risk to patients and staff

Staff assessed and managed risks to patients and themselves well. Most staff 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.

Assessment of patient risk

We looked at 12 patients' care records and saw evidence that staff completed risk assessments for each patient on arrival, and reviewed them regularly, including after any incident.

Staff used recognised risk assessment tools which included the Historical Clinical and Risk Management Tool 20 (HCR-20), the Short Term Assessment of Risk and Treatability tool (START), the Model of Human Occupation Screening Tool (MOHOST), Health of the Nation Outcome Score (HONOS) and daily risk assessments.

Management of patient risk

Staff knew about any risks to each patient and acted to prevent or reduce risks.

Staff identified and responded to any changes in risks to, or posed by, patients. We saw evidence in care records that risk management plans had been created to mitigate identified risks associated with patients.

Staff could observe patients in all areas off the wards and used closed circuit television to monitor the wards whilst in the nursing stations.

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

Use of restrictive interventions

There had been 415 incidences of restraint on the wards in the previous 12 months. The wards with the highest levels of restraint were Upper West (291), Upper East (55) and Columbus (37). Three restraints were in the prone position.

Staff made every attempt to avoid restraint by using de-escalation techniques and restrained patients only when these failed and when necessary to keep the patient or others safe. The most commonly used techniques were verbal de-escalation and re-direction.

There were blanket restrictions on the wards. These included:

- supervised access to the garden areas to wards being on higher floors, risks in relation to violence and aggression, to mitigate the risk of items being thrown over fences and to allow staff to monitor non-association with other wards.
- supervised or restricted access to the kitchen and laundry areas due to the offending histories, current risk profiles, patients presenting as high risk of violence & aggression towards others and high risk of significant self-harm

- supervised access to the internet due to a risk of patients accessing inappropriate websites and material that are related to their risk factors and a high risk of patients contacting actual or potential victims and ordering risk items.
- approval by the multidisciplinary team when patients requested access to certificate 18 media
- restricted access to mobile phones with a camera or internet access in communal areas or patients' bedrooms due to the risks of some patients taking photos of their peers, inappropriate use and security risks.

These restrictions were regularly reviewed and were next due to be reviewed in July 2022.

There were 16 incidences of rapid tranquilisation being used within the service on three of the wards; Columbus, Upper East and Upper West.

Staff did not always follow best practice when using rapid tranquilisation. For example, on Upper East ward, a doctor was aware that rapid tranquilisation medicine had been administered to a patient, but staff had not recorded this in the patient's care record. The ward manager raised an incident report when we brought this to their attention.

In the previous 12 months, there had been 71 episodes of seclusion within the service. The highest number of seclusions were Columbus (19), Upper East (19) and Upper West (17).

On East Hampton ward, staff had not informed the doctor that a patient had been placed in seclusion so no review by a medic was undertaken. We spoke with the ward manager who raised an incident report about the error.

Staff followed best practice, including guidance in the Mental Health Act Code of Practice, if a patient was placed in long-term segregation. Two patients were in long-term segregation due to their presentation and behaviours that challenged. We reviewed the documentation around them being in long-term segregation and there was evidence this was being reviewed regularly and there was clear rationale for them being nursed off the ward.

Safeguarding

Staff did not understand how to protect patients from abuse and did not always work with other agencies to do so, despite being trained on how to recognise and report abuse.

Staff within the service had made 123 safeguarding referrals to the local authority in the previous 12 months.

Staff received training on how to recognise and report abuse, appropriate for their role and were kept up to date with their safeguarding training. At the time of our inspection, the compliance rate for safeguarding training was 95%.

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

We spoke with 18 of the 67 patients who were using the service and four carers. Nine patients and one carer told us that they and their loved one had been or were being bullied by other patients and staff on the ward and they did not feel safe.

Details of the patients who raised concerns with us about being bullied were sent to the provider to look into.

The provider sent copies of two other patients' safeguarding plans who alleged they were being bullied by peers. Safeguarding plans for the patients evidenced that staff had recorded instances of verbal abuse by peers and had taken appropriate actions.

Inadequate

Forensic inpatient or secure wards

In our previous inspection in July 2020, patients on Madison ward told us they did not feel safe and this was still the case as patients told us they were being bullied by their peers on the ward. The ward manager on Madison ward said patients were not always being bullied and education around what constitutes bullying was to be rolled out to patients on the ward. This gave us concerns that allegations of abuse were not always being taken seriously, being investigated or addressed and that patients would feel discouraged to raise allegations of bullying moving forward.

When asked to give examples to demonstrate their understanding of safeguarding issues, two staff members on Columbus ward only gave examples of when the issues would affect staff such as having to call the police when a patient was attacking staff and could not be restrained and when a patient threatened staff with a knife. This gave us further concerns that staff were not putting patients' interests first.

Two patients told us they had been bullied and intimidated by a staff member on East Hampton ward. We told the ward manager the full details of the allegation, but they did not report the full extent of the alleged abuse to the registered manager which delayed the member of staff being suspended from duty. The provider took action in response to this which included:

- the incident being discussed in daily managers' meetings to raise awareness with other managers and to share lessons learnt from this incident
- the ward manager completing additional training and completing safeguarding supervision with the service's safeguarding lead
- the formulation of a handover document for ward managers to complete and submit by 4pm each day in preparation for the morning meeting detailing incidents and issues on the wards and,
- the introduction of daily online meetings across the wards to discuss issues, including safeguarding and incidents on the ward.

We asked the provider to send us details of how the current systems in place to protect patients and staff from abuse and harm were effective. Their response included:

- all staff receiving safeguarding training during induction and annual refresher training
- the safeguarding lead being in receipt of automated email notifications on submission of a safeguarding incident which were discussed daily by the senior management team
- there being regular meetings to discuss incidents and to draw actions in response to them
- there being monthly team briefs where all lessons learnt were shared and disseminated to all staff on the wards.
- the register manager attending drop in sessions and walks around the wards to enable them to have regular contact with staff and patients and a platform where concerns were raised and followed through.
- the advocate for the service having regular contact with the ward and registered manager and being able to discuss concerns raised by patients on a regular basis and follow up on any actions formulated.
- a folder containing "one-page-profiles" for each of the patients being available on each ward for all staff, including agency to read through
- managers and the multidisciplinary team being more aware of the need to consider if any new patient admissions would adversely affect the current patient intake on the ward
- there were ward improvement plans in place for Columbus and Upper East wards which were being reviewed every two weeks and monitored via the hospital action plan
- training in relation to safeguarding referrals was being delivered to improve the quality of external reports. The local authority had commented on a noted improvement since the training was delivered.

However, due to the nature and number of safeguarding concerns we found on the wards, these systems did not give us sufficient assurances that patients were always being safeguarded from abuse.

Staff followed clear procedures to keep children visiting the ward safe.

There had been no serious case reviews in the previous 12 months.

Staff access to essential information

Staff did not have easy access to clinical information. However, staff maintained high quality paper and electronic care records.

We looked at 12 patients' care records and found them to be comprehensive. However, when we asked to see certain pieces of information, staff struggled to locate it due to the combination of electronic and paper-based records. This meant we had to request information in relation to care planning and physical and mental health assessments after our inspection because staff were unable to find it for some care records while we were onsite. The registered manager told us that eventually, all paper-based information would be scanned to the electronic system, but that this was a lengthy process.

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

Records were stored securely. Paper records were in lockable cabinets and staff were required to enter a username and password to access electronic records.

Medicines management

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

Most of the time, staff followed systems and processes to prescribe and administer medicines safely.

We looked at eight prescription charts within the service and compared them against T2 forms. If there is a change in responsible clinician, a T2 form provides the authority to provide medicinal treatment and only ends if the patient's consent is withdrawn; the patient becomes mentally incapable of consenting to treatment or the treatment specified in the form changes.

Out of the eight patients' prescription charts we looked at, seven had T2 forms in place. However, on Columbus ward, we found a T2 form did not have one of the patient's medicines recorded. This was rectified when we raised it with the doctor on the ward.

We looked at the medicines management arrangements within the service and saw evidence that staff reviewed each patient's medicines regularly and provided advice to patients and carers about their medicines. Staff completed medicines records accurately and kept them up to date.

Staff did not always manage medicines appropriately. On Columbus ward, we found simple linctus, medicine for acid reflux, mouthwash, and lactulose that were past their expiry date.

Staff followed national practice to check patients had the correct medicines when they were admitted, or they moved between services.

Staff learned from safety alerts and incidents to improve practice.

We saw evidence in care records that staff reviewed the effects of each patient's medicines on their physical health according to the National Institute for Health and Care Excellence guidance.

Track record on safety

The service had a good track record on safety.

There had been seven serious incidents within the service in the previous 12 months.

These incidents were not related and included a breach of a patient's information; a patient's unauthorised absences from the hospital, a patient death, gross misconduct of a staff member, seclusion incident and concerns about a patient's health.

We saw evidence that lessons were learned, and improvements were made to the service in relation to these serious incidents.

Reporting incidents and learning from when things go wrong

The service did not always manage patient safety incidents well. Staff did not recognise incidents and did not always report them appropriately. Managers investigated incidents when they had been reported and shared lessons learned with the whole team and the wider service.

Staff gave examples of incidents reported within the service. However, when patients raised concerns about bullying, these were not always being reported in line with provider policy.

Staff reported serious incidents clearly and in line with the provider's policy.

The service had no never events on any wards.

Not all staff understood the duty of candour. Out of the 32 members of staff we spoke with, two on Columbus ward and one on Madison ward were unable to demonstrate their understanding of the duty of candour despite us giving them several prompts. The duty of candour is a legal requirement to be open and honest when things go wrong, to apologise to those affected and give a full explanation of the impact and to take steps to remedy the situation and offer support where needed.

Four duty of candour reports were submitted in the previous 12 months. These related to an injury sustained after a fall, two patients swallowing a battery and an information governance breach leading to abuse of a patient. Lessons learned included a falls review and changes in observations levels for a patient, risk items being removed from patients' bedrooms and improvements to security arrangements in relation to patient information.

Managers debriefed and supported staff after any serious incident.

Managers investigated incidents thoroughly.

Staff received feedback from investigation of incidents, both internal and external to the service. Lessons learned bulletins were pinned to the back of nurse office doors so staff could have easy access to them.

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

Inadequate

Forensic inpatient or secure wards

There was evidence that changes had been made as a result of feedback. For example, after a patient had managed to unscrew a bathroom panel and found a sharp object to self-harm, security and maintenance checks were amended to include checks of bathroom panels. Staff were informed of the incident by email, bulletins and staff meetings.

Are Forensic inpatient or secure wards effective?

Good

We rated effective as good.

Assessment of needs and planning of care

Staff assessed the physical and mental health of all patients on admission. They developed individual care plans which were reviewed regularly through multidisciplinary discussion 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.

We looked at 12 patients' care records.

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

All patients had their physical health assessed soon after admission and regularly reviewed during their time on the ward.

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.

Care plans were personalised, holistic and recovery-orientated.

The provider sent us additional information after our inspection which stated that over the past 12 months, the average percentage of patients who achieved the goals within their care plans was 74%.

However, staff found difficulty finding the information we needed to see in care records whilst we were onsite. This meant that staff may not have timely access to important information they needed to deliver appropriate care to patients.

We had to request evidence of physical health assessments, mental health assessments and care planning around specific communication needs to be sent to us after we had finished our onsite inspection ended which the provider did.

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 but access to the gymnasium was limited. Staff used recognised rating scales to assess and record severity and outcomes. They also participated in clinical audit, benchmarking and quality improvement initiatives.

Inadequate

Forensic inpatient or secure wards

Staff provided a range of care and treatment suitable for the patients in the service. Patients had access to psychology and psychiatry.

Patients had access to therapies which included Schema therapy which is designed to help break patterns of thinking, feeling and behaving, which are often tenacious, and to develop healthier alternatives to replace them. Other individual therapies included cognitive behaviour therapy, dialectical behaviour therapy, emotional management, coping skills, mindfulness, life minus violence, relapse prevention, anxiety management and self-esteem development.

Patients also had access to activities and facilities such as gardening, cookery, woodwork, film groups, use of the gymnasium, supervised access to the internet, a recovery college, tattoo sessions, console games and board games.

Patients access to the gymnasium was being delayed due to staff having to collect the keys from the security office before taking patients over to it and this process was repeated when bringing patients back from the gymnasium to the ward. This current process had been implemented when there was a requirement for people to adhere to social distancing procedures during the COVID-19 pandemic and this had not been changed when rules were relaxed. We raised this with the registered manager who said they would consider giving activities co-ordinators on the wards their own keys to the gymnasium to alleviate the time in conveying individual patients to and from the gymnasium.

Most staff delivered care in line with best practice and national guidance. However, we found a record in relation to rapid tranquilisation medicine that did not state the doctor was aware this had been administered to the patient.

We saw evidence in care records that staff identified patients' physical health needs and recorded them in their care plans.

Staff made sure patients had access to physical health care, including specialists as required. There was an onsite GP and patients had access to dentists, dieticians, diabetic nurses and opticians.

Staff met patients' dietary needs and assessed those needing specialist care for nutrition and hydration.

Staff helped patients live healthier lives by supporting them to take part in programmes or giving advice. This included exercise, cooking healthy meals and providing specific diet plans.

Staff used recognised rating scales to assess and record the severity of patients' conditions and care and treatment outcomes. These included the Health of the Nation Outcome Score (HONOS), care programme approach and ward rounds.

Staff used technology to support patients. Staff provided patients with mobile phones, supervised access to the internet, printers and tablets. However, we reviewed the last three sets of notes taken from the People's Council meetings and saw in the January 2022 notes, a reference to a request for a tablet for use on Upper East ward being made. However, a tablet had still not been provided by April 2022.

Managers used results from audits to make improvements. Audits included a full quality audit of the hospital, health and safety audits, thematic reviews, care records, observation and engagement, COVID-19 healthcare, ligature audits, infection control, safeguarding, physical health and the use of the Mental Health Act and Mental Capacity Act.

Inadequate

Forensic inpatient or secure wards

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.

The service had access to a full range of specialists to meet the needs of the patients on the ward. This included onsite GPs, psychiatrists, dentists, podiatrists, dieticians, nurses, occupational therapists and psychologists.

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 before they started work.

Permanent staff were supported by their managers to develop through yearly, constructive appraisals of their work and regular clinical supervision. The compliance rate for staff appraisals over the previous 12 months was 87% and the compliance rate for clinical supervision over the previous 12 months was 95%.

Managers made sure staff attended regular team meetings or gave information from those they could not attend. All staff team meetings took place at least once a month on each ward.

Staff were given the time and opportunity to develop their skills, knowledge and training needs that their managers had identified.

Managers made sure staff received any specialist training for their role. Specialist training undertaken by staff included handcuff training, autism, personality disorders and learning disabilities.

Managers recognised poor performance, could identify the reasons and dealt with these. The provider had a performance management system in place which included a process for addressing staff performance issues.

Multi-disciplinary and interagency teamwork

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 weekly multidisciplinary meetings to discuss patients and improve their care.

We observed a multidisciplinary team ward round on Upper East ward. Patients' risks, changes to care plans, patients' current presentation, Section 17 leave, substance misuse and other factors were discussed with the patient or their advocate who had been invited to the meeting. Staff had a good knowledge of the patients they cared for and relevant professionals attended the ward round either in person or online.

Staff made sure they shared clear information about patients and any changes in their care, including during handover meetings.

Ward teams had effective working relationships with other teams, both in and outside of the organisation.

Inadequate

Forensic inpatient or secure wards

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

Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice and discharged these well. 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, the compliance rate for Mental Health Act training was 90%.

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

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 access to information about advocacy. However, the information on patient noticeboards was not specific about whether independent mental health advocacy and independent mental capacity advocacy was available. Staff confirmed that both were provided, but some staff we asked about this did not understand the difference between the two.

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

Staff made sure patients could take section 17 leave 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. Audits were undertaken by staff from the onsite Mental Health Act team and any learning identified was shared in team meetings, reflective practice sessions and during supervision and appraisal sessions.

Good practice in applying the Mental Capacity Act

Staff supported patients to make decisions on their care for themselves. They understood the provider 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, the compliance rate for Mental Capacity Act training was 90%.

There were no deprivations of liberty safeguards applications made in the last 12 months within the service.

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

Inadequate

Forensic inpatient or secure wards

Staff knew where to get accurate advice on the Mental Capacity Act and deprivation of liberty safeguards. There was a Mental Health Act team onsite who gave advice and support to staff on the wards about the Act.

Patients had access to information about advocacy. However, the information on patient noticeboards was not specific about whether independent mental health advocacy and independent mental capacity advocacy was available. Staff confirmed that both were provided, but some staff we asked about this did not understand the difference between the two.

Staff assessed and recorded capacity to consent clearly each time a patient needed to make an important decision.

Staff audited how they applied the Mental Capacity Act and identified and acted when they needed to make changes to improve. Audits were undertaken by staff from the onsite Mental Health team and any learning identified was shared in team meetings, reflective practice sessions and during supervision and appraisal sessions.

Are Forensic inpatient or secure wards caring?

Inadequate

We rated caring as inadequate.

Kindness, privacy, dignity, respect, compassion and support

Staff did not always treat patients with compassion and kindness. They did not always respect patients' privacy and dignity. They did not always understand the individual needs of patients or support patients to understand and manage their care, treatment or condition.

Staff were not always discreet, respectful or kind when caring for patients. We spoke with 18 of the 67 patients using the service and four carers during our inspection. Six patients and one carer told us staff could be patronising, antagonistic and rude; made negative comments against patients, could be unhelpful, and had told others on the ward that they were a drugs user.

One patient on Madison ward said they felt unsafe on the ward. We reviewed community meeting notes and there were comments about staff eating patient's food and allowing patients to consume their peers food and drink.

Two patients told us they had seen staff members sleeping on duty. We raised this with the registered manager who told us some staff had been dismissed for sleeping on duty.

Staff did not always give patients help, emotional support and advice when they needed it. Complaints were not always dealt with and patients told us they had reported being bullied but nothing had been done about it.

The provider identified from analysing themes and trends from complaints that 21 out of 79 complaints in the last 12 months were in relation to staff attitudes; six of which were partially upheld and two which were fully upheld. The registered manager told us lessons had been learned including:

- compassionate based training being rolled out to both staff and patients on the wards and,
- the introduction of reflective practice with psychologists around staff attitudes towards patients.

Inadequate

Forensic inpatient or secure wards

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

Staff felt that they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards patients.

Most staff followed policy to keep patient information confidential. Staff received information governance training which included the need to always ensure patient confidentiality was maintained and the General Data Protection Regulation was adhered to. However, there had been a data breach in which information about a patient's index offence had been placed in an incorrect security box, resulting in other patients on the ward finding out what their offence was.

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. However, staff did not always ensure patients understood their care and treatment.

Involvement of patients

Staff introduced patients to the ward and the services as part of their admission.

Staff did not always ensure patients understood their care and treatment. One patient with learning difficulties told us staff provided information in a way they did not understand and did not clarify their understanding. Posters on noticeboards on the wards were in English or Welsh only and there was nothing to say information was available in other formats or languages. However, we saw evidence that signers and interpreters attended the People's Council meetings which was a forum comprising managers, staff and patients from each ward in which attendees could raise issues or make requests in order to help improve the service.

Patients could give feedback on the service and their treatment. There was a complaints procedure, satisfaction surveys, community meetings on the wards and the People's Council. There were patients from each ward who were able to provide feedback about care and treatment at clinical governance meetings.

Staff made sure patients could access advocacy services

Involvement of families and carers

Staff did not always inform and involve families and carers appropriately.

Staff did not always support, inform or involve families or carers. We spoke with four carers who told us staff did not keep them informed of their loved one's progress. One said staff were not always helpful when they rang the ward for an update, and they had not been asked to give any input into their loved one's care. Another carer said they had been unable to see their loved one on four occasions due to staff not booking in their appointment. A third carer told us that despite staff being aware of concerns over their loved one being bullied, staff had not been in contact with them to keep them informed. One of the carers told us they were unsure how to make a complaint.

The service's social worker gave carers information on how to access a carer's assessment.

Are Forensic inpatient or secure wards responsive?

Inadequate

Forensic inpatient or secure wards

Requires Improvement

We rated responsive as requires improvement.

Access and discharge

Staff planned and managed patient discharge well. They managed patients' moves to another inpatient service or to prison. As a result, patients did not have to stay in hospital when they were well enough to leave.

Bed management

Managers made sure bed occupancy did not go above 95%. The average bed occupancy in the previous 12 months was 87%.

Managers regularly reviewed the length of stay for patients to ensure they did not stay longer than they needed to.

There were 12 out of area placements in the last 12 months.

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.

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.

Discharge and transfers of care

In the previous 12 months, there had been only one delayed discharge. This was due to a suitable placement not being available to safely meet the patient's needs. However, staff were making efforts to find a placement and were in regular contact with commissioners.

Patients did not have to stay in hospital when they were well enough to leave.

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

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

Facilities that promote comfort, dignity and privacy

The design, layout, and most of the furnishings on the wards 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. Patients could make hot drinks and snacks at any time. However, patients and staff told us the food was of a poor quality.

Each patient had their own bedroom, which they could personalise.

Patients had a secure place to store personal possessions.

The service had a full range of rooms and equipment to support treatment and care. Staff and patients could access the rooms.

The service had quiet areas and a room where patients could meet with visitors in private.

Patients could make phone calls in private.

The wards had outside spaces that patients could access. Patients had supervised access to the garden areas on Columbus, Upper East and Upper West wards due to the wards being on higher floors, risks in relation to violence and aggression, items being thrown over fences and to allow staff to monitor non-association with other wards. However, patients on Upper East ward could request a security fob to access the garden area unsupervised if risk assessed to do so. Patients on all the wards had supervised access to the garden after sundown so staff encouraged them to access the garden during the day.

Patients could make their own hot drinks and snacks and were not dependent on staff.

We looked at copies of menus for the previous four weeks. These evidenced that there were three main options per meal each day. Allergy information was included and there were gluten-free and vegan options. In addition to the three main options, salads, jacket potatoes with fillings, fruit, low fat yogurts and diabetic desserts were also available on request.

However, both patients and staff told us the food provided at the hospital could be poor. Some patients told us they preferred to cook their own food due to the poor quality of food provided. The catering manager attended community meetings on the wards to get feedback and suggestions from patients about food choices. Managers encouraged staff to do random sampling of food and provide feedback to them on its quality. Food was also discussed at clinical governance meetings.

Most of the furnishings were in a good state of repair. On Upper East ward, a chair in the quiet room and three stools in the communal areas had been ripped but we saw evidence replacements had arrived and the damaged ones were waiting to be collected and disposed of. On Columbus ward, a toilet door had been damaged so it was boarded up and was awaiting a replacement.

There was a problem with the hospital's heating system which meant the central heating came on despite the warm summer temperatures. This made the temperatures within the hospital building uncomfortable for both patients and staff members. We noted one morning on Madison ward that the temperature was already 22 degrees and the heating had only just come on, so it was due to rise even higher.

We observed a community meeting on East Hampton ward. Patients raised concerns about the heating being on in June, a light from a sensor shining into their bedroom and disturbing their sleep and the office door slamming all night.

Patients' engagement with the wider community

Staff supported patients with activities outside the service, such as work, education and family relationships.

Staff made sure patients had access to opportunities for education and work, and supported patients. Patients could access an onsite recovery college to undertake courses centred around education.

Staff did not always help patients to stay in contact with families and carers. We spoke with four carers who told us staff did not keep them informed of their loved one's progress. Another carer said they had been unable to see their loved one on four occasions due to staff not booking in their appointment.

Meeting the needs of all people who use the service

The service did not always meet the needs of all patients. Staff did not always help patients with communication issues. However, staff gave patients access to advocacy and cultural and spiritual support.

The service could support and make adjustments for disabled people and those with other specific needs. There were lifts between floors. Patients with mobility issues were given accessible rooms. Patients with breathing issues affecting their sleep had been given breathing apparatus to help alleviate the symptoms. Patients whose mobility had deteriorated had been given walking frames and had their observations levels changed in order to increase their safety.

The service had limited information leaflets available in languages spoken by the patients and local community. Noticeboards within the service contained information in English and Welsh only. One patient with a learning disability told us they were given information in a way they could not understand, and staff did not clarify their understanding.

Managers made sure staff and patients could get help from interpreters or signers when needed. We saw evidence that signers and interpreters attended the People's Council meetings which was a forum comprising managers and staff and patients from each ward in which attendees could raise issues or requests in order to help improve the service.

Patients had access to spiritual, religious and cultural support.

Listening to and learning from concerns and complaints

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

Seven patients and a carer told us complaints had been made but nothing had been done about them. Some patients said they had complained up to five times and heard nothing back. We asked the provider to look into these claims which they did. Three of the patients confirmed they had not raised a complaint. However, the provider took the decision to log a complaint for one of these patients. A patient's complaint had been investigated and they were unhappy with the outcome, so the provider gave them advice on to how to lodge an appeal. Three complaints had only recently been lodged and were still being investigated and another patient confirmed they did not want to make a complaint.

The provider logged a further three complaints on behalf of the patients who spoke to us about the alleged abuse by a staff member on East Hampton ward.

Although the provider sent responses in relation to each of the complaints, we were still not assured that all complaints were being logged and investigated appropriately, particularly when the ward manager on Madison ward claimed all patients on the ward wanted their complaints dealt with on the ward only. This meant there was the likelihood that serious complaints were not being sent to the hospital complaints team in line with the provider's complaints process. We were also concerned that no action had been taken to address a patient's complaint until we raised it with the provider.

Inadequate

Forensic inpatient or secure wards

The service clearly displayed information about how to raise a complaint in patient areas. Blank complaint forms were attached to patient noticeboards on the wards. However, on Columbus ward, we noticed the forms had ran out and we had to ask staff to print more copies which indicated noticeboards were not always being checked.

The most common complaints were in relation to staff attitudes. The provider identified from analysing themes and trends from complaints that 21 out of 79 complaints in the last 12 months were in relation to staff attitudes; six of which were partially upheld and two which were fully upheld.

Managers shared feedback from complaints with staff and learning was used to improve the service. For example, following the number of complaints about staff attitudes and bullying on the wards, staff now attended reflective practice with psychology to gain a better understanding of how their attitudes affected patients. Compassionate based learning was being rolled out on the wards for both staff and patients to make people aware of the impact of their behaviour and to encourage a more friendly environment.

The service used compliments to learn, celebrate success and improve the quality of care. There had been 17 compliments received in the previous 12 months. Compliments were shared with staff in team meetings and during appraisal and supervision sessions. Compliments included patients thanking staff for their support, a thank you to the cleaning staff for their hard work and recognition for the occupational therapy team and other staff for organising fun activities.

Are Forensic inpatient or secure wards well-led?

Inadequate

We rated well led as inadequate.

Leadership

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

Leaders had the skills, knowledge and experience to perform their roles.

Leaders had a good understanding of the services they managed. They were aware of issues in relation to staff attitudes, patient dissatisfaction about the hospital food and they had access to staffing information, patient and carer feedback and other information about the wards and wider service. However, we had concerns that the issues in relation to staff attitudes, bullying on the wards, quality of food and issues previously raised in community meetings and the People's Council had not been rectified at the time of our inspection.

Leaders were visible in the service and approachable for patients and staff. However, two staff members said they only saw the registered manager if there had been an incident on the wards and needed to speak with patients about it.

Leadership development opportunities were available, including opportunities for staff below team manager level.

Vision and strategy

Staff knew and understood the provider's vision and values and how they applied to the work of their team.

Inadequate

Forensic inpatient or secure wards

The provider's purpose was to make a positive difference to the lives of the individuals it care for, their loved ones and all staff it employed.

Its vision was to provide high quality, sustainable specialist services that ensured patients felt safe and supported, staff were proud of, commissioners and patients selected, and stakeholders trusted.

The provider's mission was to work together in a positive culture of openness, honesty and inclusivity, where safe, compassionate and quality care was delivered to patients and staff enjoyed a fulfilling, rewarding work environment.

Its values were to care and respect patients, staff and visitors; ensure a bond of trust was built with them, to empower patients and to deliver quality services with integrity.

The provider's senior leadership team had successfully communicated the provider's vision and values to the frontline staff in this service.

Staff had opportunities to contribute to discussions about the strategy for their service in team meetings, reflective practice sessions and during appraisal and supervision sessions with their manager.

Culture

Staff felt respected, supported and valued. They said the provider promoted equality and diversity in daily work and provided opportunities for development and career progression. They could raise any concerns without fear.

Staff felt respected, supported and valued. They felt proud, positive, satisfied and part of the organisation's future direction.

Managers monitored staff morale, job satisfaction and sense of empowerment.

The provider had staff award and recognition schemes. Staff told us they received thank you emails from the registered manager, there was an employee of the month scheme and leave was given for birthdays and other celebratory events.

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

Staff members felt able to raise concerns without fear of reprisals. Organisational policies and procedures positively supported staff being able to speak up about any concerns. However, patients and carers told us they had raised concerns about abuse with staff on the wards and nothing had been done about it.

The provider had a whistle blowing policy in place that was accessible to all staff.

Staff had access to support for their own physical and emotional health needs through an occupational health service. They had unlimited access to an onsite GP service. The provider had an online wellbeing portal with a range of free health and wellbeing information. It included advice and tools to support physical and mental health, financial wellbeing, nutrition, a library of videos in relation to high-intensity interval training, boxing and yoga and blogs and tips for sleeping well and practicing meditation and mindfulness.

There was a staff relations group within the service. This enabled nominated staff members to speak on behalf of colleagues and ensure that their views were represented within the management of the service. There was also a freedom to speak up guardian whose details were included in laptop screensavers, so staff knew who they were and what their role entailed.

Staff reported that the provider promoted equality and diversity in its day to day work and in providing opportunities for career progression. There were black and minority ethnic champions within the service and staff received training in equality and diversity.

Governance

Although policies, procedures and protocols were reviewed and reflected best practice, governance systems and management oversight was not always effective is ensuring staff adhered to them. The service's governance systems and management oversight were not always effective.

The ward manager of East Hampton ward did not report the full extent of allegations of abuse against a staff member to the registered manager which delayed them being suspended from duty.

Patients had told staff they were being bullied by peers on the ward, but staff had not taken sufficient action to safeguard them. This was an issue at our last inspection in 2020 so the provider had not taken sufficient steps to address patient safety.

Staff carried out medicines management audits, but these were not always effective as we found medicines on Columbus ward which had expired and had not been disposed of.

Patients told us staff were not always kind and caring towards them and 21 out of 79 complaints related to staff attitudes. Patients also told us that some international staff spoke in their own language and this was causing frustration and paranoia on the wards.

A breach of patient confidentiality had led to the patient's index offence being disclosed to others on the ward which resulted in the patient being verbally abused and attacked.

Patients and staff told us the quality of the food was poor. The registered manager was aware of this and the issue was being discussed in clinical governance meetings.

We had concerns that complaints were not always being logged or investigated by the appropriate team. For example, complaints on Madison ward were only being dealt with on the ward which meant more serious complaints were potentially not being sent to the hospital complaints team in line with the provider's complaints policy.

During our inspection, staff found it difficult to find the information we needed to see within patients' care records due to the use of both paper-based and electronic systems. This meant that staff may not have timely access to important information they needed to deliver appropriate care to patients. We had to request information about mental and physical health checks and care planning for specific communication needs from the provider after our onsite inspection ended which they subsequently sent us.

However, staff were compliant with their mandatory training apart from intermediate life support, appraisal and supervision. Access and discharge were managed well. Lessons learned from incidents, safeguarding concerns and complaints were shared with staff. Staff carried out health and safety checks of the environment and took action to address any issues identified.

Incidents and complaints that had been reported were investigated and managers shared any lessons learned so the service could improve.

The provider had updated its recruitment and selection policy and process to address the regulatory breach identified during our previous inspection. Senior managers who were minded to overturn a decision made by a recruitment panel to offer or decline a job to a candidate now needed to have met or spoken to the candidate prior to making their final decision. Interview note templates had been updated to ensure the registered manager and hospital director recorded any instances in which they had overturned a decision made by the recruitment panel. The provider's human resources team required all interview notes to be signed by panel members. Managers had been given training in recruitment and selection.

All job candidates now liaised directly with a central boarding team who used a system to track pre-employment checks including references and Disclosure and Barring Service checks. Prior to commencing employment, the boarding team audited the candidate's file to ensure all checks were in line with the provider's policy. A further audit was carried out by staff from the human resources team and there were tracking systems to ensure concerns identified from pre-employment checks were followed up and recorded.

There was a clear framework of what must be discussed at a facility, team or directorate level in team meetings to ensure that essential information, such as learning from incidents and complaints, was shared and discussed.

Staff undertook or participated in local clinical audits. However, audits had not identified issues in relation to expired medicines, safeguarding and damaged furnishings.

Staff understood the arrangements for working with other teams, both within the provider and externally, to meet the needs of the clients.

Management of risk, issues and performance

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

There was a clear quality assurance management and performance frameworks in place that were integrated across all organisational policies and procedures.

Staff had access to the risk register and were able to submit items for inclusion on it. Staff concerns matched those on the risk register.

The service had plans for emergencies such as adverse weather or a flu outbreak. The service had a business continuity plan which included the processes to be followed and who to contact if an emergency arose.

Each ward had a folder containing "one-page-profiles" for each of the patients being available on each ward for all staff, including agency to read through which highlighted any associated risks and concerns.

Inadequate

Forensic inpatient or secure wards

Information management

Staff collected and analysed data about outcomes and performance and engaged actively in local and national quality improvement activities.

The service used systems to collect data from facilities and directorates that were not over-burdensome for frontline staff.

Staff had access to the equipment and information technology needed to do their work. The information technology infrastructure, including the telephone system, worked well and helped to improve the quality of care. However, staff found difficulty finding information we requested to see in patients' care records due to information being both paper-based and within the electronic care records system.

Information governance systems included confidentiality of client records. Staff ensured the service confidentiality agreements were clearly explained to clients in relation to the sharing of their information and data.

Team managers had access to information to support them with their management role. This included information on the performance of the service, staffing and client care. Information was in an accessible format, and was timely, accurate and identified areas for improvement.

Staff submitted data and notifications to external bodies as needed such as the local authority and Care Quality Commission.

All information needed to deliver care was stored securely. Paper records were stored in lockable cabinets and staff needed a login name and password to access electronic records.

The service had developed information-sharing processes and joint-working arrangements with other services where appropriate to do so.

Engagement

Managers engaged actively other local health and social care providers to ensure that an integrated health and care system was commissioned and provided to meet the needs of the local population.

We observed a multidisciplinary team ward round and noted that professionals both within and outside of the organisation had been invited to share information and provide input into patient care and treatment. We also saw evidence in patients' care records of interagency working with health and social care providers in order to meet patients' needs.

Learning, continuous improvement and innovation

A member of the psychology team had participated in research into how staff experiences of incidents on a forensic male low secure mental health ward impacted on the ward team dynamics. The research included consideration of staff burnout, health and wellbeing, stress levels and personal accomplishment.

There were innovations taking place within the service. Staff had supported a patient on Madison ward to make changes to the design and look of the ward. They had painted the walls to create a happy and therapeutic environment. This

made the patient and their peers feel more at home but also helped the patient express their thoughts, ideas and fears in a way that was easier than verbal communication and enabled them to also build better focus and discipline. Due to the success of this, staff had supported the patient to make environmental improvements to other areas of the hospital such as the recovery college.

The service had developed an induction pack specifically tailored to international nurses. The pack included information about safeguarding, emergency and medical information, policies, local information, information about the team, training and regulatory information.

The service had also developed an induction pack for patients. This included information about living with a personality disorder and feedback forms for patients to complete when they were introduced to staff members.

The service had introduced a new role called the safety audit assistant. It was introduced to assist staff with the screening of closed-circuit television, compiling reports based on findings and feeding information back to relevant individuals. The reviewing of findings was completed in collaboration with ward managers, the safety intervention team and registered managers. The role also involved providing assistance in investigations, complaints, and other ad-hoc requests regarding safeguarding or police incidents.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance • Governance processes and management oversight within the service were not always effective. We found issues in relation to the recording of safeguarding issues, complaints and follow up action to issues raised by patients on the wards such poor as food quality. • A breach of patient confidentiality had led to the patient's index offence being disclosed to others on the ward which resulted in the patient being verbally abused and attacked. • The ward manager of East Hampton ward did not report the full extent of allegations of abuse against a staff member to the registered manager which delayed them being suspended from duty. • Patients told us staff were not always kind and caring towards them and 21 complaints in the last 12 months related to staff attitudes. Patients also told us that some international staff spoke in their own language and this was causing frustration and paranoia on the wards. • Staff found difficulty finding patient information within patients' care records due to the use of both electronic and paper-based systems. • Audits within the service were not always effective in identifying areas for improvement. We found medicines on Columbus ward which had expired and had not been disposed of.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints • We were not assured that all complaints were being logged and investigated appropriately. The ward

This section is primarily information for the provider

Requirement notices

manager on Madison ward informed us that all patients on the ward wanted their complaints dealt with locally by the ward only. This meant there was the likelihood that serious complaints were not being sent to the hospital complaints team in line with the provider's complaints process.

- No action had been taken to address a patient's complaint until we raised it with the provider.
- On Columbus ward, complaints forms had run out and we had to ask staff to print more copies, so they were accessible to patients.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment • Patients had told staff they were being bullied by peers on the ward, but staff had not taken sufficient action to safeguard them. • Two patients told us they had been bullied and intimidated by a staff member on East Hampton ward. The ward manager did not report the full extent of the alleged abuse to the registered manager which delayed the member of staff being suspended from duty. • Two staff members on Columbus ward gave examples of incidents against staff only when asked about safeguarding which indicated patients' concerns were not being put first. • Six patients and one carer told us staff could be patronising, antagonistic and rude; made negative comments against patients, could be unhelpful, and had told others on the ward that they were a drugs user. • 21 complaints in the last 12 months were in relation to staff attitudes. • One patient on Madison ward said they felt unsafe on the ward. We reviewed community meeting notes and there were comments about staff eating patient's food and allowing patients to consume their peer's food and drink.

This section is primarily information for the provider

Requirement notices

- There had been a data breach in which information about a patient's index offence had been placed in an incorrect security box, resulting in other patients on the ward finding out what their offence was.

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.