Cheswold Park Hospital

Quality Report

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

Ratings

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

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

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

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

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

Summary of findings

Overall summary

We rated Cheswold Park Hospital as **requires improvement** because:

The hospital was in a period of transition with a new managing director having implemented a new management structure to improve the quality of the service in the three months prior to the inspection. This included each ward having its own manager and a nursing operational manager overseeing all of the wards. However, the senior managers had not had sufficient time to review the service following the changes or embed the new systems at the time of our inspection.

Areas where improvements are required:

- We found unclear information about when the provider would complete actions. For example, there were no timescales in place to remove ligature points or to improve visibility into patients' rooms for staff at night. Minutes of the operational and clinical risk meetings had unclear information about when they would complete actions. Where staff had carried out the investigation of serious incidents and made recommendations, we did not find specific action plans in place.
- The hospital did not have policies and procedures to inform staff about their responsibilities regarding the duty of candour. (Duty of candour is a legal duty on hospitals to inform and apologise to people if there have been mistakes in their care, which could have led to significant harm.)
- The systems in place to prevent and control infectious diseases needed improving.
- Staff kept patient information in a variety of places, which prevented them from having access to all the information from the multidisciplinary team members. This had the potential to affect the assessment and planning of patients' care and treatment needs.
- The hospital did not have enough qualified nursing staff on at night to cover the wards if an incident occurred, or when qualified nursing staff went for a break.
- The hospital needed to improve the management of medication. For example, the hospital had not followed new guidance and checked patients' physical health when administering high doses of medication. Nine patients on Foss ward did not have care plans in place to instruct staff about how the patients had to administer their own medication. Following induction, the hospital did not provide updates of medication training.
- The hospital did not have a clear written protocol, or recording mechanism, to assess a patient's physical needs following admission, which would have enabled the staff to provide a consistent approach to meeting care needs.
- Although, managers had started to address attendance by staff at supervision meetings, on Brook, Foss, Calder and Don Wards only 53% of staff had attended supervision. Supervision is a method of checking the quality of staff's work, recording action on training and cascading key information or learning to staff in the hospital.
- Information about how to complain to the CQC about detention under the Mental Health Act was either not displayed or the information displayed was out of date across the wards Also, an average of 59% of staff had carried out their Mental Health training. This lack of information potentially prevented patients from being able to complain about their detention.

However, we also saw areas where the managers and staff had displayed good practice, or had made recent improvements. For example:

- The provider held a morning meeting each day to review any issues relating to patient safety. The hospital directors, registered manager and ward managers attended the meeting. Following this, the managers met to review the staffing numbers on each ward to ensure that the wards had sufficient skilled staff to meet patients' needs.
- The hospital held a monthly governance meeting chaired by the clinical director.
- The hospital had a newly implemented register detailing risks to the patient or staff that the management team reviewed regularly. This enabled the managers to prioritise risks and take action.
- The hospital collated information about incidents, restraint and complaints to review any patterns.

Summary of findings

- The hospital had looked at staff employment contracts to make sure it improved recruitment of new staff and encouraged the retention of existing staff.
- Patients had regular and well-organised multidisciplinary team meetings.
- Records relating to the Mental Health Act were well kept and staff had a good awareness of the act.
- The provider had carried out a staff survey in July 2015.
- The managers had carried out a patient survey in March 2015, which they planned to act on.
- Staff had commenced reviewing the treatment and care of patients who had been at Cheswold Park for a long period of time to see if the hospital was still appropriate for them. Staff had discharged 23 patients from August 2014 to August 2015.
- The hospital had a fishing pond and animals within its grounds. There were a variety of activities available during weekdays.
- Patients had regular leave from the hospital.
- Managers and staff listened to the concerns and complaints of patients and responded to them.
- The hospital had clear processes in place to safeguard patients and staff knew about these.
- The hospital had trained eight staff to improve their practices when investigating complaints and incidents.
- Following several absconding incidents, the hospital commissioned an independent review to look at ways of improving practices.
- The hospital staff had a good range of skills. Staff had the qualifications needed and received specialist training specific to their roles.
- Most patients said staff treated them with kindness, dignity and respect.
- The hospital managers visited the wards regularly and staff informed us they were supportive. The senior managers had linked the vision and values of the organisation to the staff appraisal system.
- The hospital had developed an individual service for one patient with complex needs and had trained the staff to support the patient.

The hospital had involved an independent specialist consultant to make sure the service provision was of a high standard for one patient with complex needs. This had improved the experience for this patient at the hospital.

Summary of findings

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Summary of this inspection

Background to Cheswold Park Hospital

Cheswold Park Hospital is registered with the Care Quality Commission (CQC) to carry out the following regulated activities:

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

The registered manager at the time of the inspection was Jodie Leigh Roberts.

The accountable officer is Dr Richard Pearson.

Cheswold Park Hospital has nine wards for male patients aged 18 to 65.

Five low-secure wards for between 12 and 15 patients:

- Aire ward – an admission ward for patients with a mental illness.
- Esk ward – a slow stream rehabilitation ward focused on quality of life for patients with a mental illness.
- Foss ward – a rehabilitation ward for patients with a mental illness.
- Calder ward – a rehabilitation ward for patients with a personality disorder.
- Don ward – a rehabilitation ward for patients with a personality disorder.

Three medium-secure wards for between 12 and 15 patients:

- Brook ward – an admission ward for patients with a mental illness,
- Gill ward – a rehabilitation ward for patients with a learning disability,
- Hebble ward – an admission ward for patients with a learning disability.

The Isle suite which staff have adapted to meet the needs of one patient with complex needs.

The CQC inspected Cheswold Park Hospital in April 2014. We found the hospital compliant with all of the domains reviewed.

The last Mental Health Act review was on 22 June 2015 on Calder ward. The reviewer made recommendations regarding incomplete documentation, and sufficiently skilled staff. At this inspection we found similar concerns with the documentation and concerns about the use of agency staff.

Our inspection team

Our inspection team was led by:

Team Leader: Jonathan Hepworth Inspection Manager (Mental Health)

The inspection team included three Care Quality Commission inspectors. A team of specialist advisors that consisted of a hospital manager, four mental health nurses with experience of low and medium secure hospitals, an occupational therapist, a pharmacist, and a Mental Health Act reviewer.

Why we carried out this inspection

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

Summary of this inspection

How we carried out this inspection

To get to the heart of people who use services' experience of care, 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?

At the inspection we reviewed our own intelligence held on Cheswold Park Hospital and asked other organisations for information to support our inspection by sharing what they knew about the service. For example, information on how the hospital reports and investigates incidents and complaints, how they manage their contracts with commissioners and how they manage new assessments, admissions and discharges.

During the inspection, we held focus groups with staff who worked within the hospital, including nurses, ward managers and therapists.

During the inspection visit, the inspection team:

- Spoke with 26 patients who gave their views and experiences of the hospital.
- Spoke with 70 staff, including consultant psychiatrists, doctors, hospital and registered managers, ward manager, nurses, occupational therapists and an involvement co-ordinator.
- Attended two multidisciplinary team meetings, five community meetings and a patient activities session.
- Looked at 47 patient records.
- Carried out a specific check of the management of medication.
- Looked at Mental Health Act documentation to see if staff had followed the Mental Health Act Code of Practice.
- Looked at policies, procedures and other documents essential to running the service.

What people who use the service say

On the medium secure wards, we spoke with seven patients about their experiences. On Hebble and Brook wards, four patients told us that the staff had treated them with kindness and respect. On Hebble ward, we witnessed staff supporting patients when they were distressed; we saw staff reacted with kindness and support. However, three patients on Gill ward told us they did not feel respected because staff searched their rooms and staff were always in the office.

On the low secure wards, we talked to 19 patients about their experiences. We found mixed responses dependent upon wards. Most patients on Aire, Esk, and Foss told us that staff had treated them with care and respect. However, on Don ward, two out of four patients we spoke to told us that they found the staff uncaring. Also, on Calder ward, three out of six patients described the agency staff as uncaring and disrespectful, one stating staff responded to them in an "aggressive" manner.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Requires improvement 

We rated safe as requires improvement because:

- The provider did not have a timescale in place for the removal of any fixed (ligature risk) points, which a patient could use to self-harm by hanging in their bedrooms, or for the improvement of bedroom door spyholes, to provide staff with a clear vision of the patient when the door was closed.
- The systems in place to prevent and control infectious diseases needed improvements. In one of the seclusion suites there was a cracked and damaged toilet seat screwed onto the bowl. Staff were unable to clean them effectively, which could put patients at risk of contracting an infection. In addition, staff had to clean the communal areas at the weekend, but did not have the appropriate training to do this safely.
- The hospital did not have enough qualified nursing staff on at night to cover the wards if an incident occurred, or when qualified nursing staff went for their breaks.
- The prohibited and restricted items policy reviewed November 2014 did not reflect staff practices and did not reflect the differences of the restrictions between the low and medium secure wards.
- The hospital needed to improve the management of medication. For example, the hospital had not followed new guidance and checked the physical health of patients when administering high doses of medication. Nine patients' on Foss ward did not have care plans in place to instruct staff about how the patients had to administer their own medication. Following induction, the hospital did not provide updates of medication training.
- The procedure for the investigation of serious incidents did not promote an independent approach to the investigation and the incidents did not contain actions plans to implement recommendations or timescales; and we found no arrangements in place to audit the implementation of the action plans.

However, we also found:

The provider had:

- Held a morning meeting each day to review any issues relating to patient safety. The meeting was attended by the hospital directors, registered manager and ward managers.

Summary of this inspection

- Systems in place to review the number, skill and gender of staff each day to make sure they met the patients' needs.
- Clear processes in place to safeguard patients and staff knew about these.
- Commissioned an independent review to look at ways of improving practices, following several patients absconding from the hospital. As a result of this they trained eight staff to improve their practices when they investigated serious incidents.

The staff had:

- Completed most of the mandatory training to ensure they had the skills to care for patients safely.
- Undertook a risk assessment of every patient on admission and updated these regularly and after any changes to the patient's needs.

Reported and investigated incidents, and carried out meetings following incidents to look at ways of improving their practices.

Are services effective?

Requires improvement

We rated effective as requires improvement because:

- Staff kept the patient's information in a variety of places. This meant staff did not have access to all the information from the multidisciplinary team. This had the potential to affect the assessment and planning of patients' care and treatment needs.
- The hospital did not have a clear written protocol to assess a patient's physical needs following admission.
  Fifty-nine per cent of staff had carried out their Mental Health Act training.
- Attendance by staff at their supervision meetings was low on Brook, Foss, Calder and Don Wards.
- Information about the Care Quality Commission was either not displayed or did not have the correct address. This could prevent a patient being able to complain about their detention if they wished to do so.

However,

- A well-motivated staff team had devised and developed intervention programmes for patients mainly based on cognitive behavioural therapies and other interventions, recognised by the National Institute for Health and Care Excellence (NICE).

Summary of this inspection

- The psychologists used tools such as the Becks depression inventory, risk for sexual violence protocol and a comprehensive risk assessment for forensic services. This enabled the psychologists to provide the most suitable interventions required for each patient.
- The hospital had a good range of skills in the staff team. Staff had the qualifications needed and received specialist training specific to their roles.
- The hospital had developed an individual service for one patient with complex needs and had trained the staff to support them. The hospital had involved an independent specialist consultant to make sure the service provision was of a high standard. This had improved the experience of a patient at the hospital.
- There were regular and well-organised multidisciplinary team meetings.
- Records relating to the Mental Health Act were well kept and although staff had not updated their training, they had an awareness of the MHA act.

Are services caring?

Good

We rated caring as good because:

- Patients said most staff supported them.
- On Hebble ward, we saw the manager and staff approach was kind, calm and supportive when they responded to a patient incident.
- Most patients told us they had either attended a multidisciplinary team meeting, had seen their care records, or were involved in their treatment.
- Overall, the majority of patients we spoke with said staff treated them with kindness, dignity and respect. However, on Gill, Don and Calder wards some patients reported areas for improvement in the approach and attitude of some staff.
- Patients had the opportunity to have support from the advocate. However, patients and staff reported this was not well advertised

The patients had the opportunity to make their views known in the ward meetings.

Are services responsive?

Good

We rated responsive as good because:

- The hospital managers had identified where patients had remained on wards for a long time and had commenced reviewing whether Cheswold Park was the appropriate hospital for them.

Summary of this inspection

- Staff had discharged 23 patients from August 2014 to August 2015.
- The wards optimised the recovery, comfort and dignity of patients. .
- The hospital had a fishing pond and animals within its grounds. There were a variety of activities they could attend during weekdays.
- Staff made sure patients had access to activities in the community regularly.
- The hospital had provided an environment for one patient with complex needs that was specific to their individual care needs
- Managers and staff listened to the concerns and complaints of patients and responded to them.

However, we also found areas where improvements should be made because:

- The documentation did not provide a consistent approach to the planning of patients' discharge.

Activities did not take place at weekends or evenings.

Are services well-led?

Requires improvement

We rated well-led as requires improvement because:

The new managing director had implemented a new management structure to improve the quality service provision. This involved each ward having its own manager and a nursing operational manager overseeing all of the wards. However, at the time of our visit, the new system had been not fully embedded and we found some areas where the managers needed to make improvements. For example:

- The hospital did not have policies relating to the duty of candour.
- Systems in place to ensure the hospital were compliant with new National Institute for Health and Care Excellence (NICE) guidance were limited.
- The systems in place to prevent and control infectious diseases and the safe management of medicines needed improving.
- Minutes of the operational and clinical risk meetings had unclear information about when they would complete actions. Such as the removal of the fixed ligature points and bedroom spyholes so staff could easily see patients in bed at night. Where staff had carried out the investigation of serious incidents and made recommendations, we did not find action specific action plans in place.

Summary of this inspection

- Staff kept patient information in a variety of places and this prevented staff from having access to all the information from the multi-disciplinary team members. This had the potential to affect the assessment and planning of patients' care and treatment needs.

However:

- Management visited the wards regularly and staff informed us they were supportive. The senior managers had linked the vision and values of the organisation to the staff appraisal system.
- Management ensured they were aware of ward incidents and operational requirements with daily meetings involving ward representatives.
- The managers had looked at ways of improving the recruitment of staff and retaining staff.
- The hospital had built a specific service to meet the needs of one patient and trained staff to support the patient
- The hospital managers had taken action and investigated where staff had raised concerns about other staff members.

Detailed findings from this inspection

Mental Health Act responsibilities

Staff demonstrated an awareness of the Mental Health Act (MHA) and informed us that they received advice and guidance from the MHA office situated on the premises. However, compliance in attendance at MHA training was low. Fifty-nine percent of staff were compliant with MHA update training as an average for the whole hospital staff team. The lowest wards for compliance were Don and Foss wards at 32% compliant.

The hospital had systems in place to support adherence to the MHA and the MHA Code of Practice. Patients' records had the relevant information for treatments. All pre-admission papers were available and staff checked them before transferring patients. Staff completed seclusion papers correctly. Section 17 leave forms were authorised and completed as required.

The hospital had a MHA administrator who monitored the documentation to make sure it was correct. The MHA administrator also visited wards to speak to the patients regarding their rights to appeal and CPAs. Patients' had their rights under the MHA explained to them on admission and at regular intervals following admission

We did not see any Care Quality Commission (CQC) notices present or information for patients detained under the MHA on Don, Foss and Gill wards. On Calder and Aire wards, CQC information contained the wrong address. This meant that if a patient wanted to contact the CQC to complain about their detention, they would have been unable to do so.

Mental Capacity Act and Deprivation of Liberty Safeguards

The hospital provided data that showed training in the Mental Capacity Act (MCA) was incorporated into MHA training. Ward managers and qualified staff understood the process to follow should they have to make a decision about or on behalf of a person lacking mental capacity.

Staff followed the five statutory principles of the MCA. Best interest decisions had taken place, for example, regarding patient finances, and decisions about care for physical health needs. . The patient, family members, social worker and an advocate attended best interest meetings. Support workers had varied knowledge of the MCA but said they would always seek advice from more qualified staff.

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Forensic inpatient/ secure wards	Requires improvement	Requires improvement	Good	Good	Requires improvement	Requires improvement
Overall	Requires improvement	Requires improvement	Good	Good	Requires improvement	Requires improvement

Requires improvement

Forensic inpatient/secure wards

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

Are forensic inpatient/secure wards safe?

Requires improvement

Safe Environment

All wards were for male patients. All of the wards were of similar design, with a layout that allowed staff to observe patients easily in the communal areas. The wards had a central nurse station with lines of sight down the main corridor and into the lounge. We saw that staff positioned themselves in communal areas to make sure they had a clear view of the ward. This was with the exception of Isle ward, which the staff had designed to meet the specific needs of one patient.

All wards had completed audits of the potential ligature risks to patients in July 2015. Staff and managers discussed with the inspection team the potential risks of fixed (ligature risk) points, which a patient could use to self-harm by hanging. We saw on some wards the provider had refurbished up to four bedrooms, to make them ligature free and the doors had vision panels that enabled clear observation of patients when the door was closed. Staff reported observing patients closely to reduce the risk of self-harm by ligature. Staff allocated patients who had an increased risk of self-harm the refurbished bedrooms. On a night shift, when staff checked on patients, they said they would open the patient's bedroom door to make sure they remained safe. Staff were aware of where the ligature cutters were, should a patient attempt to ligature. The hospital had two sets of emergency equipment and the staff had carried out test to ensure they were easily accessible.

However, all the ward environments, except Isle, had points that patients could attach something to, which may have enabled them to self-harm by hanging (ligature). There was also the added risk of staff not being able to easily see patients on a night shift. We did not find a timescale to resolve these issues.

The ligatures points were:

- radiator grills in bedrooms,
- medication cupboards in bedrooms,
- wash basin taps in the en suite and communal bathrooms,
- some patients had left items unattended in their bedrooms, with the doors open, and this provided other patients who were at potential risk access to them.

Staff could not easily observe patients because:

- most of the bedroom doors had spyholes that did not provide staff with clear lines of sight when observing patients at night.
- patients' bedrooms had blind spots in them caused by the opening of the ensuite door and the positioning of the wardrobes.

Staff had commenced a programme of refurbishment, but the target for achieving full refurbishment was unclear. On some wards, we found that the ligature risks had been removed from four bedrooms but the refurbishment of the remaining bedrooms did not have a timescale. This meant that the environment could pose a potential risk to patients for a considerable time. In addition the risks were absent from the hospitals overall register of risks in July 2015.

Requires improvement

Forensic inpatient/secure wards

In the Lakeside and Keepmoat seclusion suites, the metal toilet had a seat fixed to the toilet bowl by screws. One of these toilet seats was cracked and damaged. This damaged and cracked toilet seat puts patients at potential risk of contracting an infectious disease.

All the wards appeared clean, tidy and free from odours. Patients, supported by staff, cleaned their bedrooms. The hospital's housekeeper and the practice nurse were responsible for cleanliness and the prevention and control of the spread of infections at the hospital. The cleaners followed daily cleaning schedules that the housekeeper monitored. The practice nurse addressed any infection control issues. Both contributed to the annual audit and action plans.

However, the systems in place to prevent and control infections were not robust. For example, the annual audit did not fully review all the areas of infection control such as hand-washing. Cleaners did not work weekends, and ward staff told us they cleaned the toilets at the weekends. Although 79% of staff had completed infection control training, we did not find any evidence this included appropriate training regarding commercial cleaning duties.

The clinic rooms were clean, tidy and equipped with the appropriate resuscitation equipment and emergency drugs that staff checked regularly. However, two airway tubes had expired, the nursing staff agreed to rectify these. Staff carried out any physical examinations in patients' bedrooms or in the practice nurse and GP room.

Staff carried personal call alarms and radios to keep themselves and patients safe. All the ward staff and managers reported that they had access to personal call alarms. A response team responded for support if staff activated the alarms. Patients had nurse call systems.

We noted that the nursing office doors did not have closure devices. This meant the doors could be left open when a member of staff left the office.

Safe staffing

The number of qualified nurses and healthcare assistants on the wards was dependent upon the number of patients and their individual needs. The ward managers and directors met each morning to review the numbers of staff on duty for the next seven days. They identified any potential issues with the number of patients, skill mix or gender of staff at the hospital. At a meeting, we saw staff also reported any additional staffing needed to escort patients on leave.

Information from the provider as of 1 June 2015 showed that the staffing establishment for the eight wards was 62 qualified staff and 149 support workers. The hospital had 14.5 full-time vacancies for qualified nursing posts (23% of the total staff required) and 8.9 full-time vacancies for support worker posts (5.9% of the total staff required). Don, Calder and Aire wards were the most affected with over 13.5% vacancies overall. Staff sickness in the 12 months prior to the inspection was 4.4%. Don, Calder and Foss wards had the highest level of sickness at approximately 8%.

To ensure a consistent and safe approach by agency or bank staff when they provided care to the patients, when staff were new to the ward, they completed an induction form that informed them about the ward routines and health and safety issue. Speaking with the agency staff confirmed that agency staff had an introduction to the hospital and that the hospital used bank or agency staff to cover for the vacancies and sickness, who worked regularly at the hospital. This was because they were confident about the patients and hospital routine.

The use of agency staff had not affected patients' escorted leave. Patients and staff said they rarely cancelled escorted leave. However, on Brook ward the four patient records we reviewed did not have evidence of permanent staff providing them with individual time to talk about their issues one-to-one. In addition, five patients on Calder ward commented that they found that the agency staff did not know the ward routines and were less effective.

Also in response to the staff vacancies, the management team had carried out a recruitment drive and had relooked at staff terms and conditions to encourage new staff to work at the hospital. The survey of staff in July 2015 found staff would be more likely to stay if they worked in an area that was relevant to their interests and experiences.

Although the managers reviewed the number of staff available each day to make sure the patient's needs were met, We found that the wards were sometimes left without

a qualified member of staff and the lack of skilled staff could potentially put patients at risk of not receiving prompt treatment or care. For example, patients would not have had prompt access to medication. We found:

- The staff rotas for July 2015 showed that on the 20 July 2015, Foss ward did not have a qualified member of staff during the day and cover was provided by another ward.
- When qualified nurses left the ward for a break they gave the ward keys to a qualified nurse working on another ward. Staff told us this was normal practice.
- One qualified nurse had the added duties of the co-ordinator. This role was to respond to any emergencies on all of the wards and make sure that the wards had sufficient staff. This meant if they had to respond to an emergency on another ward, they would leave their own ward without a qualified member of staff.

The hospital had four consultant psychiatrists, and three other doctors full time. Medical staff were available throughout the day and night. For non-urgent physical care, the hospital had a GP and two part-time practice nurses. In an emergency, the staff would use the local accident and emergency department.

The hospital had 26 other staff involved in patient care. This consisted of five occupational therapists and seven assistants; one trained psychologist and five assistants; four social workers; a teacher, a physiotherapist and a speech and language therapist.

Information from the provider showed in August 2015:

- 86% of nursing staff had completed immediate life support,
- 80% of non-qualified staff had completed basic life support,
- 79% of all staff had completed health and safety, food hygiene and infection control,
- 81% of all staff had management of violence and aggression,
- 83% of all staff had completed security training.

The hospital has recently moved to a system whereby all staff attended all of their mandatory training in one week a year. The training manager said they hoped all staff would have completed the mandatory training by the end of 2015. The training plan demonstrated planned training courses until the end of the year to improve staff compliance with mandatory training.

Assessing and managing risk to patients and staff

We looked at 23 patients risk assessments and found most staff had effectively assessed and managed any potential risks to individuals. These looked at the risk to self and others, which staff had mostly reviewed regularly and after incidents had occurred. Staff used recognised tools, including the functional analysis of care environments and historical clinical risk management-20, these assess the patient's risks.

To ensure patient' safety, the staff would routinely increase the level of patient observations for any changes to the patient's presentation and complexity. On all wards, we saw staff had carried out patient observations and recorded them. We noted the form completed by staff for 30 minute observations did not include whether the patient had any signs of life, if in bed

Staff followed two policies regarding when to search patients and the security at the hospital. The search policy was due to be reviewed in August 2015, but the security check policy had expired in 2012. Staff searched all patients on admission and on return from leave. They also carried out random room searches and regularly used dogs to search for drugs. However, a female staff member had searched one patient, when a male staff member should have done it. This action did not adhere to the search policy. Only one patient out of 21 raised the methods used to search patients as an area of concern.

Staff completed training about how to search a patient and maintain the security of the environment; most recent figures showed 83% of staff had completed this training. At the beginning, middle and end of each shift, staff checked the security of the ward. This included checking the perimeters of the building and that the patient's had replaced all cutlery after meals. We reviewed the documentation and spoke to staff. This showed staff had carried this procedure out routinely on a morning and evening, but did not always record that they had completed the lunch time check of the cutlery on Brook ward.

We asked the staff about what was different for a patient on a medium secure ward to a low secure ward. They said low

secure wards had unescorted access to the ward areas, garden, and their utensils were ceramic and not plastic, patients possessions were different and escorted leave varied. In addition, patients had access to mobile phones on low secure wards and different furniture. However, the prohibited and restricted items policy reviewed November 2014 did not differentiate between low and medium secure and did not reflect staff practices. This showed that Brook ward (medium secure) had fewer restrictions than a low secure ward. Also, Foss ward (low secure) had the same restrictions as Gill and Hebble wards (medium secure). This meant that staff may not follow a consistent approach and patients may not understand how a low secure service is less restrictive than a medium secure service.

We saw one incident where staff had implemented a restriction on all the patient's regardless of the level of individual risk, (blanket restrictions). On Hebble and Brook wards patients had to ask staff for a cold or hot drink. The registered manager responded immediately to make sure patient had access to make a drink.

Staff were able to detail and describe the application of guidance from Department Of Health, Positive and Proactive Care: reducing the need for restrictive interventions. The managers had introduced a new de-escalation training package for staff.

Eighty one percent of staff had completed the annual update of their management of violence training. Our observation of one incident, the review of records and discussion with staff showed that staff used the least restrictive practices when carrying out restraint. Staff reported that when they carried out face down (prone) restraint, they immediately turned the patient over. Staff completed incident forms when they had restrained a patient. The ward manager and the prevention of management and violence training instructor reviewed them to identify any issues or lessons learnt.

Information provided by the hospital also supported this; between 1 January and 1 July 2015, staff had restrained patients 172 times. The restraint was categorised as levels one to three. Staff used the following levels of restraint;

- level one 22 times (arm holds)
- level two 34 times
- level three 104 times (floor restraint).
- Staff used prone restraint (face facing downwards on the floor restraint) 80 times.

The majority of the instances of restraint were on Don ward (22 times) and Hebble ward (46 times) and Isle ward (50 times). The incidents on Isle and Hebble ward were in regards to the same patients. On Isle ward the staff explained they may put the patient in the prone position immediately before they left to vacate the patient's room safely. On Hebble ward, the staff had recognised that the ward did not meet two patients' needs and had taken action to rectify this. We noted from the data that it did not contain the length of time staff had carried out floor restraint and the prone restraint had not resulted in rapid tranquilisation. The collection of this data would enable the management to identify when a restraint may have been for an inappropriate length of time.

Between 1 January and 1 July 2015, staff had secluded patients 81 times. We looked at three seclusion records and found that staff had accurately recorded the period of seclusion.

Staff received training to make them aware of how to recognise and respond to any vulnerable adult and children's safeguarding incidents. Eighty three percent of staff had completed the annual training on safeguarding. Staff had sent 15 safeguarding alerts to the local authority from 1 January to 31 March 2015. Of the 15 alerts, the safeguarding team had closed nine that required no further action, and the hospital awaited further feedback regarding the rest. Managers reported that they met every three months with the local safeguarding team. In addition, the hospital reported all safeguarding activities to NHS England commissioners.

The hospital had a contract in place for the supply of medicines and for four hours of clinical pharmacy support to the wards each week. Additionally, the pharmacist supported the drugs and therapeutics committee where staff discussed all aspects of medicines handling, including a review of any medicines incidents and errors. A seven-day service was in place for the supply of medicines. However, the ward rounds or multidisciplinary team meetings (MDT) did not have pharmacist support and the pharmacists did not engage directly with patients about their medicines. The registered manager said the provider was considering increasing pharmacist support to facilitate this.

We looked at 40 patients' medicines administration charts and staff had completed records accurately, where an error had occurred this had been raised as an incident. Qualified nurses administered most medicines and the hospital had

a protocol for supporting safe medicines self-administration. Some patients managed their own medications under the supervision of a nurse and staff discussed patients' progress at multi-disciplinary team meetings.

However we found some issues with the management of medicines. For example:

- Protocols were not in place to advise ward staff when additional physical health monitoring was required for patients on high doses of antipsychotic medication. This meant there was a risk of increased adverse reactions from the medication. We raised this with the registered manager and we saw staff took immediate action to rectify this.
- We looked at nine records on Foss ward and found self-administration care plans, describing the level of support provided the patient needed, were not in place.
- Full self-administration had not been available to patients on Foss ward for the month prior to the inspection because of a lack of individual lockable storage.
- The hospital had not made easy read medicines information leaflets available to patients.
- Medication training for qualified staff was not updated following induction.

Track record on safety

- From 1 January to 10 April 2015, staff had classified three incidents as serious and requiring review. These consisted of a patient grabbing keys off a member of staff, a patient removed a resin cover from a wall, and staff gave a patient a glass bottle. We saw evidence in staff meeting minutes that reminded staff about the use of glass bottles.

  The hospital had commissioned a 'critical friend review of absconding incidents at the hospital in December 2014, following several patients absconding. An independent health professional carried out the review and recommended that the investigation of incidents needed to be improved. In response eight staff completed investigation training in July 2015 (route cause analysis) to enable them improve their practice.

  However, we also found that the investigation of incidents could be improved. We looked at six serious incidents and found

- The member of staff from the service area where the incident occurred either carried out the investigation or was part of it. This does not promote an independent approach to the investigation.
- The incidents did not contain actions plans to implement recommendations or timescales; and we found no arrangements in place to audit the implementation of the action plans

Reporting incidents and learning from when things go wrong

- The hospital recorded incidents using an electronic system, staff completed the incident forms at the time of the incident, and the ward managers, and the registered manager reviewed the forms and investigated the incidents. Staff collated the information and provided the data to hospital managers. This enabled managers to identify any concerns about individuals or patterns across the wards each month. Following an incident staff and patients talked about the incidents to review whether staff could make improvement to the way they managed incidents in the future.

  Following the inspection, the management team provided information to show staff had recorded 939 incidents between 1 September 2014 and 1 September 2015.

  The staff and clinical risk meetings minutes showed staff and managers had reviewed incidents and looked at ways to improve. We also observed that the management team discussed incidents daily at the morning management meetings. The meeting was attended by all ward managers, the nursing operational manager, and the hospital directors.

Are forensic inpatient/secure wards effective?

(for example, treatment is effective)

Requires improvement

Assessment of needs and planning of care

Requires improvement

Forensic inpatient/secure wards

We attempted to review a full history of the assessment and planning of patients care by staff and looked at three records on each ward, but found that patient notes were not stored in one place and staff did not have full access to the notes.

This was because:

- staff recorded patient notes both electronically and on paper,
- nursing staff kept their written patients' care records in locked cupboards based in each ward,
- the occupational therapists recorded either brief details in the patient paper notes on the ward, or gave a brief verbal handover, and then duplicated this electronically,
- summaries of patients meetings with the psychologist were recorded online and not shared with the ward staff,
- the practice nurse kept their own records and duplicated these in the patient records, and we identified differences in the records,
- other clinical staff such education held their notes separately,
- on Foss ward, one patient's older records identified a physical condition that staff had not carried over to the current file,
- staff were unaware of where to access all of the different records.

This meant that patients' did not have a contemporaneous record that provided staff with the information they needed to make sure that patients received the level of support and care they needed.

The hospital had two part time practice nurses. The nurses had specialist practice and knowledge areas, for example, one had experience of dealing with diabetes whilst another had experience of dealing with asthma. The nurses would do initial checks and then refer the patient to one of the GPs if required. The practice nurse described the physical health checks that they carried out on admission and as part of the annual review. The staff visited patients and carried out pre-admission assessments of their care and treatment needs prior to their admission to Cheswold Park. However, the hospital did not have protocol for staff to follow when they assessed a patient's physical health on admission.

Best practice in treatment and care

The staff team had devised and developed intervention programmes for patients mainly based on cognitive behavioural therapies and interventions recognised by The National Institute for Health and Care Excellence (NICE). The programmes included:

- schema group therapy programme for personality disorder pathway,
- thinking skills for the learning disabilities pathway,
- life minus violence,
- substance misuse,
- anger management,
- sex education. The hospital used a sex offender's treatment programme that had been adapted from a national programme written specifically for probation services contributing towards national guidance.

The occupational therapists used the model of human occupation framework, the model of human occupation screening tool and occupational self-assessment as recommended by NICE guidance.

The psychologists used tools such as the Becks depression inventory, risk for sexual violence protocol and a specific risk assessment for assessing violence and its management (HCR 20). This enabled psychologists to provide the most suitable interventions required for each patient.

Staff used the 'my shared pathway' tool to develop a recovery approach to identifying and achieving outcomes. The recovery star was used for those patients with learning disabilities. Staff used the health of the nation outcome scales (HONOS) to measure the health and social functioning of the patients.

We saw examples where the practice nurses had monitored and supported patients with their physical healthcare; this included access to specialists when needed.

The hospital had developed an individual service for one patient with complex needs and had trained the staff to support them. The hospital had involved independent specialist consultants to make sure the service provision was of a high standard.

We did not find evidence that doctors had taken part in clinical audits in the hospital.

Skilled staff to deliver care

Requires improvement

Forensic inpatient/secure wards

The team included a range of mental health disciplines required to care for the patients. Including consultant psychiatrists, specialist doctors, social workers, nurses, healthcare support workers, involvement workers, substance misuse workers, and occupational therapists.

Staff had the qualifications and skills they needed to carry out their roles effectively. Apart from Mental Health Act training, mandatory training had an overall uptake of over 95%

Staff we spoke with were positive, motivated and passionate to provide good quality care. We observed staff on the ward and in team meetings displaying knowledge about their work.

All staff reported that they attended regular team meetings, where they discussed new guidance and training. In addition, staff described support and time off given by the provider to access developmental training. This included leadership and management, advanced mental health degrees. This was reflected in the team meeting minutes. Also, the managers had supported health care assistants to become registered nurses.

Ninety per cent of staff had completed staff appraisal in the twelve months prior to June 2015.

The senior management team monitored supervision monthly at the audit meeting. The hospital had produced a clinical audit plan for supervision in July 2015. The clinical audit plan in July 2015 had recommendations to review the supervision policies and procedure, improving the recording of supervision, improved clinical supervisors training. However, the July 2015 figures showed staff compliance with supervision on Brook, Foss, Calder and Don wards averaged 53%. Supervision enables the ward managers to check the quality of the staff's work

All of the doctors who were required to had completed their revalidation. The revalidation process reviews the doctor's competency and is a requirement of continued registration with the General Medical Council (GMC).

The hospital provided staff with role specific training. For example, staff had been specifically trained to support the patient on Isle ward. Staff could access computer based learning for physical health and learning disability training.

Multidisciplinary and interagency team work

A multidisciplinary team (MDT) is a group of health care and social care professionals who provide different services for patients in a coordinated way. Members of the team may vary and will depend on the patient's needs and the condition or disorder being treated.

Multidisciplinary meetings occurred fortnightly on all wards. Most meetings were attended by the doctor, patient, psychologist, senior nurse and ward manager. The meetings were well-organised and we saw staff involved patients. Patients were given simple questionnaires prior to their meeting, so they could express how they were feeling both mentally and physically. The hospital tutor did not contribute to MDT meetings but wrote in patient notes if anything significant had occurred in the session.

On most wards patients said staff had involved them in the multidisciplinary meetings and they discussed receiving feedback from the meetings. However, on Calder ward three out of four patients described not feeling involved.

We observed one care programme approach (CPA) meeting. This was attended by a doctor, the psychologist, the advocate, an occupational therapist, a senior staff nurse, a student nurse, the patient and a relative. CPA meetings occurred every three months for each patient. Psychologists and occupational therapy would contribute to these meeting with a formal report for each patient. A CPA is a way that all inpatient and community services are assessed, planned, coordinated, and reviewed for patients. However, on Aire and Foss wards, staff felt their opinions in decision making were not taken into account.

A verbal handover of information about the patient's occurred on all wards in the morning and evening. A qualified member of staff, who was finishing work, led the handovers and all staff starting work attended. In addition, all the hospital directors, the registered manager, and ward managers attended a morning meeting where information about all the wards was shared.

Adherence to the Mental Health Act (MHA) and the MHA Code of Practice

Staff demonstrated an awareness of the Mental Health Act (MHA) and informed us that they received advice and guidance from the MHA officer situated on the premises. However, compliance in attendance at MHA training was

Forensic inpatient/secure wards

low. Fifty-nine per cent of staff were compliant with MHA update training as an average for the whole hospital staff team. The lowest wards for compliance were Don and Foss wards at 32% compliant.

The hospital had systems in place to support adherence to the MHA and the MHA Code of Practice. Patients' records had the relevant information for treatments. All pre-admission papers were available and checked by staff before the patients were transferred. Staff completed seclusion papers correctly. Section 17 leave forms were authorised and completed as required.

The hospital had a MHA administrator who monitored the documentation to make sure it was correct. The MHA administrator also visited wards to speak to patients regarding their rights to appeal and CPAs. Patients had their rights under the MHA explained to them on admission and at regular intervals following admission

We did not see any Care Quality Commission (CQC) notices present or information for patients detained under the MHA on Don, Foss and Gill wards. On Calder and Aire wards, CQC information contained old details and staff had not updated the address. This meant that if a patient wanted to contact the CQC to complain about their detention, they would have been unable to do so.

Good practice in applying the MCA

The senior managers informed us that training in the Mental Capacity Act (MCA) was incorporated into MHA training. Ward managers and qualified staff understood the process to follow should they have to make a decision about or on behalf of a person lacking mental capacity.

Staff followed the five statutory principles of the MCA. Best interest decisions had taken place, for example, regarding patient finances, and decisions about care for physical health needs. . The patient, family members, social worker and an advocate attended best interest meetings. Support workers had varied knowledge of the MCA but said they would always seek advice from more qualified staff.

Are forensic inpatient/secure wards caring?

Good

Kindness, dignity, respect and support

We spoke with 26 patients about their experiences of care. On Hebble, Aire, Foss and Brook wards, four patients told us that the staff had treated them with kindness and respect. However, three patients on Gill ward told us they did not feel respected because staff searched their rooms and staff were always in the office. Also on Don ward, two out of four patients told us that they found the staff uncaring. On Calder ward, three out of six patients described the agency staff historically as uncaring and disrespectful, with one stating staff responded to them in an "aggressive" manner. We discussed this with the registered manager who confirmed this had been investigated and referred to safeguarding.

At the inspection, we observed patient interaction with staff and saw staff responded to patients in a calm and respectful manner. We saw one incident on Hebble ward that the ward manager responded to in an attentive and supportive way.

The involvement of people in the care they receive

Each ward held community meetings. On Brook, staff and patients attended a meeting once a week. The minutes showed that patients had the opportunity to make various requests. Gill ward had held three meetings since January 2015 and staff had mostly reminded patients about cleanliness and behaviour towards others. The records had very few patient comments. On Hebble ward, a patient chaired the meetings; staff had held six since January 2015. There was a structured approach to the meeting and the minute's demonstrated good patient involvement. Foss ward held daily meeting, Don ward had daily meetings to decide about activities that day and weekly meetings to discuss any issues. Calder ward had weekly meetings; Esk ward had three community meetings since January 2015.

On most wards staff had involved patients in their care plans, apart from Calder ward where three out of four patients described not feeling involved.

The hospital had an independent advocate for 20 hours a week. They confirmed that staff referred patients to the service and they attended multidisciplinary meetings to support patients. On Gill ward, a patient told us how the advocate had assisted them to make a complaint. However, on six wards staff had not displayed information about the advocacy service. Patients also gave a mixed response about whether they saw the advocate or not on the wards.

Requires improvement

Forensic inpatient/secure wards

The hospital had carried out a patient survey in March 2015. This showed out of 88 patients, 61 knew about their care plan and that patients wanted more activities at weekends. In response to the findings, the hospital planned to increase occupational therapy from five to seven days a week. However, we did not see a specific action plan about this.

Are forensic inpatient/secure wards responsive to people's needs?

(for example, to feedback?)

Good

Access and discharge

The hospital had discharged 23 patients from August 2014 to August 2015. The number of beds occupied in the hospital in July 2015 averaged 89%.

The statement of purpose stated that the learning disability care pathway comprised of two medium secure wards, Hebble and Gill wards. Hebble ward as an admission ward for patients with complex and challenging illnesses who had a dual diagnosis of mental disorder and learning disability. Once assessed the patients would move to Gill ward, the rehabilitation and recovery ward, if beds were available. From Gill ward patients could be resettled into the community or move to a less secure environment.

On Hebble the average length of stay was three years and on and Gill ward two years. At the time of our visit on Hebble ward, two patients were awaiting discharge. One patient's discharge had been delayed because they were waiting to move to a specialist service. The ward manager on Gill ward reported that they had discharged three patients in the last six months.

Patients with a primary diagnosis of mental illness where admitted to either Brook ward a medium secure unit or the five low secure wards. Brook wards average length of stay was under 18 months, with the exception of one patient who staff had found difficult to discharge due to their complex needs and diagnosis. The average length of stay for the five low secure wards was dependent upon whether the ward was for admission and assessment or rehabilitation but ranged from just under a year to three years.

Prior to our inspection the senior management team had commenced a review of all patients to make sure that they were appropriately placed.

The hospital had responded to the specific needs of one patient for who they had designed an environment and service to meet their particular needs. The patient's records demonstrated this had helped to improve the patient's experience.

A review of the 47 patients' records found that the wards used a variety of ways to engage a patient in their discharge. For example, discharge was discussed in the care programme approach meetings every three months, some wards followed the hospitals my pathway to recovery workbook, or my recovery pathway, and Brook ward had discharge plans. During the inspection, due to patient information being held in different places and in different formats, we found it difficult to be clear about what specific documentation was used by the hospital to plan for discharge. We discussed this with two members of the senior management team who agreed that the documentation did not provide a consistent approach to the planning of patients' discharge.

The facilities promote recovery, comfort, dignity and confidentiality

The hospital had a multi-faith room and a room where patients could meet their visitors.

Patients had access to their bedrooms at all times, and had decorated their bedrooms. All patients apart from Brook ward, the medium secure admission ward, had keys to their bedrooms.

The hospital had provided an environment for one patient with complex needs that was specific to their individual care needs.

All the wards had a patient telephone on the ward that staff connected to external telephone numbers. On the low secure wards, patients had access to mobile phones, and used prepaid telephone cards.

On the medium secure wards, staff supervised patients when they used the garden. However, the garden on Hebble ward overlooked the general car park and this did not promote the patient's privacy. On the low secure wards apart from Don ward patients had free access to the enclosed gardens.

Requires improvement

Forensic inpatient/secure wards

On Brook and Hebble wards, we saw patients asked staff for hot drinks as and when they wanted one. On Gill ward, patients had access to hot and cold water flasks to make drinks. Patients on the low secure ward apart from Don ward could make themselves a hot or cold drink.

The hospital had twelve occupational therapy staff, a gym instructor and a teacher. They ran a full activity programme off the wards. The hospital had a pond, animals and activity rooms, a music room and a training kitchen.

We observed a tutor group where patients were starting a social enterprise in catering. The group covered market research skills, recruitment interviews and budgeting.

On Gill ward, we saw the activities timetable included bingo, fishing, cooking, shopping, football, pool table, badminton and gardening. Patients made positive comments about their access to activities. Most patients confirmed activities were available. On Foss ward, six out of 11 patients were on leave at the time of our visit: two fishing, one on two nights leave, three on a trip to Blackpool. Also, staff had booked patients to go to a local super market. One patient told us staff had supported them with an art degree course. Most patients confirmed activities were available during the week.

On Brook ward we saw one patient who had been on the ward for a long period of time had an extensive timetable which included, cooking, playing cards, using escorted leave into the town, having takeaways, playing bingo, using the garden and receiving visits.

Patients on all the wards stated that there were no activities on evenings or weekends. Staff informed us that each patient had an individual therapy timetable kept in their ward files, but we checked three wards and these were all out of date.

The hospital did not carry out patient-led assessments of the care environment surveys, but the patients' survey of March 2015, showed 48 out of 82 patients made positive comments about the food. Staff took one patient who had a food allergy to buy their own food.

Meeting the needs of all people who use the service

The hospital had disability access and most areas appeared to be accessible in a wheelchair. The furniture was designed to meet the needs of the patients.

The hospital had a place of worship, but the chaplain only came once a month..

Patients on Aire ward confirmed staff enabled access to interpretations services.

Staff had displayed information on noticeboards to inform patients about the hospital. However, we saw this did not always include information about the advocacy services.

Listening to and learning from concerns and complaints

The hospital had a timescale for responding to complaints: two days for a response and 20 days to complete a report. If it took longer, they would inform the person who had made the complaint. We looked at four complaints and saw staff had carried out thorough investigations. Staff confirmed that they supported patients to make complaints, using the hospital form that went to the administration department that allocated them for investigation. The agenda for the wards clinical governance meetings included a review of any complaints. We saw that senior managers went on to the wards to speak to patients and discuss their concerns.

Fifteen out of the 22 patients we talked with said they knew how to make a complaint. In the hospital's patient survey in March 2015, 23 patients gave a positive response when asked about complaints and 16 gave a range of negative responses.

Many of the wards did not display information for patients about how to make a complaint apart from Gill ward. Foss and Brook wards had recently moved and the staff said they had not yet replaced the notices.

The hospital received 82 formal complaints between July 2014 and May 2015. There had been 15 complaints originating outside of the hospital from the public, and three of these had been upheld. Don and Foss ward had the highest number of complaints upheld. Don ward contributes 30% of the total complaints received for the Cheswold Park Hospital. The complaints that staff upheld on Don ward related to removal of patients' property, staff refusing to let a patient have a personal possession in their bedroom and about staff attitude. The complaints upheld on Foss ward related to concerns regarding staff members and the amount of butter available at mealtimes. This showed us that the staff had responded to complaints.

Requires improvement

Forensic inpatient/secure wards

Are forensic inpatient/secure wards well-led?

Requires improvement

Vision and values

The ward managers understood the vision and values of the hospital and other staff shared this awareness as the manager had linked the vision and values of the hospital to the team objectives. The ward managers acknowledged that the new managing director had encouraged an improvement of the uptake and development of team objectives.

Since the new managing director had been in post staff said that senior staff and managers were more visible and held regular staff meetings which improved communication from the staff to the senior managers and vice versa.

Throughout the hospital, staff described an improvement in the visibility and support of the registered manager and the managing director who both visited the wards regularly. The senior managers had linked the vision and values of the organisation to the staff appraisal system. The ward manager on Brook described values about affordable high quality care.

The staff survey carried out in July 2015 showed that 91 staff responded out of 289. The majority of employees asked felt that the hospital had a positive work culture and staff were proud to work at Cheswold Park Hospital. In addition 65% would recommend the hospital as a good place to work.

Good governance

The new managing director had implemented a new management structure to improve the quality of service provision in the three months prior to the inspection. This involved each ward having its own manager and a nursing operational manager overseeing all of the wards. However, at the time of our visit, the new systems had not been fully embedded and we found some areas where the managers needed to make improvements. For example:

We found unclear information about when the provider would complete actions or implement timescales. For example, the provider did not have clear timescales in place to make sure the environment was safe. Staff kept patient information in a variety of places and this prevented staff from having access to all the information from the multi-disciplinary team members. This had the potential to affect the assessment and planning of patients' care and treatment needs.

The operational and clinical risk minutes had unclear information about when they would complete actions. Where staff had carried out the investigation of serious incidents and made recommendations, we did not find specific action plans in place. The risk management policy was out of date. We were unable to find a process in place to review the nursing documentation to make sure it adhered to any new National Institute for Health and Care Excellence guidance to make sure the hospital was achieving the best outcomes for patients.

The systems in place to prevent and control infectious diseases and the safe management of medicines needed improving.

The hospital did not have enough quailified nursing staff on at night to cover the wards if an incident occurred or when qualified nursing staff went for a break. The staff uptake of mental health training and clinical supervision needed to be increased.

The seclusion suites needed improvements to ensure they fully protected patients' dignity.

The hospital did not have a clear written protocol to assess a patient's physical needs following admission.

However, we also saw areas where the managers had displayed good practice or made recent improvements. For example:

Each morning the hospital management team, including representatives from each ward met to discuss any incidents that have occurred on the wards and what actions they needed to take. Following this, the managers met to review the staffing numbers on each ward to ensure that the wards had sufficient skilled staff, of the necessary gender to meet patients' needs.

The hospital held a monthly governance meeting chaired by the clinical director; we reviewed the minutes for May, June and July 2015. Ward staff had completed monthly

audits regarding patient file/information, risk assessment, and supervision. Where staff needed to make any improvements the managers gave a timescale of one month.

The hospital had a newly implemented risk register. The management team reviewed the risk and if they met the criteria be moved onto a risk treatment plan. The risk treatment plan had information about what actions staff would take, who was responsible for taking the actions, and when staff must complete the actions by. The senior management team planned to cascade this information to the wards. The minutes of the meeting of the 6 June 2015 also demonstrated that the senior management team was looking at reviewing this system.

The hospital collated information about incidents, restraint and complaints to review any patterns.

The hospital had reviewed staff employment contracts to make sure it improved recruitment of new staff and encouraged the retention of staff. The hospital had a good range of skills in the staff team. Staff had the relevant qualifications needed and received specialist training specific to their roles.

The manager had carried out a staff survey in July 2014.

Patients had regular and well-organised multidisciplinary team meetings.

Managers and staff had listened to the concerns and complaints of patients and responded to them.

Records relating to the Mental Health Act were correct and staff had a good awareness of the Act.

The managers had involved patients and carried out a patient survey in March 2015. The hospital managers had identified where patients had remained on wards for a long time and had commenced reviewing whether Cheswold Park was the appropriate hospital for them.

The hospital had a fishing pond and animals within its grounds. The patients had a variety of activities they could attend during weekdays.

Patients had regular leave from the hospital.

Leadership, morale and staff engagement

The hospital staff had an awareness of the need to be open and transparent but the hospital did not have did not have policies or procedures for staff to follow regarding the duty of candour. (The duty of candour is a legal duty on hospitals to inform and apologise to patients if there have been mistakes in their care, which could have led to significant harm).

The new managing director had implemented a new management structure that meant each ward had a manager that was present on the ward and appointed a new nursing operational manager. The ward managers said that following the changes they felt they now had the authority and support to carry out their work.

Staff on Gill, Brook, Calder, Aire, Esk, Foss and Hebble wards said morale was good. Their senior and line managers supported them and they could raise a concern or complaint with them. Some said they felt the organisation was now moving in the right direction. Staff from Don and Calder wards informed us that morale was low on their staff teams. They attributed this to lower staff numbers and the reliance on agency and bank staff. The wards had also both seen recent changes in ward management. At the time of our inspection, the new managers had introduced some changes regarding staff accountability. Information provided demonstrated that the wards and clinical teams had held staff meetings.

We observed that the managing director, medical director and director of nursing with a representative from each ward attended a meeting at nine am daily to discuss the management of the hospital. Staff talked openly about the needs of the patients and staff that day. Staff sickness for the twelve months prior to the inspection was 4.4%.

Information provided demonstrated that the hospital managers had taken action and investigated where staff had raised concerns about other staff members (whistleblowing). Staff did not express any concerns about raising concerns to the managers. The staff survey carried out in July 2015 showed that 91 staff responded out of 289. The majority of staff believed that the managers consistently responded to unacceptable behaviour by other staff. In addition, half the staff surveyed agreed or strongly agreed that they have sufficient time to do their job well.

Commitment to quality improvement and innovation

The hospital had completed the quality network for forensic mental health services, annual review cycle for both the low and medium secure services.

Requires improvement

Forensic inpatient/secure wards

The quality network reviewed the services against the standards for medium secure and low secure services in December 2014. The medium secure report commended the high level of patient involvement at the service, with patients' views and opinions considered in a range of decisions, from the ward environment and care planning, to the revision of policies and recruitment of new staff. The reviews had 111 standards and the hospital had met 101 in the medium secure wards and 97 in the low secure wards. For both, a standard that was partially met was the environment risks regarding the ligature points in the bedrooms and the difficulty in observing patients in their rooms at night.

The hospital had completed the framework of quality assurance for responsible officers and revalidation, annual organisational audit, end of year questionnaire 2014-15, from NHS England. The framework of quality assurance provides an overview of the elements defined in the responsible officer regulations, along with a series of processes to support responsible officers and their designated bodies in providing the required assurance that they are discharging their respective statutory responsibilities.

Outstanding practice and areas for improvement

Outstanding practice

The hospital had developed an individual service for one patient with complex needs and had trained the staff to support the patient. The hospital had involved independent specialist consultants to make sure the service provision was of a high standard. This involved designing the environment specifically for the patient and ensuring the staff had specific training about how to meet their needs. This had improved the experience of the patient at the hospital.

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure there is an appropriate timescale for how long it will take to remove the ligature points in the bedrooms and en suite bathrooms and improve the ability for staff to see patients in their bedrooms at night.
- The provider must ensure staff improve infection control procedures and protect patients against the spread of infections by ensuring staff are trained to carry out the cleaning in the communal areas at weekends. In addition, the provider must ensure that the toilets in the seclusion suites meet infection control standards.
- The provider must improve the administration of medication. For example, the hospital had not followed new guidance and checked patients' physical health when administering high doses of medication. Nine patients on Foss ward did not have care plans in place to instruct staff about how the patients had to administer their own medication. Following induction, the hospital did not provide updates of medication training.
- The provider must ensure all wards have sufficient numbers of qualified, competent, skilled and experienced staff deployed at all times.
- The provider must ensure all members of the multidisciplinary team share, and have access to, an accurate, complete and contemporaneous record in respect of each patient. This must include a record of the care and treatment provided to the patient and decisions taken in relation to that care and treatment.
- The provider must ensure the hospital has policies in place relating to the duty of candour and that staff are aware of their obligations.

Action the provider SHOULD take to improve

- The provider should ensure that the prohibited and restricted items policy reflects staff practices and the differences between low secure and medium secure wards.
- The provider should ensure the hospital has a clear written protocol to assess the patient's physical health needs following admission.
- The provider should ensure that staff complete the Mental Health Act and Mental Capacity Act training.
- The provider should make sure that all staff have the necessary supervision to enable them to carry out their role safely.
- The provider should ensure staff follow a consistent approach when completing discharge planning documentation, so that the patients' understand their pathway towards discharge,
- The provider should make sure minutes of the operational and clinical risk meetings have information about when staff will complete actions. In addition, where staff have carried out the investigation of serious incidents and made recommendations, the provider should ensure measurable action plans are in place.

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 12 HSCA (RA) Regulations 2014 Safe care and treatment How the regulation was not being met: The wards had fixed points that patients could attach something to that may enable them to self-harm by hanging (ligature). With an added risk of staff not being able view patients on a night through the spyholes. The provider did not have agreed timescales to resolve these issues. There was not proper and safe management of medicines. The cleaning and maintenance of the toilets in the seclusion areas was not sufficient to prevent the risk of the spread of infections. The staff who are required to clean must be appropriately trained. Including ward staff who undertook this role at weekends. This is a breach of regulation 12 (2) (d) (g) (h)

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 18 HSCA (RA) Regulations 2014 Staffing How the regulation was not being met: The hospital did not have enough qualified nursing staff on at night to cover the wards if an incident occurred or when qualified nursing staff went for their breaks. This is a breach of regulation 18 (1)

Regulated activity	Regulation

This section is primarily information for the provider

Requirement notices

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 How the regulation was not being met: Staff kept patient information in a variety of places. This meant staff did not have access to all the information from the multi-disciplinary team. This had the potential to affect the assessment and planning of patients' care and treatment needs. This was a breach of regulation 17 (1) (c)

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 20 HSCA (RA) Regulations 2014 Duty of candour How the regulation was not being met: The hospital did not have policies or procedures in place for staff to follow relating to the duty of candour. This is a breach of regulation 20