

Elysium Healthcare No.2 Limited

Thornford Park

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	Requires Improvement	
Are services safe?	Requires Improvement	
Are services effective?	Requires Improvement	
Are services caring?	Good	
Are services responsive to people's needs?	Requires Improvement	
Are services well-led?	Requires Improvement	

Summary of findings

Overall summary

Thornford Park is a 129 bedded hospital providing inpatient medium and low secure forensic mental health services including a ward for people with learning disabilities and a ward for people with autism. It also has two psychiatric intensive care units (PICUs) and three rehabilitation flats.

Our rating of this location went down. We rated it as requires improvement because:

- There were high nursing vacancy rates at the service. The hospital utilised agency staff to fill these gaps, however this was not always possible. This meant that the wards were sometimes short-staffed and on the forensic wards this had an impact on patients being able to take leave. This had an impact on patient's wellbeing and could impact on their recovery. At our previous comprehensive inspection in 2017 we told the hospital it must make improvements to ensure it always has enough appropriate staff to meet patients' needs; this was, and remains a breach of the Health and Social Care Act regulations.
- Governance and oversight processes at the hospital required improvement. The quality of care records on the forensic and PICU wards was variable. Kingsclere ward had very thorough and comprehensive records, while records on Bucklebury ward were less personalised and did not include adequate mitigation plans for identified risks. Care records did also not reflect the patient voice.
- The forensic wards looked very tired and required refurbishment. These were due to be renovated, with a programme of works due to commence in 2022.
- Staff utilised the National Early Warning System (NEWS 2) to monitor the physical health of patients. However, on the forensic and PICU wards it was not always documented what action had been taken when indicated which meant that the physical health needs of patients may not have been acted upon, placing them at risk.
- Some patients on Bucklebury and Hermitage wards told us they did not feel safe due to the risk of violence from other patients. Violence and aggression was the most common incident type reported on the wards.
- On Headley ward a patient had two T2 forms signed by two different approved clinicians in place authorising different medicines (a T2 form confirms that a patient is capable of understanding the nature, purpose and likely effects of a treatment and that they have consented to receiving this). This could have led to a patient receiving the wrong medicine, or not receiving medicine they should have.
- On Curridge ward we found that a defibrillator wasn't working. This had not been identified because the relevant audits of emergency equipment had not been carried out.
- Patients on the PICUs told us that there were not enough activities to occupy them during evenings and weekends.
- Staff on the PICUs did not always receive regular individual supervision. Compliance rates for individual supervision in the quarter prior to the inspection were 68%.

However:

- The learning disability and autism wards were rated as good overall. Staff demonstrated a commitment to providing person-centred care for patients and we saw some excellent use of communication methods.
- Staff had handled the COVID-19 pandemic very well. None of the patients at the hospital had tested positive since April 2020.
- The senior leadership team had a good understanding of the key challenges the service faced. The hospital director was a visible presence throughout the hospital and approachable for patients and staff.
- The provider had worked with a local university to develop an adapted Sexual Offender Treatment Programme (SOTP).

Summary of findings

- Patients we spoke with gave excellent feedback about the way staff treated them. They said they were always kind and compassionate.
- Patients were involved in their care and developments in the hospital. There was a patient council made up of representatives from each ward and patients also attended ward-based and hospital-wide clinical governance meetings.
- Staff were supported to develop in their roles. For example, all ward managers were able to complete level five leadership training.
- The hospital had robust safeguarding procedures in place. Staff had good knowledge of these procedures and the provider had supported 11 staff members to complete level four safeguarding training.
- Patients had good access to physical healthcare and were supported to make healthy lifestyle choices, e.g. offered nicotine replacement therapy and weight management programmes. The hospital also had an onsite gym and ran exercise classes to encourage patients to exercise.
- Staff had recently begun hosting a monthly online carers' forum which provided an opportunity for carers to learn more about the hospital.

Summary of findings

Our judgements about each of the main services

Service

Acute wards for adults of working age and psychiatric intensive care units

Requires Improvement



Rating

Summary of each main service

Our rating of this service went down. We rated it as requires improvement because:

- The environment on Curridge ward was stark and the layout of the communal area was untherapeutic, with furniture all pushed to the sides.
- There were two lead nurses which were shared across the forensic and PICU wards, however we found a number of inconsistencies in how things were done on the PICU wards. Leaders had recognised this and a PICU lead nurse was due to start in post shortly after the inspection. Their focus would be on improving standards on these wards.
- Staff were unaware of the provider's restrictive practice policy and did not understand why some behaviours would be perceived as restrictive practice.
- Staff did not always follow the procedures that were in place to ensure that medicines were safely prescribed, administered, recorded and stored.
- Care plans on the wards were generic and did not reflect the involvement of patients in the development of their plans.
- There were insufficient activities on the wards to provide meaningful, therapeutic engagement for patients to support their path to recovery.
- Staff on the PICUs did not always receive regular individual supervision. Compliance rates for individual supervision in the quarter prior to the inspection were 68%.
- Governance processes did not operate effectively at ward level.

However:

- Staff assessed and managed risk well.
- Staff had a good understanding and knowledge of safeguarding procedures.

Summary of findings

- Staff understood and discharged their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, and understood the individual needs of patients.

Forensic inpatient or secure wards

Requires Improvement



Our rating of this service went down. We rated it requires improvement because:

- The wards looked very tired and required refurbishment. A programme of works was due to begin in 2022.
- There was generally enough staff on the wards to keep people safe, but not enough staff to ensure that patients could always take planned leave from the ward. All of the patients we spoke with told us they had leave cancelled.
- The quality of care plans was variable across the wards and some care plans were generic and not reflective of individual patient needs.
- We found that governance processes required improvement – we found issues with treatment authorisation forms and ligature audits that had not been picked up by the provider's own quality assurance processes.

However:

- Staff assessed and managed risk well. They minimised the use of restrictive practices and followed good practice with respect to safeguarding.
- Ward managers had a good understanding of patients' needs. They knew the patients well.
- 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 and the Mental Capacity Act 2005.

Summary of findings

- Staff treated patients with compassion and kindness, respected their privacy and dignity, and understood the individual needs of patients. They actively involved patients and families and carers in care decisions.
- Staff planned and managed discharge well and liaised with services that would provide aftercare. As a result, patients rarely had their discharge delayed for other than a clinical reason.

Wards for people with learning disabilities or autism

Good



This was the first time we rated this service. We rated it as good because:

- The care provided to patients was of a very high standard.
- Ward managers had an excellent understanding of their services and of patients' needs. They were visible and approachable for patients and staff.
- Care plans, risk assessments and Positive Behavioural Support (PBS) plans were clear and informative.
- Individual needs were met and staff demonstrated skill and kindness. Patients said that they were listened to, could ask for help, were able to participate in their care plans and planning their future. Staff helped them achieve their goals and supported them to make decisions.
- Patients stated they were happy with their care and treatment and the support offered.
- Staff were confident in being able to express their thoughts and on the whole felt really well supported by the ward managers. They felt they were given opportunities to improve their skills and develop.
- The provider had worked with a local university to develop an adapted Sexual Offender Treatment Programme (SOTP).
- Staff ensured physical health was well monitored and documented.
- Discharge plans were discussed and documented as achievable goals for individuals' needs.

Summary of findings

- Staff used verbal de-escalation to manage patient incidents and there was low use of restrictive interventions.

However:

- Some staff on Tadley ward felt that they were not supported by senior staff following incidents, that there were no senior management staff at the debriefing sessions to discuss the management and outcomes of incidents.
 - Staff on Tadley ward were unable to locate the ligature audit for the ward.
 - High fridge temperatures had been recorded on Tadley ward, however no action had been taken to address this.
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Summary of findings

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Summary of this inspection

Background to Thornford Park

Thornford Park is a 129 bedded hospital providing inpatient medium and low secure forensic mental health services including a ward for people with learning disabilities and a ward for people with autism. It also has two psychiatric intensive care units and three rehabilitation flats which can accommodate up to eight patients. A full breakdown of the wards is provided below:

- Bucklebury, 12 bedded male acute medium secure unit
- Tadley, 10 bedded male medium secure unit for people with a learning disability
- Hermitage, 14 bedded male rehabilitation medium secure unit
- Kingsclere, 13 bedded male rehabilitation low secure unit
- Donnington, 14 bedded male low secure unit for people with autism
- Headley, 11 bedded male acute low secure unit
- Highclere, 17 bedded male low secure unit for older people
- Theale, Nine bedded male enhanced low secure unit
- Crookham, 11 bedded male psychiatric intensive care unit
- Curridge, 10 bedded female psychiatric intensive care unit
- Midgam, Two bedded male low secure flat
- Ashford, Five bedded male low secure flat
- Donnington Flat, One bed male low secure flat for people with autism

Thornford Park is registered to provide the following regulated activities:

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

There was a registered manager in post at the time of the inspection.

We had previously inspected the service in November 2017. Following this inspection the service was rated good overall, with the responsive key question rated as requires improvement. Following this inspection in 2017 we told the provider it must make the following improvements: The provider must ensure that there are sufficient numbers of suitably qualified, competent, skilled and experienced staff to meet the needs of the patients as patients did not always have facilitated escorted leave or access to enough therapeutic activities to meet their needs and support their recovery journey.

We found that this issue remained at this inspection.

In June 2020 we carried out a focused inspection of Curridge (female PICU) and Tadley (male medium secure unit for people with a learning disability). This was due to concerns raised about the quality of care delivered to patients and about the increasing number of incidents that the provider had sent us notifications about alleged abuse and significant injuries. We did not re-rate this service following this inspection. However, we told the hospital it must take action to:

- Ensure records were up to date and accurate so staff could mitigate risk and meet the changing needs of patients.

We found that this issue remained at this inspection.

Summary of this inspection

What people who use the service say

Patients on the forensic wards told us that staff treated them well and that the wards were clean. All of the patients we spoke with told us that there are not enough staff on the wards and that they sometimes have their leave or planned activities cancelled as a result of this. However, patients told us that while there are not enough staff, the staff who are there are kind, attentive and respectful. Patients we spoke with on Kingsclere ward told us they felt safe at the hospital, however patients on Hermitage and Bucklebury wards said they did not always feel safe due to patients assaulting other patients.

Patients on the PICUs told us that there were limited daily activities offered and the timetable that was provided did not meet their needs in terms of the limited range of activities available and the lack of structured activities in the evenings and at weekends. Patients understood that the recent Covid-19 pandemic had affected their ability to attend occupational therapy led group work and were looking forward to new opportunities becoming available.

Patients on the learning disability and autism wards told us their rights were respected and they understood their rights of appeal. They told us the ward manager was on the ward most of the time. They said they had daily meetings with staff and their comments were taken seriously and action taken on issues they requested. Patients stated they felt safe, and although incidents occurred, staff responded quickly to these and they felt safe.

Some concerns were raised about there not being enough staff all the time, but most of the time there were staff they knew, just sometimes they didn't feel too confident with the agency staff as it takes time to get to know them and trust them.

The people we spoke to said they were happy with their environment and were allowed to personalise their rooms. They also said they were given easy read paperwork if they needed or asked for it and that they felt involved in their care.

Patients on Donnington ward said that they didn't like it when staff shone a torch in their room at night but understood why it was done. They have discussed this at a meeting with staff and this is now being looked into to find an alternative approach to checking patients at night.

How we carried out this inspection

The team that inspected the hospital comprised the head of hospitals inspection for the region, an inspection manager, six inspectors, five specialist advisors and three experts by experience.

Before the inspection visit, we reviewed information we held about the hospital.

During the inspection visit, the team:

- Visited all of the wards and communal areas within the hospital to review the environment and observe how staff were caring for patients
- Observed a variety of meetings including a site business meeting, risk management meeting and ward rounds
- Spoke with 20 patients
- Spoke with four relatives

Summary of this inspection

- Spoke with members of the senior leadership team including the hospital director, deputy hospital director, medical director, director of nursing, director of allied health professionals, director of support services, lead psychologist and lead nurses
- Spoke with 33 other staff including nurses, occupational therapy assistants, healthcare assistants, consultant psychiatrists, ward managers, deputy ward managers, occupational therapists, nurse associates and social workers
- Reviewed four Human Resource files
- Reviewed 48 care records and 38 medicines charts
- Looked at a range of policies, procedures and other documents in relation to the running of the service.

Outstanding practice

We found the following outstanding practice:

- Donnington ward demonstrated some excellent practice in managing communication with people who have autism, they had a variety of communication aides on the individuals' room doors to enable staff to understand how individual patients were feeling that day, ensuring that risk minimisation was first and foremost combined with the individuals wants and needs.
- The provider had worked with a local university to develop an adapted Sexual Offender Treatment Programme (SOTP) which involved patients on Donnington ward and was presented by therapists and ward staff.

Areas for improvement

Action the service **MUST** take is necessary to comply with its legal obligations. Action a service **SHOULD** take is because it was not doing something required by a regulation, but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the service **MUST** take to improve:

- The provider must ensure that there are sufficient staff to facilitate leave for patients on the forensic wards (Regulation 18 (1)).
- The provider must ensure it consistently manages supervision on the PICUs (Regulation 18 (2) (a)).
- The provider must ensure that care records on the forensic and PICU wards are of a consistently good quality and that they include the patient voice. There must be clear mitigation plans in place for any identified risks. (Regulation 17 (2) (c)).
- The provider must ensure that there are robust systems in place to ensure it is clear for staff which medications have been authorised for patients on the forensic wards (Regulation 17 (1)).
- The provider must ensure that on the forensic and PICU wards it is consistently recorded what action has been taken when it is indicated that a NEWS2 score should be escalated (Regulation 17 (2) (c)).
- The provider must ensure that emergency equipment audits are put into place and carried out on Curridge ward (Regulation 17 (2) (a)).
- The provider must ensure that the reducing restrictive practices policy is followed and understood by the staff teams on the PICU wards (Regulation 17 (2) (a)).
- The provider must ensure that a range of therapeutic activities is available to meet patients' needs in the PICUs in accordance with guidance from the National Institute of Health and Care Excellence (Regulation 9 (1)).

Action the service **SHOULD** take to improve:

Summary of this inspection

- The provider should ensure that the garden areas are well maintained, including ensuring that any loose flagstones are secured to reduce the risk of accidents (Regulation 12 (2) (d)).
- The provider should consider alternative systems for key management, to ensure that staff can access equipment promptly when needed (Regulation 12 (2) (d)).
- The provider should ensure that there are regular staff meetings happening on Crookham ward (Regulation 18 (2) (a)).
- The provider should ensure that the local clinical governance structure on the PICU wards identifies actions with timeframes for completion (Regulation 17 (2) (a)).
- The provider should ensure that staff are aware of where to find the ligature audit on Tadley ward (Regulation 12 (2) (b)).

Our findings






Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Acute wards for adults of working age and psychiatric intensive care units	Requires Improvement	Requires Improvement	Good	Good	Requires Improvement	Requires Improvement
Forensic inpatient or secure wards	Good	Good	Good	Requires Improvement	Requires Improvement	Requires Improvement
Wards for people with learning disabilities or autism	Good	Good	Good	Good	Good	Good
Overall	Requires Improvement	Requires Improvement	Good	Requires Improvement	Requires Improvement	Requires Improvement

Acute wards for adults of working age and psychiatric intensive care units

Requires Improvement 

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

Are Acute wards for adults of working age and psychiatric intensive care units safe?

Requires Improvement 

Our rating of safe went down. We rated it as requires improvement.

Safe and clean care environments

Crookham ward was safe, clean, well equipped, well furnished, well maintained and fit for purpose. Curridge ward environment was clean but the environment was older and damaged due to the high acuity of the patients. On Curridge ward clinical room checks and audits were not being carried out regularly.

Safety of the ward layout

Staff completed and regularly updated thorough environmental risk assessments of all ward areas and removed or reduced any risks they identified. We saw completed ligature risk assessments and there were enough staff to observe patients in all areas of the wards.

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

Staff knew about any potential ligature anchor points and mitigated the risks to keep patients safe. Staff were familiar with the wards ligature risk assessments and ward managers or their nominated deputy knew where the high risk ligature points were.

Staff had easy access to alarms and patients had easy access to nurse call systems. Alarms were checked and managed by the reception area and there were checks in place to ensure that all alarms were charged and working.

In the airlock onto Curridge ward there was a staff toilet which was normally left unlocked. The toilet was found to have COSHH (Control of Substances Hazardous to Health) cleaning materials on the shelf which were a risk if a patient managed to push passed staff and access this area. We addressed this immediately with the ward manager who ensured that the room would remain locked and a sign was put up. This issue was not identified on the ward daily environmental checklist.

Maintenance, cleanliness and infection control

On Crookham the ward area was clean, well maintained, well-furnished and fit for purpose. The ward environment on Curridge was older and in need of updating to match the environment on Crookham. The fixtures and fittings on

Acute wards for adults of working age and psychiatric intensive care units

Requires Improvement 

Curridge were well worn and the environment was stark and untherapeutic. It was unclear whether the five year renovation and improvement plan for the hospital would mean all the wards would be brought up to the same specification that some parts of the hospital had been upgraded to or whether this was just to undertake general, more basic updating and maintenance.

Staff across both wards followed infection control policy, including handwashing and it was evident that additional infection control procedures had been introduced in order to manage the spread of Covid 19.

Seclusion room

The seclusion room available to Crookham ward was just outside the ward environment and met the environmental criteria for seclusion as described in the Mental Health Act Code of Practice.

The seclusion room on Curridge ward was occupied at the time of the inspection which meant we were unable to fully inspect it. Within the three months prior to the inspection there had been 17 episodes of seclusion on Curridge ward. In five of these episodes patients from Curridge ward had been secluded elsewhere due to the seclusion suite already being occupied.

Clinic room and equipment

The clinic room on Crookham ward was fully equipped with accessible resuscitation equipment and emergency drugs that staff checked regularly. Clinic room checks were happening and staff maintained and cleaned the equipment.

On Curridge ward the clinic room was equipped with accessible resuscitation equipment but at the time of the inspection there were no regular checks and audits of clinic room equipment happening. The ward manager had not reallocated the responsibility for this when the previous responsible person had left the ward. The defibrillator was found to be out of use as the battery had expired and this had not been picked up by ward audits. This was addressed with the lead nurse and a new defibrillator was put on the ward during the inspection. The issue of no clear oversight of clinic room audits had been identified by the organisation in a “dealing with medical emergencies audit” carried out in March 2021. The actions identified in the audit were to “establish and develop a formal system” but this had not been completed at the time of the inspection.

Safe staffing

The service had enough nursing and medical staff, who knew the patients and received training to keep people safe from avoidable harm.

Nursing staff

The service used locum agency staff who were familiar with the wards and knew the patients well, to fill vacancies. The PICU wards had a total of four registered mental health nurse vacancies and 8.7 support worker vacancies. Managers told us that ongoing recruitment was happening in order to fill the vacancies. The staffing issue was identified on the hospital risk register as an amber risk and was being reviewed monthly by the senior management team.

The ward manager on Curridge was able to adjust staffing levels according to the needs of the patients. On Crookham there was no ward manager in post and the ward was being overseen by a lead nurse who was able to make adjustments to the rota dependent on patient needs. The ward manager post had been vacant since February and the hospital was in the process of recruiting to the position.

Acute wards for adults of working age and psychiatric intensive care units

Requires Improvement 

Staff knew which incidents to report and how to report them. Managers debriefed and supported staff after any serious incidents. Staff told us that the senior management team offered debrief opportunities if needed.

Patients reported that there were not always enough female staff on Curridge ward to support the 1:1 and 2:1 staffing requirements. During the inspection we observed this, with one female patient almost completely supported by two male staff members at all times during the day. This meant that it was difficult for the patients' needs to always be met when required as staff had to be swapped around within the hospital to maintain this need and could pose a risk to the privacy and dignity of patients. Managers told us that female staff would be assigned to observe patients during personal care and would also be assigned if this was a need identified within their care plan.

Medical staff

For each of the PICU wards the consultant psychiatrist was shared with one other ward. The wards had speciality grade doctors working under the consultants. On Curridge there was also a nurse practitioner, but this was not the case on Crookham.

Managers could call locum medics when they needed additional medical cover.

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

Out of hours the hospital operated with a first and second on call system. The first on call was the nurse practitioner and the junior doctors and then if additional support was required the second on call were the consultants on a rotation.

Medical cover was provided by a GP who attended the hospital and patients on Crookham could access the weekly GP clinic. The on-call GP would attend if required.

Mandatory training

Managers monitored mandatory training and alerted staff when they needed to update their training. Information provided by the hospital identified that figures for the whole hospital were good.

Assessing and managing risk to patients and staff

Staff assessed and managed risks to patients and themselves well and followed best practice in anticipating, de-escalating and managing challenging behaviour. Staff used restraint and seclusion only after attempts at de-escalation had failed.

Assessment of patient risk

Staff completed risk assessments for each patient on admission. Basic risk assessments were in place across the two wards. Staff updated risk assessments regularly.

Hospital wide clinical governance meeting minutes indicated that during June the hospital as a whole had no incidents of prone or supine restraint that exceeded 10 minutes.

Staff carried out patient risk assessments using recognised risk assessment tools, which included historical information as well as short-term assessment of risk and treatability. Staff included factors which protected patient's wellbeing.

Management of patient risk

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

Acute wards for adults of working age and psychiatric intensive care units

Requires Improvement 

Staff could observe patients in all areas across both wards.

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

Use of restrictive interventions

Levels of restrictive interventions were not being effectively monitored and managed across the wards. On Curridge ward the staff were aware the organisation had a reducing restrictive practices monthly meeting but were not aware of any changes that had been made or were being monitored as a result of this monthly meeting. Staff were not aware of a reducing restrictive practices policy.

Staff could not always identify restrictive practices and it was perceived as something that was in the process of being reviewed. This meant there were many restrictive practices that were in place that were not being reviewed to see if they were still necessary. For example, patients did not have access to keys to their rooms or lockable storage in their rooms they could access. Most internal doors were locked, including access to the laundry and de-escalation rooms. Staff locked the laundry rooms due to them containing high risk items. Patients could request access from staff at any time. The gardens on both wards were open during daylight hours and accessible with staff at night.

Staff made every attempt to avoid using restraint by using de-escalation techniques and restrained patients only when these failed and when necessary to keep the patient or others safe. Patient restraints and seclusion were being reviewed on every ward by the monthly reducing restrictive practices meeting.

Safeguarding

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

Both the wards had identified safeguarding leads who ensured that if a safeguarding issue was identified that the correct investigation was carried out and reported to the local authority when required.

Staff understood how to protect patients from abuse and the hospital worked well with other agencies to do so. Staff had face to face training in safeguarding adults and children in their induction and then used e-learning modules to ensure they were up to date. Across the hospital 85% of staff were up to date with safeguarding training level one and 85% of staff were up to date with safeguarding training level two.

Ninety one percent of staff had also completed training in Prevent, which is training designed to support vulnerable people from engaging in any threat from terrorism.

Staff access to essential information

Staff had easy access to clinical information but they did not always maintain high quality clinical records.

The quality of the clinical records was variable across the two wards. We reviewed eight sets of patients' electronic notes and found the daily notes were comprehensive and detailed the patient's presentation for the shift. However, the four sets of care plans we looked at on Crookham were not holistic and at times were generic. Care plans on Crookham ward did not include the patients voice or involvement and lacked input from occupational therapists and psychologists.

Acute wards for adults of working age and psychiatric intensive care units

Requires Improvement 

Medicines management

The service had systems and processes to safely prescribe, administer, record and store medicines however these systems were not always followed. Staff did not regularly review the effects of medications on each patient's mental and physical health.

We reviewed 16 patients' medicines records and saw that staff mostly followed the correct procedure and practices for prescribing and administering medicine. The hospital used an external pharmacy company to audit and advise the clinicians and the clinical governance team on the safe management of medication, however this may not have been effective as we found a number of issues across the wards. Out of the eight medicine cards we reviewed on Curridge ward we found one card had signature omissions and one of the cards had not been dated by the prescriber. Three of the medicine cards had had more than one antipsychotic prescribed and where the dosages exceeded the BNF (British National Formulary) limits there were no high dose antipsychotic therapy forms in place. We were told that the forms were due to be completed at the next ward round. One of the patients was receiving Lithium and Clozapine treatment, the clozapine monitoring was in place however the Lithium monitoring was not in place. The nurse practitioner put this into place during the inspection to ensure it was addressed.

The wards had two clinic rooms that had the relevant equipment. On Curridge ward the recording of the emergency equipment was sporadic, the last weekly check recorded was over a month prior to the inspection. We were told that the nurse in charge of the checks had recently changed their hours and it had not been reallocated at the time of the inspection. The defibrillator on Curridge ward was showing a red cross in the window indicating it was not able to be used. This had not been picked up as the checks had not been reallocated. The hospital had a number of new defibrillators and a new one was brought to the ward on the day of the inspection.

Room temperatures and fridge temperatures were recorded and audited regularly. The clinic rooms all had labelled containers for the safe disposal of medicines which was signed for securely by two nurses.

The hospital had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely.

The service used a system for monitoring escalations in physical health related issues for all patients called NEWS2 (National Early Warning Score 2). Some staff across both wards were confused with where the NEWS2 forms should be kept. Some staff stated they should be kept with the medication cards and some staff believed they were held in a separate folder. When we located the NEWS2 forms we found NEWS2 forms were present for all patients however some recordings were not scored and where scores had indicated an escalation, the correct escalation procedures had not been followed.

Reporting incidents and learning from when things go wrong

Staff recognised incidents and reported them appropriately. Managers investigated incidents, but not all staff felt that the managers shared the lessons learned.

Are Acute wards for adults of working age and psychiatric intensive care units effective?

Requires Improvement 

Our rating of effective went down. We rated it as requires improvement.

Acute wards for adults of working age and psychiatric intensive care units

Requires Improvement 

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 holistic and recovery-oriented.

We reviewed eight sets of care records and found care plans were variable across the two wards. Some of the care plans on Crookham ward did not always reflect patients' assessed needs and the patients voice. The care plans were prescriptive and generic detailing what the staff would do to the patient and not how patients and staff would work collaboratively.

Audits of care plans were carried out on both wards and fed back to the managers or nominated deputy in managerial supervision. Some patients we spoke to told us that they did not feel involved in their care planning, and some did not know they had a care plan.

The service utilised an electronic patient recording system called care notes to record and store patient correspondence. This system ensured safe storage of personal information.

Best practice in treatment and care

Staff did not fully provide a range of treatment and care for patients based on national guidance and best practice. Staff used recognised rating scales to assess and record severity and outcomes.

Staff delivered a very brief occupational therapy activity program of two sessions a day Monday to Friday during the day, this was not in line with National Institute for Health and Care Excellence (NICE) guidelines which recommend meaningful and culturally appropriate activities seven days a week and not limited to 9am to 5pm. Occupational therapy staff told us that this was under review. At the weekends activities were allocated to ward staff to do such as one session of table tennis for Saturday but this was not always carried out due to staff availability. Patients felt that there was not enough to do to engage them.

Staff made sure patients had access to physical healthcare, including specialists as required. A GP visited the hospital twice a week and patients were able to visit the main hospital building for appointments.

The wards had limited psychological interventions which were based on patient need. A permanent psychologist worked on Crookham ward, with support from an assistant psychologist one day per week. A locum psychologist worked on Curridge ward, however a permanent candidate had recently been appointed. An assistant psychologist also worked on the ward full time. The input was mostly formulation work and little input of psychological interventions was evident from reviewing the patient care plans.

Staff used recognised rating scales, such as the Health of the Nation Outcome Scale (HONOS) to measure patients' progress on the unit.

Skilled staff to deliver care

The ward teams had access to specialists required to meet the needs of patients on the wards. The ward manager and lead nurse supported staff with appraisals, ad hoc supervision and some opportunities to update and further develop their skills.

A psychiatrist was allocated to each ward, in addition Curridge had a nurse practitioner supporting the psychiatrist and Crookham had a junior doctor.

Acute wards for adults of working age and psychiatric intensive care units

Requires Improvement 

Staff attended reflective practice sessions with a psychologist twice a month. Staff did not always receive individual supervision. Data showed that supervision compliance rates were 68% in the quarter prior to the inspection.

The managers would try to catch up with the staff members once a month but we were told formal managerial supervision was not happening regularly.

Mandatory training was managed off the ward by the training department. When required they would contact the managers who completed the rota and staff were allocated sessions to attend training. The staff also had access to the “Good Practice Hub” which had a library of additional training subjects such as: autism training and trauma informed care training.

Multi-disciplinary and interagency teamwork

Staff 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 ward round meetings to discuss the patients.

The hospital had a contract with an NHS trust and a number of beds on Curridge ward were specifically allocated to patients only from this trust. The staff worked closely with this trust to manage the beds and environment, through regular calls and meetings.

Staff shared information about patients and any changes in their care, during handover meetings. These meetings had a clear structure and the minutes were recorded on the electronic notes system.

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 stored copies of patients' detention papers and associated records correctly and staff could access them when needed. Informal patients knew that they could leave the ward freely, but we did not see any information or posters on the wards informing them of this.

Staff had access to support and advice on implementing the Mental Health Act and its Code of Practice. Staff knew who their Mental Health Act administrator was and when to ask them for support. Patients had easy access to information about independent mental health advocacy. 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 in the patient's notes each time.

Mental Health Act training was part of the mandatory training for all staff. This was currently online training. At the time of the inspection 82% of staff on Curridge and 90% of staff in Crookham had completed this.

Good practice in applying the Mental Capacity Act

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

Acute wards for adults of working age and psychiatric intensive care units

Requires Improvement 

Staff supported patients to make decisions on their care for themselves. They understood the provider's policy on the Mental Capacity Act 2005 and staff on both wards recorded capacity to consent to treatment clearly for patients who might have impaired mental capacity. Staff knew where to get accurate advice on the Mental Capacity Act and deprivation of liberty safeguards.

We found the recording of capacity to consent to treatment on both wards was completed on admission.

Mental Capacity Act training was part of the mandatory training for all staff. This was currently online training. At the time of the inspection 65% of staff on Curridge and 80% of staff on Crookham had completed this.

Are Acute wards for adults of working age and psychiatric intensive care units caring?

Good 

Our rating of caring stayed the same. We rated it as good.

Kindness, privacy, dignity, respect, compassion and support

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

Staff were discreet, respectful, and responsive when caring for patients. Staff were warm, showed a genuine interest in patients' wellbeing and respected patients' privacy and dignity. Staff used effective de-escalation skills to manage conflict well and with confidence. Patients told us that staff were kind.

Carers we spoke with said that staff were very respectful, caring and kept them informed.

Involvement in care

Patients did not feel involved in care planning and risk assessment but the wards actively sought their feedback on the quality of care provided through regular patient meetings on the ward. They ensured that patients had easy access to independent advocates.

Involvement of patients

Some patients we spoke to told us that they did not feel involved in their care planning, and some did not know they had a care plan. Most patients told us that they had not received copies of their care plans.

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

Staff made sure patients could access advocacy services. Advocates visited the wards each week. The advocates would ring the wards weekly to find out if there had been new admissions or discharges.

We saw "you said, we did" boards on the wards but these were not being used at the time of the inspection and had historic information on them.

Acute wards for adults of working age and psychiatric intensive care units

Requires Improvement 

Involvement of families and carers

Staff informed and involved families and carers appropriately.

Staff supported, informed and involved families or carers. Carers told us they felt welcome at the weekly ward round. Staff told us that they had regular contact with families and carers. Staff actively sought patient consent to share information with relatives before sharing information. Patients told us that their families and carers were involved in their care.

The service used video calling during Covid-19 pandemic restrictions, when visiting was not allowed.

Are Acute wards for adults of working age and psychiatric intensive care units responsive?

Good 

Our rating of responsive stayed the same. We rated it as good.

Access and discharge

Staff managed beds well. A bed was available when needed. Staff told us that some patients' discharge was delayed due to non-clinical reasons.

Bed management

Staff managed beds well. Curridge ward had a contract with an NHS trust which commissioned their beds. Crookham ward took referrals from all over the United Kingdom. The manager on Curridge felt very involved in the referral process and was able to review the appropriateness of referrals into the PICU in line with national guidance.

Managers and staff worked to make sure they did not discharge patients before they were ready. We were told the average length of stay in the PICU wards was three to four weeks.

When patients went on leave there was always a bed available when they returned.

Discharge and transfers of care

There was only one patient who had their discharge delayed from Curridge and this was due to availability of a suitable placement in the patient's local area. Managers monitored the number of instances where patients' discharge had been delayed.

Facilities that promote comfort, dignity and privacy

The design, layout, and furnishings of the ward supported patients' treatment, privacy and dignity; however, patients did not have keys to their rooms. Each patient had their own bedroom with an en-suite bathroom. There were quiet areas for privacy but these areas were normally kept locked to maintain the safety of the ward.

Acute wards for adults of working age and psychiatric intensive care units

Requires Improvement 

Patients did not have their own keys for their bedrooms. All the bedroom doors were self-locking and needed a staff member to unlock the door. Patients told us that they felt the ward was too restrictive and they were unhappy with not having a key to their bedroom. Patients did not have lockable storage in their room that they could access. Patients had a small locker on each ward, that contained high risk items. These were in the ward corridors and only accessed by the ward staff.

The hospital had quiet areas and a room where patients could meet with visitors in private. Patients could meet with visitors in rooms located at the reception of the hospital. However, the quiet room and de-escalation room on both wards were behind a locked door.

Patients on both wards could access the gardens during daylight hours. Patients could access the garden with staff at night.

Patients had access to a multi-faith room.

Patients could ask staff to make them hot drinks whenever they wanted. Patients could ask staff for snacks throughout the day. The service provided a variety of food to meet the dietary and cultural needs of individual patients. Patients told us that they liked the food and were given choices.

Meeting the needs of all people who use the service

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

Managers made sure staff and patients could get help from interpreters or signers when needed. Staff told us that they could access translation services when needed. On Crookham ward, staff had requested to use online translation services for the everyday needs of patients whose first language was not English.

Patients could make phone calls in private. Patients also had access to their own mobile phones.

Patients had access to spiritual, religious and cultural support.

Listening to and learning from concerns and complaints

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

Patients knew how to complain or raise concerns. Information was provided to patients in their welcome pack upon arrival. Staff knew how to handle complaints sensitively.

If a complaint could not be resolved, this was escalated to the unit manager. We saw evidence of complaints that had been responded to.

Are Acute wards for adults of working age and psychiatric intensive care units well-led?

Acute wards for adults of working age and psychiatric intensive care units

Requires Improvement 

Requires Improvement 

Our rating of well-led went down. We rated it as requires improvement.

Leadership

Leaders had a good understanding of the services they managed and were visible in the service and approachable for patients and staff.

The hospital director was a visible presence throughout the hospital. Staff told us that other members of the senior leadership team were less visible on the wards but that they were contactable if needed. The director of nursing was relatively new in post and still developing into her role, her team and the vision and direction for nursing.

The senior leadership team had a good understanding of the key challenges the service faced. They were focused on improving recruitment and retention to improve the service for both patients and staff. The provider had worked to develop career progression pathways for staff at all levels to try and improve retention. The hospital director was also working with the group Human Resources director on a project to improve staff recruitment and retention.

Leaders were supported to complete leadership training. For example, the hospital's director of nursing was completing level seven leadership training and some of the ward managers were completing level five. Completion of the training required staff to complete a project which was then used to improve practice at the hospital. For example, staff were completing projects around how to improve the induction for healthcare assistants and least restrictive practice.

Culture

Staff felt respected, supported and valued. They could raise any concerns without fear.

Most staff felt respected, supported and valued within their teams. Staff spoke about there being different organisational cultures across the two wards, with Crookham processes more embedded and staff understanding their roles and responsibilities. Staff felt Crookham ward was more settled and organised despite not having a full time ward manager at the time of the inspection. Staff told us they could raise any concerns to the ward manager on Curridge without fear but did not always feel that they were able to make changes to the running of the wards.

We saw some disconnect between the senior nursing management team and the ward team around decisions taken. Senior managers felt that systems and processes such as the reducing restrictive practices and NEWS2 systems were embedded and functioning but this was not reflected at ward level.

At the time of our inspection, managers told us no grievance procedures were being pursued within the wards and there were no allegations of bullying or harassment.

Staff were aware of the whistleblowing process if they needed to use it.

Staff felt there was a heavy reliance on agency staffing and this sometimes made established staff feel undervalued.

Governance

Our findings from the other key questions demonstrated that governance processes did not always operate effectively at team level and that organisational processes were not always managed well.

Acute wards for adults of working age and psychiatric intensive care units

Requires Improvement 

Staff on the wards told us they were not receiving regular supervision, the ward staff were not always aware who their supervisor was and when they were next due supervision. On the wards there were not always records of supervisions and the online matrix was not up to date.

Safe staffing levels were monitored on a shift by shift basis using a recognised safe staffing tool.

There were no regular staff meetings taking place on Crookham ward. Staff on Curridge ward had attended three team meetings within the last four months. Although staff could give feedback or raise concerns directly with senior leaders via different mechanisms including staff open forums, there was no clear and consistent way of capturing and escalating feedback and concerns from the ward staff teams.

Managers engaged actively with 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 a national population.

Issues such as the checking of emergency medical equipment had been highlighted in the audit “dealing with medical emergencies” in March 2021 on Curridge ward and actions had been identified to address this, however these had not been followed up and this had led to the defibrillator not being regularly checked.






Management of risk, issues and performance

There was a clinical governance structure in place with local meetings happening to ensure information and risk was discussed. We reviewed six sets of local clinical governance minutes and we could see that these issues were identified however actions were being allocated without timeframes for completion and were not being picked up in the following meetings actions arising so we were not reassured they were always being addressed and completed.

Information management

The ward manager and the lead nurse had systems and dashboards in place to support them in their roles. This included information on staffing, supervision and appraisals, training and hospital performance data. It was not clear how these were used at ward level to inform the clinical and managerial supervision processes.

Forensic inpatient or secure wards

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

Are Forensic inpatient or secure wards safe?

Good 

Our rating of safe stayed the same. We rated it as good.

Safe and clean care environments

All wards were safe, clean, well equipped and fit for purpose. The ward décor was tired.

Safety of the ward layout

Staff completed and regularly updated thorough risk assessments of all ward areas and removed or reduced any risks they identified. Staff completed weekly environmental checks of all ward areas and were required to document any required actions for escalation to the maintenance team. The ward manager then signed this off once all outstanding actions had been completed. However, staff on Highclere ward stored equipment such as wheelchairs and a hoist in one of the corridor areas. This meant that patients could not access the handrail along the corridor and presented a falls risk. We told staff about this during the inspection and the obstructing items were removed. Bedroom doors had anti-barricade fittings and staff had recently carried out audits to check that these were in a good state of repair and that staff knew how to use them. The audits highlighted some gaps in staff knowledge around how to use these and that some of the doors on Theale ward had been installed incorrectly. These issues had been reviewed within the site governance meetings and an action plan was in place to address the findings. One of the bedrooms on Highclere ward did not have an anti-barricade fitting. This room was vacant at the time of the inspection and we were told that a risk assessment would be carried out prior to a patient being allocated the room.

Staff could observe patients in all parts of the wards. Some of the wards had blind spots at the end of corridors, however these were mitigated with the use of mirrors and staff observation.

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

Staff knew about any potential ligature anchor points and mitigated the risks to keep patients safe. Managers had completed ligature audits for all wards and communal areas within the last 12 months. Where ligature anchor points were identified there was a documented plan in place for how to manage these. However, we found that on Hermitage

Forensic inpatient or secure wards

ward there were some ligature points in the garden that had not been included on the ligature audit. Staff we spoke with were aware of ligature heat maps on their wards, which showed where the high risk areas were. Some of the en-suite bathrooms on Headley and Theale wards did not have anti-ligature fittings, however patients were risk assessed prior to being placed in those rooms and there was a programme of works due to start to replace them.

Staff had easy access to alarms and patients had easy access to nurse call systems. All staff carried an alarm and a radio. Patients had access to call buttons in their bedrooms and bathrooms.

Maintenance, cleanliness and infection control

Ward areas were clean and fit for purpose, however not always well maintained. We found the ward areas to be tired and in need of refurbishment, with stains on the walls and marks on the floors. Managers told us that there was a five year plan for site renovations, with improvements to the environment on Kingsclere, Theale, Highclere, Headley and Bucklebury wards to take place in 2022. However, it was unclear whether this would bring all the wards up to the same specification that some parts of the hospital had been upgraded to or whether this was just to undertake more basic updating and maintenance. When we visited Bucklebury ward we observed there were some loose cables hanging out from a broken light switch on the wall. We raised this with managers who agreed to review and address this. On Headley ward there had been a shower leak and so the wall was stained with dirty water marks. We found the garden areas on Theale and Headley wards were not well maintained. There were some loose and unlevel flagstones in the garden on Kingsclere ward which could put patients and staff at risk of tripping.

Staff made sure cleaning records were up-to-date and the premises were generally clean. Housekeeping staff cleaned patient bedrooms once a week. Patients were encouraged to keep their rooms clean and tidy in-between.

Staff followed infection control policy, including handwashing. Staff had managed infection control throughout the Covid-19 pandemic very well, with no patients testing positive for the virus since April 2020. Staff completed regular cleaning of high touch point areas and were required to document this. This was then audited on a monthly basis. The audit results showed that there was good completion of this on Headley, Highclere and Theale wards, but that there were gaps identified on Kingsclere, Bucklebury and Hermitage 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. However, the clinic rooms on Kingsclere and Headley wards were very small and the clinic room on Bucklebury was dirty, with cobwebs on the cupboards. We also observed that staff on Hermitage and Bucklebury wards were slow to find the relevant key to open things such as the drugs fridge or a cupboard where fire extinguishers were stored. This was because they had a large bundle of keys.

Staff usually checked, maintained, and cleaned equipment. However, we found some gaps in the daily checks of fridge and room temperatures on Kingsclere ward.

Safe staffing

The service had enough nursing staff to keep patients safe. The service had enough medical staff. Staff received basic training to keep people safe from avoidable harm.

Forensic inpatient or secure wards

Nursing staff

The service had enough nursing and support staff to keep patients safe.

The service had a nursing vacancy rate of 20%. They had high use of bank and agency nurses and healthcare assistants to help cover shifts. Between 1 June 2021 and 31 August 2021 bank and agency staff completed 53.5% of shifts on Theale ward, 49.6% of shifts on Bucklebury ward, 36.7% shifts on Highclere ward, 23.1% of shifts on Hermitage ward, 22.2% of shifts on Kingsclere ward and 20.6% of shifts on Headley ward. Where possible, managers requested staff familiar with the service. The senior leadership team had plans in place to try and recruit more staff for the hospital and there was a central recruitment team dedicated to this. They also recruited international nurses, advertised on the provider's website and external recruitment boards, held open days, put out radio adverts and dropped flyers in the local area.

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

The service had relatively low staff turnover rates, the average from 1 June 2021 to 31 August 2021 was 7.9%.

Managers supported staff who needed time off for ill health.

Managers accurately calculated and reviewed the number and grade of nurses and healthcare assistants for each shift.

The ward manager could adjust staffing levels according to the needs of the patients. For example, we observed that where patients required one to one observation extra staff had been requested.

The service had enough staff on each shift to carry out any physical interventions safely. Each ward had a designated responder to assist with incidents on other wards when required.

Staff shared key information to keep patients safe when handing over their care to others.

Medical staff

The service had enough daytime and night-time medical cover and a doctor available to go to the ward quickly in an emergency. There was always a doctor available within the hospital as well as a consultant and a junior doctor on call.

Managers could call locums when they needed additional medical cover.

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

Mandatory training

Staff had completed and kept up to date with their mandatory training. Staff were able to complete e-learning training at home within their own time and received remuneration for this.

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

Managers monitored mandatory training and alerted staff when they needed to update their training. Training compliance was one of the items reported on within clinical governance meetings.

Forensic inpatient or secure wards

Assessing and managing risk to patients and staff

Staff assessed and managed risks to patients and themselves well. They achieved the right balance between maintaining safety and providing the least restrictive environment possible to support patients' recovery. Staff 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. The ward staff participated in the provider's restrictive interventions reduction programme.

Assessment of patient risk

Staff completed risk assessments for each patient on admission, using a recognised tool, and reviewed this regularly, including after any incident. Nurses also completed risk assessments prior to patients going out on section 17 leave.

Staff used a recognised risk assessment tool. Staff utilised the Short-term Assessment of Risk and Treatability (START) and Historical Clinical and Risk Management (HCR-20) assessment tools.

Management of patient risk

Staff knew about any risks to each patient and acted to prevent or reduce risks. However, we found that staff on Bucklebury ward did not always include mitigation plans for identified risks within patient's care records.

Staff identified and responded to any changes in risks to, or posed by, patients. However, patients on Hermitage and Bucklebury wards told us that they did not always feel safe on the wards due to the risk of violence and aggression from other patients. Between 1 June 2021 and 31 August 2021 there had been 86 incidents of violence and aggression on Bucklebury ward and 13 incidents of violence and aggression on Hermitage ward. The vast majority of these incidents resulted in either low or no harm being sustained. We saw evidence that where incidents had occurred, staff had responded appropriately and supported patients to report any incidents involving aggression to the police.

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

Staff followed policies and procedures when they needed to search patients or their bedrooms to keep them safe from harm. Patients were advised that their belongings would be searched on admission and a list made of their possessions. Staff also used a metal detector when patients were admitted and when they returned from leave. This helped to ensure that no high risk items were brought onto the wards.

Use of restrictive interventions

Levels of restrictive interventions were low. Between 1 June and 31 August 2021 there had been 29 incidents where restraint was used across Bucklebury, Hermitage and Theale wards. One of these incidents involved prone restraint. There were no restraints on Kingsclere, Highclere or Headley wards.

Staff participated in the provider's restrictive interventions reduction programme, which met best practice standards. The restrictive intervention training given to staff was certified as meeting the restraint reduction network standards.

Staff made every attempt to avoid using restraint by using de-escalation techniques and restrained patients only when these failed and when necessary to keep the patient or others safe. Patients had preventing violence and managing aggression plans which staff utilised to help manage incidents.

Staff followed NICE guidance when using rapid tranquilisation, although this was rarely used. Between 1 June and 30 August 2021 there had been two uses of rapid tranquilisation on Theale ward and two uses on Bucklebury ward. None had been used on the other wards.

Forensic inpatient or secure wards

When a patient was placed in seclusion, staff kept clear records and followed best practice guidelines.

Staff followed best practice, including guidance in the Mental Health Act Code of Practice, if a patient was put in long-term segregation.

Safeguarding

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

Staff received training on how to recognise and report abuse, appropriate for their role.

Staff on most wards kept up to date with their safeguarding training. However, only 72% of staff on Bucklebury and 73% of staff on Hermitage wards were up to date with this. Eleven senior staff from a variety of disciplines had also completed level four safeguarding training.

Staff could give clear examples of how to protect patients from harassment and discrimination.

Staff knew how to recognise adults and children at risk of or suffering harm and worked with other agencies to protect them. All staff we spoke with had good knowledge of safeguarding procedures and were able to give examples of action they had taken to safeguard patients when needed. The hospital held a quarterly safeguarding panel which was attended by representatives from the local authority, Provider Collaborative and CQC.

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

Staff knew how to make a safeguarding referral and who to inform if they had concerns. All staff we spoke with knew how to make a safeguarding referral and who their designated safeguarding officer was. The deputy hospital director held the safeguarding lead role while recruitment for a lead social worker was taking place.

Staff access to essential information

Staff had easy access to clinical information.

Staff could easily access patients' notes.

When patients transferred to a new team, there were no delays in staff accessing their records. All wards utilised the same electronic system which meant that when patients were transferred staff on the new ward were able to access the patient's care records instantly.

Records were stored securely.

Medicines management

The service used systems and processes to safely prescribe, record and store medicines. Some processes for administering medicines could be unclear. Staff regularly reviewed the effects of medicines on each patient's mental and physical health.

Staff followed systems and processes when prescribing, recording and storing medicines. However, we found that systems and processes could have been improved to make the administration process clearer for nursing staff. The

Forensic inpatient or secure wards

provider did not have a policy around protocols for pro re nata (as required) medication. This meant that multiple medications could be prescribed for the same patient for the same reason, e.g. agitation, and it was not clear for staff which one to administer in the first instance. Following the inspection the hospital director raised this with the provider's group director of nursing and group medical director so that the policy could be reviewed. On Headley ward we also found that one patient had two different T2 forms completed by two different doctors and authorising different medications. A T2 form confirms that a patient is capable of understanding the nature, purpose and likely effects of a treatment and that they have consented to receiving this. Staff administering medications are required to check that the appropriate treatment authorisation is in place prior to doing so. T2 forms can only be completed by the clinician in charge of the patient's care. Therefore, having two different forms signed by two different doctors authorising different medications could lead to staff not administering a medication that should be given, for example if they thought the more recent form signed by a different doctor was the valid one.

Staff reviewed patients' medicines regularly and provided specific advice to patients and carers about their medicines. Staff gave patients information and advice when medicines were prescribed and during ward rounds. Patients on some wards were able to self-administer medicines and there was a process in place to support patients through the different stages of this. Where patients were self-administering medicines they had a locked cupboard in their bedroom to store them in.

Staff stored and managed medicines and prescribing documents in line with the provider's policy.

The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely. Staff discussed safety alerts within clinical governance meetings.

Decision making processes were in place to ensure people's behaviour was not controlled by excessive and inappropriate use of medicines.

Staff reviewed the effects of each patient's medication on their physical health according to NICE guidance.

Track record on safety

The service had a good track record on safety.

The service reported four serious incidents between January and August 2021. Three of these were expected deaths and one was a patient who absconded whilst on section 17 leave.

Reporting incidents and learning from when things go wrong

The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team but not the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

Staff knew what incidents to report and how to report them. Between 1 June and 31 August 2021 staff reported 431 incidents on the forensic wards. The most common incident type was violence and aggression.

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

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

Forensic inpatient or secure wards

The service had no never events on any wards.

Staff understood the duty of candour. They were open and transparent, and gave patients and families a full explanation if and when things went wrong.

Managers debriefed staff after any serious incident. However, some staff told us they would appreciate more support following incidents, for example for managers to make an effort to ask how they were in the days/weeks following an incident.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations. The Provider Collaborative's serious incident panel also reviewed any serious incident reports. A Provider Collaborative is a group of providers of specialised mental health, learning disability and autism services who have agreed to work together to improve the care pathway for their local population.

Staff received feedback from investigation of incidents on their wards but not from other wards. Staff we spoke with said they would hear about incidents on other wards and any lessons learned if they covered a shift on another ward, but that these were not routinely disseminated across the hospital. Managers told us that lessons learned from incidents across the hospital would be shared in the morning business meetings, however this information was not then passed on to staff on the wards.

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

There was evidence that changes had been made as a result of feedback. On Theale ward there had been an increase in incidents of racial abuse, so staff had arranged for local police to visit the ward and speak to patients.

Are Forensic inpatient or secure wards effective?

Good 

Our rating of effective stayed the same. We rated it 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 on most wards were personalised, holistic and recovery-oriented. They included specific safety and security arrangements and a positive behavioural support plan.

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

All patients had their physical health assessed soon after admission and regularly reviewed during their time on the ward. Staff checked patient's physical health observations at least weekly using the National Early Warning System (NEWS2), or more frequently if indicated. When we reviewed NEWS2 charts it did not always state whether scores had been escalated when they reached the threshold for this. We raised this with managers who were aware that details of escalations were not being recorded in the correct place, and that this had been highlighted via internal auditing processes as an area for improvement which would be reviewed via monthly clinical governance meetings.

Forensic inpatient or secure wards

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.

The quality of care plans was variable. Care plans on Kingsclere, Highclere, Theale, Headley and Hermitage wards were personalised, holistic and recovery-oriented. However, care plans on Bucklebury ward were less personalised and we found examples where they contained the wrong patient's name because the information had been copied and pasted from another patient's care plan.

Best practice in treatment and care

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

Staff provided a range of care and treatment suitable for the patients in the service. The psychology team provided individual therapies for patients tailored to individual needs. These included therapies which were trauma focused, schema work and cognitive behavioural therapy.

Staff delivered care in line with best practice and national guidance.

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. A GP visited the hospital twice a week. A dentist and a chiropodist also regularly visited the hospital. We saw evidence that patients were taken off site to attend appointments with various other specialists. There was also a full-time physical health nurse and a full-time associate physical health nurse for the hospital.

Staff met patients' dietary needs and assessed those needing specialist care for nutrition and hydration. The hospital had recently recruited a dietician to work one day a week.

Staff helped patients live healthier lives by supporting them to take part in programmes or giving advice. The hospital had a no smoking policy and supported patients with nicotine replacement therapy or by offering vaping products. The hospital also had a weight management programme.

Staff used recognised rating scales to assess and record the severity of patients' conditions and care and treatment outcomes. Staff utilised the health of the nation outcome scale (HoNOS).

Staff took part in clinical audits, benchmarking and quality improvement initiatives. Managers used results from audits to make improvements.

Skilled staff to deliver care

The ward team 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.

Forensic inpatient or secure wards

The service had access to a full range of specialists to meet the needs of the patients on the wards. Patients had access to psychology, occupational therapy, art therapy, drama therapy and speech and language therapy. Each ward had an occupational therapy assistant to deliver activities for patients. Occupational therapists carried out patient assessments but usually covered multiple wards, depending on the ward size.

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

Managers gave each new member of staff a full induction to the service before they started work.

Managers supported staff through regular, constructive appraisals of their work. All staff on Headley, Hermitage, Highclere and Kingsclere wards had received an appraisal in the last year. Eighty-seven percent of staff on Bucklebury ward and 81% of staff on Theale ward had also received an appraisal.

Managers supported staff through regular, constructive clinical supervision of their work. Managers also supported staff with reflective practice sessions which were either run by a psychologist or an art therapist. Although there was no lead social worker in post, managers ensured that the social work team continued to receive supervision from an external supervisor from another hospital run by the provider. Junior doctors were supervised by consultants, consultants were supervised by the medical director and there was also a peer support group for consultants.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge.

Managers made sure staff received any specialist training for their role. The hospital had recently invested in training in dialectical behavioural therapy for staff.

Managers recognised poor performance, could identify the reasons and dealt with these.

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 and engaged with them early on in the patient's admission to plan discharge.

Staff held regular multidisciplinary meetings to discuss patients and improve their care.

Staff made sure they shared clear information about patients and any changes in their care, including during handover meetings. However, some multidisciplinary team staff who did not attend handover told us they did not always receive important information.

Ward teams had effective working relationships with other teams in the organisation. The director of nursing ran a daily site meeting which was attended by all ward managers for them to give an update on things such as staffing, observation levels and incidents. This helped ensure that managers were aware of what was going on across the hospital. We saw evidence of where staff supported other teams within the hospital. For example, where the psychology team had delivered training and offered extra reflective practice sessions to support staff to care for a patient with challenging behaviour on Headley ward.

Forensic inpatient or secure wards

Ward teams had effective working relationships with external teams and organisations.

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.

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

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

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

Patients had easy access to information about independent mental health advocacy and patients who lacked capacity were automatically referred to the service.

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 could not always ensure that patients could take section 17 leave (permission to leave the hospital) when this was agreed with the Responsible Clinician and/or with the Ministry of Justice. This was due to staffing issues at the hospital.

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 in clinical governance meetings. However, on Bucklebury ward we found that a patient had been prescribed medication without the appropriate treatment authorisation in place. This had not been picked up by internal auditing processes.

Good practice in applying the Mental Capacity Act

Staff supported patients to make decisions on their care for themselves. They understood the provider's 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.

Forensic inpatient or secure wards

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

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

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

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

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

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

Are Forensic inpatient or secure wards caring?

Good 

Our rating of caring stayed the same. We rated it as good.

Kindness, privacy, dignity, respect, compassion and support

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

Staff were discreet, respectful, and responsive when caring for patients. Patients told us that staff always knock on their bedroom door before entering. We observed staff speaking about patients in a respectful manner throughout our inspection.

Staff gave patients help, emotional support and advice when they needed it.

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

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

Patients said staff treated them well and behaved kindly.

Staff understood and respected the individual needs of each patient. Staff knew patients well and we saw lots of examples of person-centred care being delivered.

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

Staff followed policy to keep patient information confidential.

Forensic inpatient or secure wards

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.

Involvement of patients

Staff introduced patients to the ward and the services as part of their admission. Each ward had a peer support representative who helped to show new patients around and explained the ward systems and procedures to them. Staff also gave patients an information booklet which contained key information about the hospital.

Staff involved patients and gave them access to their care plans and risk assessments. Patients told us that they reviewed their care plans with staff once a month and that staff always asked them what they would like to be included.

Staff made sure patients understood their care and treatment. Patients we spoke with all felt supported to understand their care and treatment. They had been involved in setting goals and were aware of steps they needed to take to progress towards being discharged.

Staff involved patients in decisions about the service, when appropriate. The hospital had a patient council which was made up of patient representatives from each ward and was attended by the senior leadership team. They were consulted about changes to the service, for example, changes to the newly refurbished dining room or updating the patient information booklet. Patient representatives also attended both ward and hospital based clinical governance meetings. Staff ran fortnightly community meetings on the wards which were chaired by patients and provided opportunities for them to give feedback about their care. Any issues which could not be resolved within the community meetings were escalated to the patient council.

Patients could give feedback on the service and their treatment and staff supported them to do this. All of the wards had a “you said, we did” board which showed suggestions patients had made and actions taken by staff.

Staff supported patients to make advanced decisions on their care.

Staff made sure patients could access advocacy services. Staff displayed posters detailing how to access advocacy services in all ward areas. Patients told us that they access advocacy services.

Involvement of families and carers

Staff informed and involved families and carers appropriately.

Staff supported, informed and involved families or carers. Relatives we spoke with gave positive feedback about the hospital. They told us that they felt involved in the care of their loved ones. Staff had begun utilising online video services to conduct CPA meetings during the pandemic which meant that more relatives were able to dial in, particularly those who lived some distance away.

Staff helped families to give feedback on the service. Staff had recently started running monthly online meetings for carers which hospital staff gave presentations at. The hospital had also recently run a carers survey.

Are Forensic inpatient or secure wards responsive?

Forensic inpatient or secure wards

Our rating of responsive stayed the same. We rated it as requires improvement.

Access and discharge

Staff planned and managed discharge well. They liaised well with services that would provide aftercare and were assertive in managing care pathways for patients who were making the transition to another inpatient service or to prison. As a result, patients rarely had their discharge delayed for other than clinical reasons.

Bed management

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

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.

Discharge and transfers of care

The service had low numbers of patients whose discharges were delayed and these were monitored by managers. There was only one patient who had their discharge delayed on Theale ward. Staff were working with the patient's case manager to try and source a suitable placement.

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

Each patient had their own bedroom, which they could personalise. Communal areas of the ward were also tailored to the patient group. For example, on Highclere ward there were pictures of celebrities from the 1950s/60s on the walls.

Patients had a secure place to store personal possessions. Patients either had lockable storage in their bedrooms or access to a locker in the communal area of the ward which they had a key for.

The service had a full range of rooms and equipment to support treatment and care. All of the wards had well equipped group rooms. However, on Bucklebury there was a lack of communal space. The ward was also very noisy. The hospital also had a gym which patients could use. The equipment in the gym was old, however staff told us that new equipment had been ordered and would arrive in October 2021.

Forensic inpatient or secure wards

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

Patients could make phone calls in private. Patients had access to mobile phones and there was also a payphone available on each ward.

All wards had an outside space that patients could access easily.

Patients could make their own hot drinks and snacks and were not dependent on staff. Each ward had galley kitchen facilities for patients to make hot drinks. On some wards patients also had access to a full kitchen but this was dependent on individual risk assessment. We observed staff on Highclere ward offering to make drinks for patients who may have struggled to make their own.

The service offered a variety of good quality food. Patients had a choice of going to the communal dining room for lunch/dinner or remaining on the ward. The communal dining area had recently been refurbished and had a very pleasant atmosphere, including a large mural on the wall which patients had helped to create, and dimmable lighting. A patient survey carried out in September 2021 showed that 65% of respondents felt there was enough choice of food.

Patients' engagement with the wider community

Staff supported patients with activities outside the service, such as work, education and family relationships. Patients were not always able to take their designated section 17 leave due to a lack of staff being available to facilitate this.

Managers could not always ensure that shifts were filled which meant that patients were not always able to take leave from the wards. Between 1 June 2021 and 30 August 2021 4.2% shifts on Hermitage ward, 3.8% shifts on Kingsclere ward, 3.7% shifts on Headley ward, 2.9% shifts on Highclere ward, 2.8% shifts on Theale ward and 2.2% shifts on Bucklebury ward had not been filled. When this happened, managers moved staff around from other wards to ensure the wards with the highest needs/risk were covered, however this still put pressure on staff on other wards to ensure that all relevant tasks were completed. Patients and staff told us that section 17 leave was often cancelled due to lack of staff.

The hospital offered some paid and voluntary work positions within the hospital, for example doing gardening, in the gym and running the patient café on a Saturday. All of these roles had clear job descriptions in place and patients were required to apply for them and attend an interview. Staff then provided them with a contract of employment. The occupational therapy team also ran a "groundbusters" team which took grounds jobs from the estates team for patients to complete. The hospital ran the Crookham common conservation project which involved patients maintaining the common and ensuring it was kept clean and tidy. Patients were involved in maintaining a lock at a local canal. Tutors from a nearby local college attended the hospital one day a week to deliver courses in numeracy and vocational skills. A healthcare assistant with a background in IT was also running an IT course for patients.

Staff helped patients to stay in contact with families and carers.

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

Meeting the needs of all people who use the service

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

Forensic inpatient or secure wards

The service could support and make adjustments for disabled people and those with communication needs or other specific needs.

Wards supported disabled patients and Highclere ward was dementia friendly.

Staff made sure patients could access information on treatment, local services, their rights and how to complain. This information was displayed on notice boards on the wards.

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

Patients had access to spiritual, religious and cultural support. There was a multi-faith room at the hospital. Priests and Imams also visited. Patients were supported to attend church on Sundays.

Listening to and learning from concerns and complaints

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

Patients, relatives and carers knew how to complain or raise concerns.

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

Staff understood the policy on complaints and knew how to handle them.

Managers investigated complaints and identified themes.

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

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

Managers shared feedback from complaints with staff and learning was used to improve the service. Where complaints were upheld, action plans were created to ensure improvements were made.

The service used compliments to learn, celebrate success and improve the quality of care.

Are Forensic inpatient or secure wards well-led?

Our rating of well-led went down. We rated it as requires improvement.

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.

Forensic inpatient or secure wards

The hospital director was a visible presence throughout the hospital. Patients told us that the hospital director frequently visited the wards and would engage in activities with them, for example playing pool. Staff told us that other members of the senior leadership team were less visible on the wards but that they were contactable if needed. The director of nursing was relatively new in post and still developing into her role, her team and the vision and direction for nursing.

The senior leadership team had a good understanding of the key challenges the service faced. They were focused on improving recruitment and retention to improve the service for both patients and staff. The provider had worked to develop career progression pathways for staff at all levels to try and improve retention. The hospital director was also working with the group Human Resources director on a project to improve staff recruitment and retention.

Leaders were supported to complete leadership training. For example, the hospital's director of nursing was completing level seven leadership training and some of the ward managers were completing level five. Completion of the training required staff to complete a project which was then used to improve practice at the hospital. For example, staff were completing projects around how to improve the induction for healthcare assistants and least restrictive practice.

Vision and strategy

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

The organisation's values were kindness, integrity, teamwork and excellence (KITE). Staff we spoke with were aware of these and how they impacted on their day to day working. Staff told us that their development objectives were linked to the organisation's values. Some of the occupational therapy team were working with patients to make a large kite to display the values.

Culture

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

Leaders told us they were proud of how well the staff had supported the patients and one another through the challenges of the last couple of years.

Staff had mixed views on how well supported they were. Some staff felt well supported; others told us they felt over-worked and under-valued. Staff told us they would be comfortable to raise concerns if needed, either at ward manager level or with the senior leadership team.

The senior leadership team held staff forums twice a month which were held both during the day and at night to ensure all staff had the opportunity to attend. Actions from the meetings were documented and updates given at subsequent meetings. Where staff suggestions had not been implemented, a rationale had been documented.

The provider ran a staff recognition scheme called "star award". Staff could nominate one another to receive an award and then the operations director selected "stars of the month".

Governance

Our findings from the other key questions demonstrated that some governance processes required improvement.

Forensic inpatient or secure wards

The service had governance structures in place. Each ward had a monthly governance meeting and there was also a hospital governance meeting. There was a regional governance meeting which was attended by all hospital directors in the south of England and Wales, and there was a corporate governance meeting which covered all sites. Information from the corporate, regional and hospital governance meetings was cascaded to ward staff via their monthly governance meetings.

The hospital had a restrictive practice committee which was chaired by the ward manager from Donnington ward. They were working with the regional governance lead to develop an audit tool for restrictive practice which staff could complete with patients. However, the monthly committee meetings were not always well attended, for example in July 2021 only the meeting chair had attended. The provider had also recruited a regional violence reduction lead who would be working with teams to look at reducing restrictive practice.

The hospital director chaired a regional seclusion and long-term segregation review panel. Senior clinicians from across the region attended these meetings to identify any trends in where seclusion is occurring, times of day and duration of episodes. No trends had yet been identified in relation to the use of seclusion and long-term segregation at Thornford Park.

Our findings from some of the other key questions indicated that some governance processes required improvement. For example, we found that a patient on Headley ward had two T2 authorisation forms in place which could cause confusion for nursing staff. This had not been picked up via the provider's quality assurance processes. We also found there was variation in the quality of care records on the forensic wards. For example, the records on Kingsclere ward were holistic and comprehensive, whereas the records on Bucklebury ward had identified risks that did not have clear mitigation plans in place and the care plans on this ward were not as personalised as examples we saw on other wards, with some being clearly copied and pasted from one patient's records to another.

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.

Staff had good access to the resources required to carry out their work effectively.

Information management

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

All managers had access to an online dashboard which showed data on a variety of topics for their wards such as when section rights were due to be renewed or when care plans were coming up for review. This enabled them to prompt staff about completing these things to ensure they were all done in time.

Engagement

Managers engaged actively with 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. Managers from the service participated actively in the work of the local Provider Collaborative.

Forensic inpatient or secure wards

The hospital worked closely with the Provider Collaborative. Members of the senior leadership team attended the Provider Collaborative's serious incident panels, reducing restrictive practice committee, learning disability and autism and clinical governance meetings. Leaders told us that these meetings were very useful for sharing lessons learned across the region.






Learning, continuous improvement and innovation

The service participated in the Royal College of Psychiatrists' Quality Network for Forensic Mental Health Services (QNFMHS).

Staff were in the process of implementing safe wards, with different wards trialling different initiatives, e.g. some wards had brief biographies about staff on their notice boards, others were using soft words.

Staff carried out simulations of emergency events to practice their response. Debriefs took place following these simulations and action plans were developed to address any areas for improvement. Managers kept oversight of action plans via monthly clinical governance meetings.

Wards for people with learning disabilities or autism

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

Are Wards for people with learning disabilities or autism safe?

Good 

We rated safe as good.

Safe and clean care environments

Both wards were safe, clean, well equipped, well furnished, well maintained and fit for purpose.

Safety of the ward layout

Staff completed and regularly updated thorough risk assessments of all ward areas and removed or reduced any risks they identified. The nominated safety/security staff member carried out environmental checks every day. All faults or damages were documented and reported to the appropriate department for repair or removal. The ward manager audited these each week and authorised sign off when completed.

Staff were able to observe patients at all times and any areas that were blocked or unclear were mitigated by staff observations, mirrors and cameras. We did identify that the galley kitchen was an area out of sight to staff, as well as the telephone room and parts of the lounge, but were assured that these would be observed by staff out on the ward.

There was no mixed accommodation on the ward.

The identified ligature points had all been removed and anti-ligature doors were used throughout the ward. Staff were aware of where to locate the ligature cutters which were stored safely in the staff office. All staff were aware of the alarm system, carried a personal alarm and radio and there were alarm buttons in each of the patient bedrooms and bathrooms. There was a visible digital notification board identifying incidents and location. Staff on Tadley ward were unable to locate the ligature audit for the ward.

Maintenance, cleanliness and infection control

The ward areas were very clean and the housekeeper was observed to be maintaining a high standard of infection control throughout the day with regular surface and door cleaning.

We saw copies of cleaning records for the day and week had been completed and signed off by a manager.

Wards for people with learning disabilities or autism

Staff acted in accordance with the policy for infection control, handwashing and use of hand gels.

All staff were wearing masks at all times.

Clinic room and equipment

Clinic rooms were fully equipped, with accessible resuscitation equipment and emergency drugs that staff checked and recorded daily/weekly in line with service policies.

Clinic rooms were clean and organised. There was an accessible treatment room in the main building area which housed the treatment bed, this was used by visiting GPs to treat patients.

Safe staffing

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

Nursing staff

Usual staffing for the wards was two Registered Nurses during the day and two at night. There were five healthcare assistants during the day and three at night.

Ninety-one percent of all shifts that went to agency/bank were filled.

Seven shifts were not fully staffed in August. In these instances managers utilised staff from other wards across the hospital.

All staff were given an induction to the ward. Bank staff completed the provider's internal induction and training. Regular agency staff completed ward specific training. Agency staff on the preferred use list had the same training as ward staff.

The ward had enough staff to ensure risk management and patient safety.

All patients had one to one time and this was agreed and reviewed weekly in the named nurse's supervision and logged on the computer system. All activity was recorded on the system so managers could see the meaningful activity completed by each patient.

Staff were supported by the managers when they required time away due to illness, but if there were more than three episodes of sickness in a 12 month period the staff member was not paid, pending review and Occupational Health assessment.

Levels of sickness were low and reducing.

The managers could increase staffing numbers on the ward as and when observation levels were increased. At the time of the inspection there were six healthcare assistants during the day and four at night due to patients requiring one to one observation.

Medical staff

Wards for people with learning disabilities or autism

A GP visited the hospital two days a week and the ward psychiatrist was available during the day 09.00 to 17.00 and an on-call system was available 17.00 to 09.00 covered by the junior doctors.

All locum doctors had a local induction prior to working in the hospital. They were able to get to the ward within 30 minutes of a call.

Mandatory training

Staff completed and kept up to date with their mandatory training. Staff were able to complete e-learning training at home within their own time and received remuneration for this.

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

Managers monitored mandatory training and alerted staff when they needed to update their training. Training compliance was one of the items reported on within clinical governance meetings.

Assessing and managing risk to patients and staff

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

Assessment of patient risk

Staff completed risk assessments for each patient on admission, using a recognised tool, and reviewed this regularly, including after any incident. Nurses also completed risk assessments prior to patients going out on section 17 leave.

Staff used recognised risk assessment tools. Staff utilised the Short-term Assessment of Risk and Treatability (START) and Historical Clinical and Risk Management (HCR-20) assessment tools.

Staff had developed some very thorough and detailed risk assessments. These were easy to understand and follow and staff we spoke to were fully aware of them and how to implement them.

Staff followed procedures to minimise risks where they could not easily observe patients. We were able to see the observation levels of patients being implemented and recorded.

Management of patient risk

Staff knew about any risks to each patient and acted to prevent or reduce risks. Patients we spoke to said they felt safe on the wards and that the staff kept them safe and made them feel safe.

Staff identified and responded to any changes in risks to, or posed by, patients.

Wards for people with learning disabilities or autism

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

Use of restrictive interventions

Staff used verbal de-escalation as a preference and on Donnington ward re-directing patients to an area where they could undergo a one to one session to problem solve was always the preferred option. On Donnington ward there had been two physical interventions since April 2021 for two different patients.

Seclusion was used on Tadley ward and there had been two seclusions in the last 12 months. The seclusion area complied with the requirements of the Mental Health Act Code of Practice and had access to fresh air. Seclusion was only used as a last resort on Tadley ward and the preferred and most effective intervention was verbal de-escalation.

Safeguarding

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

All staff had received safeguarding training, managers notified them when refreshers or updates in training were required.

Staff knew how to recognise adults and children at risk of or suffering harm and worked with other agencies to protect them. All staff we spoke with had good knowledge of safeguarding procedures and were able to give examples of action they had taken to safeguard patients when needed. The hospital held a quarterly safeguarding panel which was attended by representatives from the local authority, Provider Collaborative and CQC.

Staff could give clear examples of how to protect patients from harassment and discrimination.

Staff knew how to recognise adults and children at risk of or suffering harm and worked with other agencies to protect them.

Children were not allowed on the ward but there was a family room available for visits.

Staff knew how to make a safeguarding referral and who to inform if they had concerns.

Staff made safeguarding referrals when patients were cared for in long term seclusion.

Managers took part in serious case reviews and made changes based on the outcomes.

Staff access to essential information

Staff had easy access to clinical information and it was easy for them to maintain high quality clinical records.

Staff could easily access patients' notes.

When patients transferred to a new team, there were no delays in staff accessing their records. All wards utilised the same electronic system which meant that when patients were transferred staff on the new ward were able to access the patient's care records instantly.

Wards for people with learning disabilities or autism

Records were stored securely.

Medicines management

The service used systems and processes to safely prescribe, administer, record and store medicines. Staff regularly reviewed the effects of medications on each patient's physical health. They knew about and worked towards achieving the aims of STOMP (stopping over-medication of people with a learning disability, autism or both).

Staff followed systems and processes when prescribing, support from an external pharmacy was efficient and monitored when medications required ordering and reviewing.

We reviewed 17 medicines charts and found there were three missed signatures on one chart, all other charts were complete and accurate. We raised this with staff and they agreed to look into the reason for this and acknowledged this should not be happening.

Our review of Olanzapine monitoring showed that although physical observations were adhered to, side effect monitoring was not complete.

We found that systems and processes could have been improved to make the administration process clearer for nursing staff. The provider did not have a policy around protocols for pro re nata (as required) medication. This meant that multiple medications could be prescribed for the same patient for the same reason, e.g. agitation, and it was not clear for staff which one to administer in the first instance. Following the inspection the hospital director raised this with the provider's group director of nursing and group medical director so that the policy could be reviewed. Staff stored and managed medicines and prescribing documents in line with the provider's policy.

High fridge temperatures had been recorded on Tadley ward, however no action had been taken to address this.

The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely. Staff discussed safety alerts within clinical governance meetings.

Decision making processes were in place to ensure people's behaviour was not controlled by excessive and inappropriate use of medicines.

Staff reviewed the effects of each patient's medication on their physical health according to NICE guidance.

Reporting incidents and learning from when things go wrong

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

All staff were aware of what incidents were, how to report and document them.

The service had no never events on any wards.

Staff were aware of the duty of candour and how to inform individuals and families when this was required.

Wards for people with learning disabilities or autism

Managers were present following incidents and de-briefing was offered and documented. Staff on Tadley ward told us that support from managers following incidents could be improved, particularly in the days/weeks following an incident.

Managers investigated all incidents thoroughly and gave feedback to staff on their wards, however this was not shared with other wards.

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

Staff commented that they were very well supported following incidents and that they were listened to.

Are Wards for people with learning disabilities or autism effective?

Good 

We rated effective as good.

Assessment of needs and planning of care

Staff undertook functional assessments when assessing the needs of patients who would benefit. They worked with patients and with families and carers to develop individual care and support plans, and updated them as needed. Care plans reflected the assessed needs, were personalised, holistic and strengths based.

A comprehensive assessment was completed for each patient on admission, it was needs led, holistic and included activities of daily living.

Physical health assessments were completed either on or very shortly after admission.

The care plans were informative, achievable, needs led and well documented. They were also in easy read formats where appropriate and used in a scheduled manner on the autism ward. They were regularly updated, addressed current issues and had a plan for future discharge.

Each patient had a positive behaviour support (PBS) plan which was supported by a comprehensive assessment.

Physical care was documented and recorded weekly using the National Early Warning System (NEWS2), should observations be required more frequently, this was well documented and implemented.

The quality of the care plans throughout the service was of a high standard. They were reviewed at multi-disciplinary team (MDT) meetings and changes were made when issues were resolved or if further requests were made by the patient.

Best practice in treatment and care

Staff provided a range of treatment and care for patients based on national guidance and best practice. This included access to psychological therapies, support for self-care and the development of everyday living skills and meaningful occupation. Staff supported patients with their physical health and encouraged them to live healthier lives.

Wards for people with learning disabilities or autism

Staff used recognised rating scales to assess and record severity and outcomes. They also participated in clinical audit, benchmarking and quality improvement initiatives.

Staff provided a wide range of care and treatment to meet individual needs.

Care was delivered within the best practice guidelines.

Staff had a good understanding of the PBS plans and worked jointly with MDT members to promote good outcomes with the individual patients.

Staff identified physical health needs, care planned them and documented this in patients' notes. Areas of need, for example, dietary needs were identified and patients were referred to a dietician for advice and support.

A GP visited the hospital twice a week.

A dentist and a chiropodist also regularly visited the hospital. We saw evidence that patients were taken off site to attend appointments with various other specialists. There was also a full-time physical health nurse and a full time associate physical health nurse for the hospital.

Staff helped patients live healthier lives by supporting them to take part in programmes or giving advice. The hospital had a no smoking policy and supported patients with nicotine replacement therapy or by offering vaping products. The hospital also had a weight management programme.

Staff used recognised rating scales to assess and record the severity of patients' conditions and care and treatment outcomes. Staff utilised the health of the nation outcome scale (HoNOS).

Staff used technology to support patients.

Staff took part in clinical audits, benchmarking and quality improvement initiatives. Managers used results from audits to make improvements.

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 wards. Patients had access to psychology, occupational therapy, art therapy, drama therapy and speech and language therapy. Donnington ward also had a full time PBS practitioner.

Managers made sure staff had the right skills, qualifications and experience to meet the needs of the patients in their care, including bank and agency staff. This included learning disability, autism and positive behaviour support training.

Managers gave each new member of staff a full induction to the service before they started work.

Wards for people with learning disabilities or autism

Managers supported staff through regular, constructive appraisals of their work.

Managers supported non-medical staff through regular, constructive clinical supervision of their work.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge.

Managers made sure staff received any specialist training for their role.

Managers recognised poor performance, could identify the reasons and dealt with these with performance management.

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 staff from services that would provide aftercare following the patient's discharge and engaged with them early on in the patient's admission to plan discharge.

Staff held regular multidisciplinary meetings to discuss patients and improve their care. These were attended by the patients for ten minute slots to discuss their care or concerns.

We attended a full staff meeting on Donnington ward which was very well organised and presented staff with information and opportunities to contribute.

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 in the organisation.

Ward teams had effective working relationships with external teams and organisations. The teams on both wards were proud to highlight their contact with external agencies in respect of patients moving on and updates. They also said that there had been an increase in attendance at care programme approach (CPA) meetings since these had been available to join online.

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.

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

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

Wards for people with learning disabilities or autism

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

Patients had easy access to information about independent mental health advocacy and patients who lacked capacity were automatically referred to the service.

Staff explained to each patient their rights under the Mental Health Act in a way that they could understand, repeated and recorded it clearly in the patient's notes each time. This was completed monthly and there were no omissions noted.

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.

Care plans included information about after-care services available for those patients who qualified for it under section 117 of the Mental Health Act.

Managers and staff made sure the service applied the Mental Health Act correctly by completing audits and discussing the findings. We observed this being discussed in the staff meeting, to ensure a good understanding and knowledge.

Good practice in applying the Mental Capacity Act

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

Staff received and kept up to date with training in the Mental Capacity Act and had a good understanding of at least the five principles.

There was a clear policy on the Mental Capacity Act and Deprivation of Liberty Safeguards, which staff could describe and knew how to access.

Staff knew where to get accurate advice on the Mental Capacity Act and Deprivation of Liberty Safeguards.

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

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

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

Staff made applications for a Deprivation of Liberty Safeguards order only when necessary and monitored the progress of these applications.

The service monitored how well it followed to the Mental Capacity Act and acted when they felt this was necessary.

Wards for people with learning disabilities or autism

Are Wards for people with learning disabilities or autism caring?

Good 

We rated caring as good.

Kindness, privacy, dignity, respect, compassion and support

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

Staff were discreet, respectful, and responsive when caring for patients.

Staff gave patients help, emotional support and advice when they needed it.

Staff used appropriate communication methods to support patients to understand and manage their own care treatment or condition. There was a variety of communication schedules, door boards and general information posters displayed throughout the ward.

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

Patients said staff treated them well and behaved kindly.

Staff understood and respected the individual needs of each patient.

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

Staff followed policy to keep patient information confidential.

Involvement in care

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

Involvement of patients

Staff introduced patients to the ward and the services as part of their admission. There was a ward information pack available for patients and this was devised by two of the patients on the patient council.

Staff involved patients and gave them access to their care plans and risk assessments. These were available in an easy read document, pictorial and adapted documents to meet the individual needs of the patients. This was an assurance for all concerned that the plans were understood and agreed to. This applied to current and future plans.

Staff involved patients in decisions about the service, when appropriate.

Wards for people with learning disabilities or autism

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

Staff supported patients to make advanced decisions on their care.

Staff made sure patients could access advocacy services. There were good, clear posters and details available on both wards, and by the telephone on each ward.

Staff involved patients in decisions about the service, when appropriate. The hospital had a patient council which was made up of patient representatives from each ward and was attended by the senior leadership team. They were consulted about changes to the service, for example, changes to the newly refurbished dining room or updating the patient information booklet. Patient representatives also attended both ward and hospital based clinical governance meetings. Staff ran fortnightly community meetings on the wards which were chaired by patients and provided opportunities for them to give feedback about their care. Any issues which could not be resolved within the community meetings were escalated to the patient council.

Patients could give feedback on the service and their treatment and staff supported them to do this. Both of the wards had a “you said, we did” board which showed suggestions patients had made and actions taken by staff.

Involvement of families and carers

Staff informed and involved families and carers appropriately.

Staff supported, informed and involved families or carers. Relatives we spoke with gave positive feedback about the hospital. They told us that they felt involved in the care of their loved ones. Staff had begun utilising online video services to conduct CPA meetings during the pandemic which meant that more relatives were able to dial in, particularly those who lived some distance away.

Staff helped families to give feedback on the service. Staff had recently started running monthly online meetings for carers which hospital staff gave presentations at. The hospital had also recently run a carers survey. One relative we spoke to said they had not been offered a feedback opportunity on Tadley ward.

Are Wards for people with learning disabilities or autism responsive?

We rated responsive as good.

Access and discharge

Staff planned and managed discharge well. They liaised well with services that would provide aftercare and were assertive in managing the discharge care pathway. As a result, patients rarely had their discharge delayed for other than clinical reasons.

Bed management

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

Wards for people with learning disabilities or autism

When patients went on leave there was always a bed available when they returned.

Managers and staff worked together to make sure patients were not moved before they were assessed as ready to move and the appropriate accommodation had been found.

Patients were not moved between wards.

Staff did not move or discharge patients at night or very early in the morning.

Discharge and transfers of care

One patient had their discharge delayed in the last year.

Staff carefully planned patients' discharge and worked with care managers and coordinators to make sure this went well. There appeared to be good working relationships with the MDT and outside agencies.

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

The service followed national standards for transfer.

Facilities that promote comfort, dignity and privacy

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

Each patient had their own room with en-suite facilities. The rooms we looked at were personalised and private, with some of the rooms having communication boards on the outside of the doors to inform staff of how the patients were feeling that day. The ward manager stated this had helped to reduce the levels of anxiety and reduce potential incidents if someone wished to be left alone until they felt better. The general décor was clean and fresh on both wards.

There were rooms on the ward for activities and quiet areas where people could go to a calm environment and have quiet uninterrupted discussions with staff. On Tadley the ward manager highlighted that they had converted what was his office, into a quiet room where much of the verbal de-escalation was undertaken, he said it had become a valuable asset to all.

Due to current circumstances visitors were not being accepted onto the ward, but there was an alternative provision at the reception area.

Patients could make phone calls in private. Patients had access to mobile phones and there was also a payphone available on each ward.

Patients could make their own hot drinks and snacks and were not dependent on staff. Each ward had galley kitchen facilities for patients to make hot drinks. On some wards patients also had access to a full kitchen but this was dependent on individual risk assessment. We observed patients making their own drinks on both wards.

Wards for people with learning disabilities or autism

There was a kitchen available for patient use providing they had undertaken an occupational therapy assessment and were deemed low risk to themselves and others, to use the equipment in the kitchen. These sessions are all supervised and planned.

Staff used a full range of rooms and equipment to support treatment and care.

The service had an outside space that patients could access easily. This was the case on both wards.

Some patients were more than satisfied with the quality and variety of meals available, but there were others who said the food needed to improve. The general opinion was that the new chef had made a big improvement.

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. The hospital offered some paid and voluntary work positions within the hospital, for example doing gardening, in the gym and running the patient café on a Saturday. All of these roles had clear job descriptions in place and patients were required to apply for them and attend an interview. Staff then provided them with a contract of employment. The occupational therapy team also ran a "groundbusters" team which took grounds jobs from the estates team for patients to complete. The hospital ran the Crookham common conservation project which involved patients maintaining the common and ensuring it was kept clean and tidy. Patients were involved in maintaining a lock at a local canal. Tutors from a nearby local college attended the hospital one day a week to deliver courses in numeracy and vocational skills. A healthcare assistant with a background in IT was also running an IT course for patients.

Staff helped patients to stay in contact with families and carers.

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

Meeting the needs of all people who use the service

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

The service could support and make adjustments for people with communication needs or other specific needs. The variety of communication aides were excellent and needs led.

Staff made sure patients could access information on treatment, local service, their rights and how to complain. This information was displayed on notice boards on the wards.

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

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

Patients had access to spiritual, religious and cultural support. There was a multi-faith room at the hospital. Priests and Imams also visited. Patients were supported to attend church on Sundays.

Wards for people with learning disabilities or autism

Listening to and learning from concerns and complaints

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

Patients, relatives and carers knew how to complain or raise concerns.

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

Staff understood the policy on complaints and knew how to handle them.

Managers investigated complaints and identified themes.

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

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

Managers shared feedback from complaints with staff and learning was used to improve the service.

The service used compliments to learn, celebrate success and improve the quality of care.

Are Wards for people with learning disabilities or autism well-led?

We rated well-led as good.

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.

The hospital director was a visible presence throughout the hospital. Patients told us that the hospital director frequently visited the wards and would engage in activities with them, for example playing pool. Staff told us that other members of the senior leadership team were less visible on the wards but that they were contactable if needed. The patients we spoke to all said that the hospital director would speak to them and understood them. The director of nursing was relatively new in post and still developing into her role, her team and the vision and direction for nursing.

The senior leadership team had a good understanding of the key challenges the service faced. They were focused on improving recruitment and retention to improve the service for both patients and staff. The provider had worked to develop career progression pathways for staff at all levels to try and improve retention. The hospital director was also working with the group Human Resources director on a project to improve staff recruitment and retention.

Wards for people with learning disabilities or autism

Leaders were supported to complete leadership training. For example the head of nursing was completing level seven leadership training and some of the ward managers were completing level five. Completion of the training required staff to complete a project which was then used to improve practice at the hospital. For example, staff were completing projects around how to improve the induction for healthcare assistants and least restrictive practice.

Vision and strategy

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

The organisation's values were kindness, integrity, teamwork and excellence (KITE). Staff we spoke with were aware of these and how they impacted on their day to day working. Staff told us that their development objectives were linked to the organisation's values. Some of the occupational therapy team were working with patients to make a large kite to display the values.

Culture

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

Leaders told us they were proud of how well the staff had supported the patients and one another through the challenges of the last couple of years.

Staff had mixed views on how well supported they were. Some staff felt well supported; others told us they felt over-worked and under-valued. Staff told us they would be comfortable to raise concerns if needed, either at ward manager level or with the senior leadership team.

At ward level on both wards there was a definite feeling of confidence to raise any issues with management without discrimination.

The senior leadership team held staff forums twice a month which were held both during the day and at night to ensure all staff had the opportunity to attend. Actions from the meetings were documented and updates given at subsequent meetings. Where staff suggestions had not been implemented, a rationale had been documented.

The provider ran a staff recognition scheme called "star award". Staff could nominate one another to receive an award and then the operations director selected "stars of the month".

Governance

Our findings from other key questions showed that most governance processes operated effectively at ward level.

The service had governance structures in place. Each ward had a monthly governance meeting and there was also a hospital governance meeting. There was a regional governance meeting which was attended by all hospital directors in the south of England and Wales, and there was a corporate governance meeting which covered all sites. Information from the corporate, regional and hospital governance meetings was cascaded to ward staff via their monthly governance meetings.

Wards for people with learning disabilities or autism

The hospital had a restrictive practice committee which was chaired by the ward manager from Donnington ward. They were working with the regional governance lead to develop an audit tool for restrictive practice which staff could complete with patients. However, the monthly committee meetings were not always well attended, for example in July only the meeting chair had attended. The provider had also recruited a regional violence reduction lead who would be working with teams to look at reducing restrictive practice. This remains an ongoing piece of work and something the manager on Donnington ward is enthusiastic and positive about.

The hospital director chaired a regional seclusion and long-term segregation review panel. Senior clinicians from across the region attended these meetings to identify any trends in where seclusion is occurring, times of day and duration of episodes. No trends had yet been identified in relation to the use of seclusion and long-term segregation at Thornford Park.

Engagement

Managers engaged actively with 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. Managers from the service participated actively in the work of the local Provider Collaborative.

The hospital worked closely with the Provider Collaborative. Members of the senior leadership team attended the Provider Collaborative's serious incident panels, reducing restrictive practice committee, learning disability and autism and clinical governance meetings. Leaders told us that these meetings were very useful for sharing lessons learned across the region.

Learning, continuous improvement and innovation

The provider had worked with a local university to develop an adapted Sexual Offender Treatment Programme (SOTP) which involved patients on Donnington ward and was presented by therapists and ward staff.

Staff were in the process of implementing safe wards, with different wards trialling different initiatives, e.g. some wards had brief biographies about staff on their notice boards, others were using soft words.

Staff carried out simulations of emergency events to practice their response. Debriefs took place following these simulations and action plans were developed to address any areas for improvement. Managers kept oversight of action plans via monthly clinical governance meetings.

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

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

Diagnostic and screening procedures

Treatment of disease, disorder or injury

Regulation

Regulation 9 HSCA (RA) Regulations 2014 Person-centred care

The provider did not ensure that a range of therapeutic activities were available to meet patients' needs in the PICUs in accordance with guidance from the National Institute of Health and Care Excellence.

Regulated activity

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

Diagnostic and screening procedures

Treatment of disease, disorder or injury

Regulation

Regulation 18 HSCA (RA) Regulations 2014 Staffing

The provider did not ensure that there were sufficient staff to facilitate leave for patients on the forensic wards.

The provider did not ensure that supervision was consistently managed on the PICUs.

Regulated activity

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

Diagnostic and screening procedures

Treatment of disease, disorder or injury

Regulation

Regulation 17 HSCA (RA) Regulations 2014 Good governance

The provider did not ensure that care records on the forensic and PICU wards were of a consistently good quality and that they included the patient voice. Some identified risks did not have clear mitigation plans in place.

The provider did not ensure that there were robust systems in place to ensure it was clear for staff which medications had been authorised for patients on the forensic wards.

This section is primarily information for the provider

Requirement notices

The provider did not ensure that it was consistently recorded what action has been taken when it was indicated that a NEWS2 score should be escalated on the forensic and PICU wards.

The provider did not ensure that emergency equipment audits were carried out on Curridge ward.

The provider did not ensure that the reducing restrictive practices policy was followed and understood by the staff teams on the PICU wards.