Wellesley Hospital

Quality Report

Westpark 26
Chelston
Wellington
TA21 9FF
Tel:01823 668150
Website:http://www.elysiumhealthcare.co.uk/locations/wellesley/

Date of inspection visit: 24 and 25 and 31 October and 1 November 2017
Date of publication: 08/02/2018

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

Overall summary

- The monitoring of side effects following rapid tranquilisation (RT) was not always completed in line with the National Institute for Health and Care Excellence (NICE) guidance. Not all registered nurses knew where Flumazenil, (which is a medicine that is used to reverse the potentially harmful effects of benzodiazepine medication), was kept or what it was for. Although improving, there were various medication administration errors on Mendip ward, including missed staff signatures. Records to show that emergency medical equipment on Mendip ward was checked regularly was missing or incomplete.
- Mendip ward was currently experiencing a high volume of patient on patient and patient on staff assaults. This was due to the current mix of patient's. All five patients we spoke with shared concerns relating to staffs ability to safely diffuse situations. Although there was a comprehensive induction programme for all new starters at the hospital, this had failed to ensure that staff understood the differences between patients being nursed within a medium and low secure setting. Morale was varied at the hospital. Some staff that we spoke with prior, during and post the inspection visit described low morale, but did not feel able to raise this with senior managers for fear of recrimination. Not all staff said that their colleagues represented the values set by Elysium Healthcare, describing situations where communication could be better.
- The rights of patients on Mendip, the low secure ward, were not being protected. Policies and procedures that should have been in place to protect the rights of patients not requiring medium security were either inadequate or missing. Care records were not in line with professional standards for record keeping. Daily records relating to patients general wellbeing, mental health and activity levels were either missing or poorly recorded. Care pans relating to specific health needs and or patient activities were poorly recorded and or absent. Records relating to the seclusion of patients were either completed incorrectly and / or incomplete. Dental care was available for patients who were able to leave the hospital but was not available for those that could not.

However:

- Ligature risks had been reduced by minimising ligature points within the building. Ligature assessments were up to date and available on each ward. There was a meeting each weekday morning to discuss incidents, staffing and other risk related issues.

Summary of findings

- Safeguarding events were recorded by staff and information sent to the safeguarding lead for further consideration and escalated to the local authority if necessary. The importance of relational security was covered in the staff induction. There was access to an advocate Monday to Friday.
- The assessment of patient's physical health was completed on admission and routinely and regularly thereafter. We observed staff interacting with patients in a patient and caring manner. Community meetings were held weekly on both wards. There was a patient council group within the hospital. A daily planning book was completed by patients in partnership with the lead occupational therapist (OT). All patients had their own bedrooms with ensuite facilities

Summary of findings

Contents

Wellesley Hospital

Services we looked at
Forensic inpatient/secure wards;

Summary of this inspection

Background to Wellesley Hospital

Wellesley Hospital, owned by Elysium Healthcare is a new purpose built 75 bed hospital in South West England for men and women with mental health problems.

It provides care for patients aged over 18 years within a medium and low secure setting. Many patients, but not all, who are admitted to a secure service will have been in contact with the criminal justice system. Patients who are admitted to a secure hospital will be subject to a detention under the Mental Health Act 1983.

Wellesley Hospital has been established since December 2016 and the first patients arrived in February 2017.

The hospital formed part of the south west forensic care pathway programme which has been commissioned by NHS England. This programme aims to reduce patient's length of stay and reduce the number of out-of-area patient placements.

Two wards were open at the time of our visit. Quantock ward, a medium secure ward for men and Mendip ward, a low secure ward also for men. Both wards were full, with 15 patients allocated to each ward.

The new female low secure ward was due to open on the 1 November 2017.

Our inspection team

On 24 and 25 October 2017 our inspection team comprised; two inspectors, one being the team leader, and an inspection manager. Due to concerns relating to restrictive practice we revisited the hospital again on the 31 October 2017, with a Mental Health Act Reviewer. On 1 November 2017, Mendip ward was inspected by a pharmacy inspector.

Why we carried out this inspection

On 24 and 25 October 2017 we visited the Wellesley hospital to undertake a comprehensive inspection as part of our ongoing comprehensive mental health inspection programme. However, we identified several areas of concern and as such we judged that it would be inappropriate to continue with the comprehensive inspection. We returned to the hospital on 31 October 2017 and conducted a focused inspection to look in detail at the specific areas of concerns identified at our visit the previous week. As this was a focused inspection we did not rate this service and will return in the near future to conduct a comprehensive inspection. As part of that inspection we will also follow up on all the areas of concern identified in this report to see whether the provider has made the required improvements. Following the comprehensive inspection we will rate the hospital in line with our methodology.

How we carried out this inspection

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

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

Before the inspection visit, we reviewed information that we held about the location.

During the inspection visit, the inspection team:

Summary of this inspection

- visited both wards at the hospital, looked at the quality of the ward environment and observed how staff were caring for patients
- spoke with five patients who were using the service
- spoke with the hospital manager and managers or acting managers for each of the wards
- spoke with six other staff members; including doctors, nurses, occupational therapist, psychologist and social workers
- spoke with the patient advocate
- looked at 30 care and treatment records
- looked at five seclusion records and 10 records relating to the Mental Health Act and Mental Capacity Act
- carried out a specific check of the medication management on both wards
- looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the service say

We spoke with five patients at Wellesley Hospital.

Patients we spoke with told us that the staff were kind and respectful, however all said that they had little confidence about the ability of staff to deal with and manage incidents safely.

Some patients told us of occasions where they have involved themselves in incidents to stop any further harm coming to either staff or patients.

All patients we spoke with were complimentary about the food and choices. All said that they were comfortable at Wellesley Hospital and liked the facilities that were available.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

- Mendip ward was experiencing a high volume of patient on patient and patient on staff assaults. This was due to the current mix of patients.
- The monitoring of side effects following rapid tranquilisation (RT) was not always completed in line with the national institute for health and care excellence (NICE) guidance. Flumazenil, which is a medicine that is used to reverse the potentially harmful effects of benzodiazepine medication, was available on both wards. However, not all registered nurses we spoke with knew precisely where it was kept and or what is was used for.
- Emergency medical equipment was checked regularly by staff on Quantock ward. However, Mendip ward had failed to ensure that medical emergency equipment was being checked on a regular basis.
- Although improving, there were various medication administration errors on Mendip ward, including missed staff signatures. This meant there was a risk of patients not receiving safe care and treatment.
- Records relating to the seclusion of patients were not appropriately completed.

However

- Ligature risks had been reduced by minimising ligature points within the building. Ligature assessments were up to date and available on each ward. Ligature cutters were available on both wards and staff we spoke with, knew where and how to access them.
- Safeguarding events were recorded by staff and information sent to the safeguarding lead for further consideration and escalated to the local authority if necessary.
- Both wards had a de-escalation area and seclusion room, with ensuite facilities available and access to secure outside space. There was clear observation of all parts of the seclusion room.
- Medication management procedures were in place including the storage and disposal of medicines. Fridge temperatures where medication was stored were within range and checked regularly.

Summary of this inspection

Are services effective?

- Care records were not in line with professional standards for record keeping. Daily records relating to patients general wellbeing, mental health and activity levels were either missing or poorly recorded. Care pans relating to specific health needs and or patient activities were poorly recorded and or absent. Most care plans showed evidence of cut and pasting, with standardised care plans containing the same information for most patients. There was very little evidence of patient involvement in the planning of their own care and treatment.
- All five patients we spoke with shared concerns relating to staffs ability to safely diffuse situations. Some patients described times when they have intervened in order to ensure no further harm came to any persons involved.
- Although there was a comprehensive induction programme for all new starters at the hospital, this had failed to ensure that staff understood the differences between patients being nursed within a medium and low secure setting.
- Dental care was available for patients who were able to leave the hospital but was not available for those that could not.

However

- The assessment of patient's physical health was completed on admission and routinely and regularly thereafter.
- The hospital had on display information relating to the 'see think act' initiative which aims to promote and raise awareness of the importance of relational security in secure care settings. The importance of relational security was covered in the staff induction.
- Although there were vacancies within the multi-disciplinary team, patients had access to a range of professionals including medical and nursing staff, social workers, psychologists and occupational therapists. There was access to an advocate Monday to Friday.

Are services caring?

- All patients we spoke with were positive about the care and treatment they received from medical staff. Patients particularly appreciated the badminton sessions held by one doctor.
- We observed staff interacting with patients in a patient and caring manner, which at times, was good humoured and light-hearted.

Summary of this inspection

- Community meetings were held weekly on both wards. There was a patient council group within the hospital and each ward had a patient representative that would attend.
- A daily planning book was completed by patients in partnership with the lead occupational therapist (OT).

However

- Care records did not always demonstrate patient participation.

Are services responsive?

- The rights of patients on Mendip, the low secure ward, were not being protected. Patients on Mendip ward who did not require care in line with medium security were subject to the same policies and procedures as the patients on the medium secure ward. Patients within low and medium security will typically have complex mental health disorders, a proportion of which would have come into contact with the criminal justice system at some point. The varying levels of security are designed to respond to the level of risk posed by patients to others. The lower the security level – the lower the risk posed. Policies and procedures that should have been in place to protect the rights of patients not requiring medium security were either inadequate or missing.
- Access to mobile phones was not clearly defined in either policy or the admissions information booklet.

However

- Most of the patients currently at Wellesley Hospital were transferred from other health facilities around the country. For most patients this meant being nearer to their families. Families and children were able to visit patients at the hospital by prior arrangement.
- All patients had their own bedrooms with ensuite facilities. Patients were able to personalise their bedrooms and we saw evidence of this by way of family photographs, books and ornaments.
- There was a range of activities available, including at weekends. The occupational therapy (OT) programme was overseen by the lead OT and included art and craft sessions, healthy eating groups and social events. IT equipment was available at the hospital, subject to risk assessment. We met patients with specific interests, including music and books. One patient was able to source a range of reading material and as a result, with the intention of opening a library at the hospital.

Summary of this inspection

- A recovery college initiative was being developed and we saw minutes of the development meeting for August and September.
- There was a clear system in place to respond to complaints.

Are services well-led?

- The senior team did not have full oversight of the fact that some of the care being delivered at the hospital was restrictive. There were no clear systems in pace to identify where this was occurring.
- The hospital was subject to a policy migration plan (the hospital had previously been under the ownership of Partnerships in Care), however, this was slow and only a few up to date policies were in place.
- Morale was varied at the hospital. Some staff that we spoke with prior, during and post the inspection visit described low morale, but did not feel able to raise this with senior managers for fear of recrimination. Many staff expressed their concerns about the patient mix on Mendip ward and the high level of incidents and potential for injury to both staff and patients.
- Not all staff said that their colleagues represented the values set by Elysium healthcare, describing situations where communication could be better.

However

- There was an obvious commitment from the senior staff management team, to ensure that Wellesley hospital evolved into a safe and caring environment for patients.
- There was a meeting each weekday morning to discuss incidents, staffing and other risk related issues. Members of the multi-disciplinary team, senior managers and ward managers attended.

Forensic inpatient/secure wards

Safe	
Effective	
Caring	
Responsive	
Well-led	

Are forensic inpatient/secure wards safe?

Safe and clean environment

- Mendip ward was experiencing a high volume of patient on patient and patient on staff assaults. This was due to the current mix of patients. During our time over the course of three days we were made aware of several incidents that had occurred, including injury to staff. We raised our concerns with the senior management team, who in partnership with the lead NHS England commissioner were addressing the issue.
- Both wards were modern and bright. All patients had their own bedrooms with ensuite facilities. There was however, an odour on Mendip ward which staff said was due to incontinence. Cleaning records did demonstrate the efforts that were being made to minimise the odour on Mendip ward. In addition there was an unpleasant odour on Quantock ward upon entering, which was due to the bins being stored within the sluice area, which led directly onto the central, communal area of the ward. Patients we spoke with shared with us their concerns about hygiene, due to the location of the bins. We brought this to the attention of ward management and the bins were removed immediately.
- Staff on Quantock ward checked emergency medical equipment regularly; we saw records to demonstrate this. All the necessary emergency medical equipment was present, in date and in working order. However, staff on Mendip ward had failed to ensure that medical emergency equipment was checked on a regular basis.
- Both wards had a de-escalation area and seclusion room, with ensuite facilities available and access to secure outside space. There was clear observation of all parts of the seclusion room. Staff were able to communicate with patients who were in seclusion by way of a drop down hatch within the seclusion room door itself. There was access to a television and music during periods of seclusion.
- Ligature risks had been reduced by minimising ligature points within the building and through the use of patient observations. A ligature point is anything which could be used to attach a cord, rope or other material for the purpose of hanging or strangulation. Ligature assessments were up to date and available on each ward. Ligature cutters were available on both wards and staff we spoke with, knew where and how to access them.
- There were measures in place that meant that staff could observe patients in all parts of the hospital building. For example, CCTV cameras were in operation and staff monitored patient's whereabouts through regular observation. We reviewed all 30 records relating to the use of observations; all were complete and up to date.
- There were visual prompts for hand washing techniques in the communal toilet facilities and infection control information displayed on notice boards.
- All staff had access to personal alarms which would be used to call for assistance during times of a psychiatric or medial emergency. These alarms were collected from reception at the air lock which was situated at the front of the hospital at reception. Finger print recognition was required to access keys. All staff were required to check that their alarms were working prior to leaving the air lock at reception. On each ward and on each shift, a nurse was allocated responsibility for security on the ward. This involved overall awareness of any potential safety and or security issues that may occur. In addition they kept a record of visitors entering and leaving the ward.

Forensic inpatient/secure wards

Safe staffing

- Wellesley hospital was continuing to recruit a range of health care staff. Many staff had relocated into the surrounding area to work at Wellesley hospital.
- There were three registered mental nurse (RMN) vacancies and seven health care support worker (HCW) vacancies on Quantock ward. On Mendip ward there were four RMN vacancies and six HCW vacancies. Where there were vacancies, the hospital had recruited agency staff on longer term contracts to provide consistency. These agency staff were subject to the same two week induction package as permanent staff.
- Since opening there had been a number of staff leavers. We were told by the hospital director this was in part due to fact that nursing patients within a secure environment is a highly specialised area of health care and did not suit all staffs career choice and pathway. Between January and July 2017 there had been a total of 11 staff leavers.
- Wellesley hospital ran a two shift system, with both day and night working. The day shift started at 7:30am until 7:45pm. The night shift started at 7.30pm and ended at 7.45am. Where possible, both wards aimed to have two registered nurses on duty during day shifts and one registered nurse at night.
- On Quantock ward, between January and July 2017 53 shifts were filled by bank staff to cover sickness and vacancies. 242 shifts were filled by agency staff. There were 11 shifts that had not been filled by bank or agency staff. On Mendip ward, for the same time period, 31 shifts were filled by bank staff, 265 shifts with agency staff and 22 shifts had not been filled by either bank or agency staff. Where staffing levels were below the required levels, ward managers, the lead nurse and other senior staff would work on the wards.
- The ward manager was able to address staffing levels as required in order to meet patient and need and clinical demand.
- Compliance for statutory and mandatory training ranged between 56% for suggestions, ideas and complaints to 100% for life support and breakaway techniques training. Management of Violence and Aggression had a compliance rate of 98%. All staff received a two week induction prior to starting work on the wards.

Assessing and managing risk to patients and staff

- The monitoring of side effects post rapid tranquilisation (RT) was not always completed in line with the national institute for health and care excellence (NICE) guidance. Records relating to the administration of RT, including seclusion documents, were incomplete, indicating that staff had failed to monitor patients for potentially life threatening effects. Rapid tranquillisation is when medicines are given to a patient who is very agitated or displaying aggressive behaviour to help quickly calm them down. This is to reduce any risk to themselves or other people.
- Flumazenil, a medicine that is used to reverse the potentially harmful effects of benzodiazepine medication, was available on both wards. However, not all registered nurses we spoke with knew precisely where it was kept and or what is was used for. Benzodiazepines are a group of medicines that are commonly used during a RT event to induce sedation and or muscle relaxation.
- We found evidence in one patients care records to show that least restrictive principles with regards to the use of RT had not been adhered to. We saw information in the care record stating that intra muscular (IM) benzodiazepine medication should be used as the first choice in managing challenging behaviours. This is not in line with NICE guidance and the Code of Practice (CoP) which states that attempts to administer oral medication for the purposes of RT should be made in the first instance.
- We reviewed five records relating to the seclusion of patients. Most records did not adhere to Code of Practice (CoP) guidance. Records were either completed incorrectly or incomplete. We bought this to the attention of senior management who have taken immediate action to improve the quality of records relating to the seclusion of patients.
- Mobile phones were not allowed on Quantock ward. Although access was restricted, mobile phones were allowed on Mendip ward. Access was subject to risk assessment and agreement from the patient's multidisciplinary team. We were told by senior staff that patients had to agree to certain conditions before they were allowed access to their mobile phones however this was not clearly defined in either the policy and/or the admissions information.
- Safeguard events were recorded by staff and information sent to the safeguard lead for further consideration and escalated to the local authority. All

safeguard events and any incidents were discussed at a managers meeting that was held daily Monday to Friday. This ensured that all incidents that should be categorised as a safeguarding event were escalated to the local authority for further consideration.

- Patients were subject to regular and routine risk assessments. Risk information was detailed and updated following incidents. The hospital used the Historical Clinical Risk Management (HCR20) tool, which is an assessment tool for monitoring the risk of violence in patients.
- Between February and July 2017 Quantock ward reported five incidents involving restraint involving four different patients. None were reported as being in the prone position. Prone restraint means holding a patient in a face down position. Risks related to prone restraint include asphyxiation. Mendip ward reported there were 32 incidents involving the use of restraint, involving five different patients. Of these 32, the hospital reported three were in the prone position.
- Wellesley Hospital received support from an external company with regards to medication management. Pharmacists visit the hospital weekly to undertake stock checks and audit. Although improving, (due to the oversight of the visiting pharmacist) there were various administration errors on Mendip ward, including missed staff signatures. The clinic rooms on both wards were well organised. Medication management procedures were in place including the storage and disposal of medicines. We saw records to show that fridge temperatures where medication was stored were within range and checked regularly.
- Child visiting was subject to risk assessments and other considerations, including accessing further information from the local authority if necessary.

Track record on safety

- There had been no serious incidents reported since the hospital opened.

Reporting incidents and learning from when things go wrong

- Staff knew what to report and how to report incidents. Wellesley hospital used an electronic incident recording system. We reviewed 15 incident records relating to incidents, five of which we reviewed more closely. Of these five the quality and detail contained within the incident record allowed a good understanding of what had occurred and what actions were taken. In addition, the incident reporting system linked directly to care records. This meant that incident was automatically updated in the care records.
- Incidents were reviewed by relevant ward managers and escalated to senior managers. We spoke with the hospital director who was able to show a good level of knowledge into incidents that had occurred and what actions had since been taken. In addition all incidents were reviewed at the manager's morning meeting which was held daily Monday to Friday.

Are forensic inpatient/secure wards effective?

(for example, treatment is effective)

Assessment of needs and planning of care

- We reviewed 30 care records across both wards and found examples of where records were not in line with professional standards for record keeping. Two patients on Mendip ward had not had any entries relating to their general wellbeing, mental health and daily activities made onto the electronic care record system on three separate days. Some of the content relating to patients was subjective, describing one patient as 'needy'.
- Care plans relating to authorised unescorted leave for one patient was absent. This was of particular concern given the risks to the public that had been previously identified. Care plans relating to specific health needs including epilepsy and opiate addictions where poorly recorded and or absent. Some patients had been prescribed Clozapine medication. Although routine monitoring of vital signs was taking place, if not monitored correctly, Clozapine can produce side effects that are life threatening. Care plans relating to the care and treatment of patients on Clozapine were limited and did not guide staff as to what level of monitoring was required. Most care plans showed evidence of cut and pasting, with standardised care plans containing the same information for most patients. There was very little evidence of patient involvement in the planning of their own care and treatment. We bought this to the attention of senior management who have taken action to improve the quality of care plans and record keeping.
- Patients had their physical health assessed on admission and an annual health check was carried out

thereafter. We reviewed 30 care records and saw that this was the case. On-going physical health checks such as blood pressure or weight monitoring took place routinely and regularly.

Best practice in treatment and care

- Many of the patients on Mendip ward were subject to high doses of anti-psychotic medication. All of these patients had in place high dose anti-psychotic therapy (HDAT) guidance forms. High dose anti psychotics occur when medications are prescribed that exceed the recommended amount outlined by the British National Formulary (BNF). All patients on high-dose antipsychotic treatment must be monitored in the interests of the patient's health and safety. We saw evidence in all cases to show that the monitoring of these patients health and safety was being completed.
- General medical care was the responsibility of medical and nursing staff at Wellesley hospital. Although staff were trained in life support, in the event of an emergency, 999 services were required. In addition a GP and practice nurse visited the hospital weekly to support patients physical health needs.
- The hospital director informed us that dental care for patients who were able to leave the hospital was sourced locally. However, dental provision for those patients that were unable to leave the hospital grounds was still yet to be sourced and the provider was seeking assistance from NHS England (NHSE) in doing so.

Skilled staff to deliver care

- Due to Wellesley Hospital being new, there was a mixture of experienced and inexperienced staff. This posed challenges to the hospital with regards to staff being able to confidently respond to incidents. Although de-escalation skills were taught as part of restraint training, five patients we spoke with shared concerns relating to staffs ability to safely diffuse situations. Some patients described times when they have intervened in order to ensure no further harm came to any persons involved.
- Although there was a comprehensive induction programme for all new starters at the hospital, this had failed to ensure that staff understood the differences between patients being nursed within a medium and low secure setting. Staff we spoke with told us that they had not been taught at induction how to preserve the rights of patients within differing levels of security.
- The hospital had on display information relating to the 'see think act' initiative which aims to promote and raise awareness of the importance of relational security in secure care settings. Relational security is a term used to demonstrate the level of knowledge and understanding staff have of a patient and of the environment; and how that knowledge and understanding informs care delivery. Relational security was covered in the staff induction.
- Patients had access to a range of professionals including medical and nursing staff, social workers, psychologists and occupational therapists. There was a vacancy for a lead psychologist. Interim arrangements had been made to support the assistant psychologist and the hospital planned to advertise this vacancy in the near future.
- Staff performance issues were addressed as and when they arose.
- Staff were receiving clinical supervision. The hospital reports that as of July 2017 showed 90% of staff were engaged in clinical supervision. Staff we spoke with confirmed they received regular monthly supervision.
- Between 1 January and the 31 July 2017 the hospital reports and overall total of 1.2% staff sickness on both Quantock and Mendip ward.

Multi-disciplinary and inter-agency team work

- The hospital formed part of the south west forensic care pathway programme which had been commissioned by NHS England. This programme aimed to reduce patient's length of stay and reduce the number of out-of-area patient placements. As a result, there were patients at Wellesley Hospital who were now nearer their families in the south west region.
- The hospital held regular meetings with the NHS England commissioners with regards to patients care and treatment.

Adherence to the MHA and the MHA Code of Practice

- We did not complete a formal Mental Health Act monitoring visit as part of this inspection. However, we did review some Mental Health Act (MHA) paperwork as part of the overall inspection.
- All paperwork relating to consent to treatment was in place, up to date, available and in order.
- Information was available to patients about how to access the Independent Mental Health Advocacy service (IMHA).

Forensic inpatient/secure wards

Good practice in applying the MCA

- We did not complete a formal Mental Capacity Act monitoring visit as part of this inspection. However, we did review some Mental Capacity Act (MCA) paperwork as part of the overall inspection.
- For patients who might have impaired mental capacity, staff assessed and recorded capacity to consent appropriately. We found that seven of the 11 records we looked at contained capacity assessments.
- When required, decision specific capacity assessments were completed.

Are forensic inpatient/secure wards caring?

Kindness, dignity, respect and support

- All patients we spoke with were happy about the care and treatment they received from medical staff. Patients particularly appreciated the badminton sessions held by one doctor.
- We observed staff interacting with patients in a patient and caring manner, which at times, was good humoured and light-hearted.
- Several patients were willing to share their experience of mental health and of their time at Wellesley Hospital through the use of music and lyrics. This provided good insight into patient's journey and aspirations.

The involvement of people in the care they receive

- Community meetings were held weekly on both wards. This was an opportunity for patients to raise any concerns or thoughts they may have about the service. Senior managers would also attend where possible.
- A daily planning book was completed by patients in partnership with the lead occupational therapist (OT). Patient birthdays were celebrated through personal requests for their favourite foods.
- There was a patient council group within the hospital and each ward had a patient representative that would attend.
- The hospital employed an advocate who was available for patients Monday to Friday.
- Care records did not always demonstrate patient participation. We found evidence on most records to show that the cut and pasting of sentences and information had been used from one patient's records to another.

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

Access and discharge

- Referrals, access and potential discharges would be discussed through the south west forensic care pathway programme. Once placed in Wellesley Hospital, patients' needs and progress were continually monitored as part of the forensic care pathway.
- Most of the patients currently at Wellesley Hospital were transferred from other health facilities around the country. Most of the patients currently at Wellesley lived within the south west area. Access to the hospital was by referral from other health services and or the criminal justice system.
- Both wards were currently full with 15 patients on each. There had been no discharges as yet from the hospital.
- Movement between wards was based on the clinical need of patients.
- Transfer between wards was always done at appropriate times of the day, unless the need to manage increased risk dictated otherwise.

The facilities promote recovery, comfort, dignity and confidentiality

- All patients had their own bedrooms with ensuite facilities. These rooms were spacious and bright. Patients we spoke with told us that they were comfortable.
- Patients were able to personalise their bedrooms and we saw evidence of this by way of family photographs, books and ornaments.
- Although not fully functional, the hospital had various rooms and areas, including a café and art room. There was a gymnasium which was being used by patients and regular badminton sessions were being held by medical staff.

Forensic inpatient/secure wards

- Families were able to visit patients at the hospital by prior arrangement. All visits were held off the wards in a designated room near the hospital reception.
- Hot and cold drinks were available on both wards at all times, unless the level of risk on either ward dictated otherwise. Any restrictions of this kind were temporary and access would be reinstated once the risks had minimised.
- Both wards had a private space for patients to make telephone calls.
- Personal belongings were kept in bedrooms. Subject to risk assessment, some patients had their own keys to their bedrooms. Restricted items were kept in a secure area on each ward, accessed only by staff.
- The Occupational Therapist had recently been appointed and had introduced and was developing further an activity plan that included art and craft sessions, healthy eating groups and social events. In addition the hospital had recently appointed a physical activity assistant who would support patients to use the gymnasium and engage on other activities such as football.

Meeting the needs of all people who use the service

- The rights of patients on Mendip ward were not being protected. Patients who did not require care in line with medium security were subject to the same policies and procedures as the patients on the medium secure ward. Policies and procedures that should have been in place to protect the rights of patients not requiring medium security were either inadequate or missing. As a result this meant that patients on Mendip ward had their rights restricted, including access to outside space. Post inspection we shared our concerns with the local NHS England commissioner. At the time of our inspection, we brought this to the attention of senior management who were taking action to ensure that policies and procedures were adjusted and or completed to reflect the rights of patients who do not require care in line with medium secure arrangements.
- We met patients with specific interests, including music and books. One patient was able to source a range of reading material and as a result, a library will be available in the near future at the hospital. We were told by the hospital management that they will consider a music room for the hospital.
- A recovery college initiative was being developed and we saw minutes of the development meeting for August and September 2017. The recovery college would aim to provide patients with tools and skills for future employment.
- IT equipment was available at the hospital and subject to risk assessment; access was agreed by the patient's multidisciplinary team.
- The hospital provided facilities suitable for disabled patients, including easy access exits and entrances, lift access to the upstairs wards, wide corridors for the safe navigation of wheel chairs and assisted bathroom facilities.
- Information related a range of illnesses and treatments were available for patients.
- Access to interpreters would be sourced locally as and when required.
- There was a multi faith room for patients form different denominations. The hospital was yet to source a range of religious representatives who could visit the hospital on a routine and as required basis.

Listening to and learning from concerns and complaints

- There was a clear system in place to respond to complaints. Complaints from patients on the ward were initially reviewed by the ward manager with attempts made to resolve them at a local level. If ward managers were unable to resolve complaints at this stage, a formal complaint would be raised with the hospital director. An example of a recent investigation was a complaint about the lack of activities available. We were able to see that this had been addressed, including the appointment of a new fitness instructor. All complaint information fed into the board report for senior managers to review.
- There were four complaints in progress at the time of our inspection. We reviewed two response letters that had been signed by the hospital director. Responses contained apologies for failings where necessary and guidance of how patients could escalate their concerns if they were unhappy with the outcome of the hospitals investigation. Patients could be supported by the advocate to raise concerns if they so wished.

Forensic inpatient/secure wards

Are forensic inpatient/secure wards well-led?

Vision and values

- The values for Elysium healthcare are as follows: innovation, empowerment, collaboration, compassion and integrity. Staff we spoke with at Wellesley hospital knew the companies values and agreed with them. However not all staff said that their colleagues represented the values set by Elysium healthcare, describing situations where collaborative working could be better.

Good governance

- The hospital was subject to a policy migration plan (the hospital had previously been under the ownership of Partnerships in Care), however, this was slow and only a few up to date policies were in place. For example, one policy surrounding the escorting of section 37/41 and 48/49 MHA 1983 patients was unclear about the requirements of staff undertaking the escorting duties. This meant that potentially the hospital would be in breach of its own policies and procedures. At the time of our inspection, we brought these matters to the attention of the senior team and a plan of action was put in place.
- There was a meeting each weekday morning to discuss incidents, staffing and other risk related issues. Members of the multi-disciplinary team, senior managers and ward managers attended. Actions to address issues were set and previous actions were followed up. We saw records to show that this was the case.
- There was an electronic dashboard available to senior managers and ward managers that allowed monitoring of their teams performance against key performance indicators (KPI). The dashboard also contained other general information about patients, including commissioning and GP details. Information relating to supervision were held on a supervision data base that managers had access to.
- There was a risk register in place which was reviewed through the governance meetings by senior management.

Leadership, morale and staff engagement

- Although there was an obvious commitment from the senior staff management team, to ensure that Wellesley hospital evolved into a safe and caring environment for patients. There was a lack of oversight and awareness with regards to restrictive practices.
- The senior management team had recognised the need to have gradual increase in-patient admissions in order to ensure that staff; processes and facilities were able to cope effectively. The senior management team reported that the local area commissioners and members of the forensic network initiative were supportive of this approach.
- Most staff described the senior staff management team as visible and accessible. All ward staff we spoke with described the two ward managers as supportive and enjoyed working under their leadership.
- Ward staff we spoke with told us that when an incident occurred and alarms were raised, that senior staff, including the hospital director would attend. Staff shared that they appreciated the additional support at these times.
- However, morale was varied at the hospital. Some staff that we spoke with prior, during and post the inspection visit described low morale, but did not feel able to raise this with senior managers for fear of recrimination. Many staff expressed their concerns about the patient mix on Mendip ward and the high level of incidents and potential for injury to both staff and patients. We shared staffs concerns with senior management who have taken action, in partnership with the NHS England commissioners to address the patient mix on Mendip ward and in addition, promote opportunities for staff to raise their concerns with confidence in the future.

Commitment to quality improvement and innovation

- The hospital is a member of a new partnership arrangement within the south west of England that seeks to transform secure care by minimising hospital admissions and out of area placements.
- Once more established, the hospital intends to register with the Royal College of Psychiatrist forensic quality network programme, which seeks to improve upon and maintain high standards of care within secure services.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that it continues to progress the policy migration plan and reviews and adjusts all polices to reflect the differing needs between low secure and medium secure patients.
- The provider must ensure that the rights of patients are maintained, particularly those who do not require medium secure care.
- The provider must ensure that patient safety is maintained and take measures to reduce the level of assaults occurring within the hospital.
- The provider must ensure that all staff are adequately equipped to manage and respond safely to incidents.
- The provider must ensure that all records relating to the use of seclusion are completed in line with the Code of Practice.
- The provider must ensure that standards relating to record keeping are improved and maintained in line with professional standards.
- The provider must ensure that patients are included in the planning of their care and treatment and that a patient centred care approach is reflected in records.
- The provider must ensure that all records relating to the administration and monitoring of rapid tranquilisation are completed in line with NICE guidance. In addition, the provider must ensure that staff are familiar with where to locate Flumazenil and what it is used for.
- The provider must ensure that records relating to the checking of medical emergency equipment are completed.

Action the provider SHOULD take to improve

- The provider should secure dental care for those patients who are not able to leave hospital.
- The provider should ensure that the improvements with regards to medication management on Mendip ward are maintained.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 13: Safeguarding service users from abuse and improper treatment. Service users must be protected from abuse and improper treatment in accordance with this regulation. Patient on patient assaults were common at Wellesley hospital. This was particularly so on Mendip ward due to the current mix of patients. This is a breach of Regulation 13 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 12: Safe care and treatment: The provider must ensure that persons providing care or treatment to service users have the qualifications, competence, skills and experience to do so safely. All patients we spoke with shared concerns relating to staffs ability to safely diffuse situations. This is a breach of regulation 12 (2c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Requirement notices

Care and treatment must be provided in a safe way for service users.

The monitoring of side effects post rapid tranquilisation (RT) was not always completed in line with the national institute for health and care excellence (NICE) guidance.

The provider must ensure that persons providing care or treatment to service users have the qualifications, competence, skills and experience to do so safely.

Staff did not always know where to locate Flumazenil and what is was used for.

These are a breach of regulation 12 (1) and (2c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 17: Good Governance The provider must ensure that they and staff maintain an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided. Care records were not in line with professional standards for record keeping. Daily records relating to patients general wellbeing, mental health and activity levels were either missing or poorly recorded. Care plans relating to specific health needs and or patient activities were poorly recorded and or absent. Records relating to the seclusion of patients were either filled in incorrectly and or incomplete. These are a breach of regulation 17 (2c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Requirement notices

The provider must ensure that systems or processes are established and that such systems or processes must enable the registered person to assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity (including the quality of the experience of service users in receiving those services).

Policies and procedures that should have been in place to protect the rights of patients not requiring medium security were either inadequate or missing.

Records relating to the checking of medical emergency equipment on Mendip ward were missing and or incomplete.

This is a breach of regulation 17 (1) and (2a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 9: Person Centred Care. The provider must ensure that they and staff carry out, collaboratively with the relevant person, an assessment of the needs and preferences for care and treatment of the service user. Most care plans showed evidence of cut and pasting, with standardised care plans containing the same information for most patients. There was very little evidence of patient involvement in the planning of their own care and treatment. This is a breach of regulation 9 (3a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Requirement notices

The provider must ensure that the care and treatment of service users is appropriate and meets their needs.

We were concerned to learn that the rights of patients on Mendip ward were not being protected. Patients who did not require care in line with medium security were subject to the same policies and procedures as the patients on the medium secure ward.

This is a breach of regulation 9 (1a) and (1b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.