Cygnet Hospital Beckton

Quality Report

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

Ratings

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

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

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

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

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

Summary of findings

Overall summary

We rated Cygnet Hospital Beckton as **requires improvement** because:

- The provider had not identified in its risk assessments, all the points where a ligature could be tied. Where it had identified potential ligature points and work was required, the provider had not set dates when this would be completed.
- For two patients, the assessments completed prior to their admission were either not available, or had not been considered by staff when developing initial risk assessments along with the measures required to manage or mitigate the risks. One patient on Hooper ward did not have areas of the care plan that addressed their holistic needs and two care plans for patients on Bewick ward did not contain their views on their care and treatment.
- Staff could prevent patients from leaving the de-escalation room on Hooper ward. Staff did not recognise that this constituted seclusion and did not provide patients with the proper safeguards. Staff had not recorded some incidents of restraint properly and had not carried out some of the checks required after rapid tranquilisation of patients. The provider monitored the use of restraint but staff were not able to identify trends in the use of restraint.
- Staff had not recognised a significant safeguarding concern at the hospital and had not followed appropriate safeguarding procedures. The provider did not have robust systems to share learning about incidents and complaints between wards.
- Not all staff understood how to apply the Mental Capacity Act or the circumstances when a capacity assessment would be appropriate. The provider did not have robust systems in place to ensure that they were using the Mental Capacity Act appropriately.
- Staff had not administered all medicine appropriately and within the prescribed guidelines. For some patients, staff had not addressed how they were meeting physical health care needs in care and treatment records.
- When some patients received rapid tranquilisation, staff had not appropriately monitored their physical health afterwards. New Dawn one and two shared an emergency grab bag which may have resulted in delays in an emergency.
- On New Dawn ward not all nursing and support staff had received dialectical behavioural therapy training. The provider did not have figures for the numbers of staff who had completed this training and patients commented that nurses and support staff did not understand their needs or the necessary therapeutic approach.
- Some patients on Hooper and Hansa wards were not able to access drinks and snacks without having to ask staff to open the dining room.

However:

- Wards were clean and well maintained. The provider maintained safe staffing levels and staff had access to personal alarms. Staff completed appropriate mandatory training.
- Patients were able to access a range of psychological therapies and the multidisciplinary team included an appropriate mix of disciplines.
- We observed positive interactions between patients and staff. Staff were caring and respectful of patients' needs. Overall, patients spoke positively about staff and felt they were friendly. Staff had a good understanding of patients' individual needs and projected a caring approach when discussing patients.
- Staff held regular community meetings on each ward. Patients were also able to participate in staff recruitment and quality improvements within the hospital and feed back on the care and treatment they received.
- Overall, staff provided appropriate activities on the wards. Patients had unrestricted access to outside areas and a range of communal spaces were available on each ward. A range of meals were available to meet patients' dietary requirements. Staff could support patients to access spiritual support. Staff could request interpreters, if required.
- Line managers supported staff appropriately. Managers at different levels had oversight of incidents,

Summary of findings

complaints, supervision and appraisals. The provider met targets for a range of key performance indicators. Staff undertook audits, with actions identified and followed through.

- Sickness rates were low and overall staff morale was good. The hospital had developed a values-based recruitment process and recruitment to vacant posts was on-going. The hospital was part of the accreditation for inpatient mental health services (AIMS) and was an "investor in people", an independent framework to promote leadership, support and good management of staff.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Acute wards for adults of working age and psychiatric intensive care units	**Requires improvement** 	We gave an overall rating of requires improvement because: • Staff had not identified potential ligature points in the quiet room. We observed that the hinges, the door and a hole in the door all presented ligature points. It was unclear whether the description in the risk assessment addressed this. Staff had also not included picture frames and had no control measures to mitigate. • Staff had not updated the ward's ligature risk assessment following a serious incident. The provider had reviewed and updated the ligature risk assessment on New Dawn ward following a serious incident involving a potential anchor point, but staff on Hooper ward had not put measures in place to mitigate the risk. • Staff did not afford protection to patients prevented from leaving the de-escalation room. Staff informed us that if patients wanted to leave the de-escalation room, they might use restraint and detain them. This constituted as seclusion and staff had not recorded the time and reasons for seclusion. The Mental Health Act code outlines a number of practices to protect patient rights when being nursed in seclusion, including recording of the time seclusion started, the reasons for the seclusion and regular checks during the period of seclusion. • Staff had not recorded and given appropriate physical health checks to patients after administering rapid tranquilisation. Staff had given 10 doses of Lorazepam injections to patients on Hooper ward from 8 August until 25

Summary of findings

August 2015. The rapid tranquilisation observation record indicated that four charts were completed for the same period. Of these four, two had been completed in line with provider's policy "The prevention and management of aggression". This meant that on six occasions patients had not received appropriate checks.

- Staff on Hooper ward had not taken appropriate action to safeguard a patient. A member of staff had inappropriately restrained a patient and the patient made a complaint which was upheld. Staff had not recognised this constituted a safeguarding concern and had not raised a safeguarding alert.
- Staff had not considered all available information relating to risk at the point of admission. We reviewed a patient who had recently self-harmed and had episodes of poor care. Staff had not included this in the patients risk assessment and had not put appropriate measures in place to address this.

However:

- There were sufficient staff on duty to meet patient needs and maintain a safe environment.
- The provider had developed specific care plans with certain patients regarding violence and aggression and liaised with local police. As a result, the ward had experienced a recent downward trend in the number of incident reports relating to violence and aggression.
- Ward staff spoke highly of the specialist training they had received relating to the development and use of de-escalation techniques.

Summary of findings

- We observed positive interaction between patients and staff. Staff were caring and respectful of patients' needs.
- The patients we spoke with felt the food was of good quality.

Forensic inpatient/ secure wards

Good

We gave an overall rating of good because:

- There were no incidents of rapid tranquilisation on the ward from November 2014 to the time of our inspection. The ward manager attributed this to the successful use of de-escalation methods
- From the care records we reviewed, staff had identified physical health needs and followed these up. An example of this was a patient who had a history of chest infections. The ward doctor was aware of the issue and had highlighted the risk in the care plan.
- Care plans were reviewed regularly and were recovery orientated and ran in conjunction with eight outcome areas; my mental health recovery, stopping my problem behaviours, getting insight, recovery from drug and alcohol problems, making feasible plans, staying healthy, my life skills and my relationships. The clinician and patient rated each of the eight outcome areas against a series of outcome statements.
- Patients had access to a range of psychological interventions and the ward was recovery focused. Staff supported patients to develop their skills with a view to moving to independent living.
- Some staff had awareness training in dialectical behaviour therapy, START risk assessment and cognitive behavioural therapy training.
- We observed high levels of positive interaction between patients and staff.

Summary of findings

The staff and patient "social lunch" was an example of this, with staff and patients engaging with each other in a relaxed atmosphere.

However:

- Staff had not given a detailed and accurate description of risks on the ligature risk assessment. They had not addressed plans to address the risk or established dates for works required to remove ligature anchor points.
- Staff restricted visitors from bringing phones with cameras into the ward. Staff told us this was to protect patients from the risk of unauthorised photographs. Patients commented that this impacted upon family involvement as they could not view pictures or videos of family unable to visit.
- Staff had not recorded patients' views in care plans. Whilst care plans were individualised and comprehensive, staff had not recorded patients' views in relation to their objectives.

Wards for people with learning disabilities or autism

Requires improvement

We gave an overall rating of requires improvement because:

- Staff had not clearly identified ligature risks. Hansa ward had not reviewed and updated the ligature assessment after serious incidents involving a ligature anchor point on New Dawn ward, some of which had occurred at ligature points not previously identified as posing a potential risk. This was of concern as similar ligature anchor points were in place on Hansa ward. The provider could not be sure that they had identified all ligature points on Hansa ward and that appropriate measures were in place to manage and mitigate them.
- Staff had not appropriately recorded incidents of restraint. We examined a sample of recent incident reports and

Summary of findings

found that staff had not completed the appropriate reporting form. This meant that there was no record of staff involved in the restraint, which parts of the patient's body they had been in contact, and how long the hold had been maintained.

- Staff had not administered medicine appropriately and within prescribed guidelines. We observed that staff had prescribed one patient Haloperidol 5 -10 mg every four to six hours with a maximum of 10 mg in 24 hours. On the 24 August 2015, we saw staff had given 20 mg in a 24-hour period exceeding the maximum dose prescribed.

However:

- Staff displayed a good understanding of safeguarding and could identify events that should trigger a safeguarding alert and how to make one.
- Hansa ward used an adapted version of the dialectical behavioural therapy programme with the majority of patients having a diagnosis of emotionally unstable personality disorder or traits associated with this. An assistant psychologist co-facilitated the skills group with the clinical psychologist. This involved skills coaching sessions as and when patients requested.
- The treatment approach was similar to the structure, positive (approaches and expectations), empathy, low arousal, link framework. Activities and occupation were a key feature of the programme, along with a positive acceptance approach and a low stimulus environment.
- We observed positive interaction between patients and staff. We observed that staff were caring and respectful of patients' needs and actively supported patients.

Summary of findings

Tier 4 personality disorder services

Requires improvement 

We gave an overall rating of requires improvement because:

- The ward had not identified dates for completion of works on some ligature points. For example, staff had noted pipe work on New Dawn one as “protect/cover” but the ligature risk assessment had no timescales.
- The ward had not identified light fittings as presenting a ligature risk and had not recorded control measures. The provider had changed one light fitting on the ward because of a serious incident that involved a patient fixing a ligature but other en suite toilets still contained the original light fitting.
- The ward did not have sufficient emergency medical equipment available on the ward. There was only one emergency grab bag between New Dawn one and New Dawn two. There was a locked door between the units, which meant there could be a delay in staff accessing the emergency equipment in the event a patient collapsed.
- Staff on New Dawn ward had not received specialist training. Nurses and support workers had completed introductory training in dialectical behavioural therapy but had not completed any comprehensive training. There were no training records that showed the numbers of nurses and nurse assistants that completed any specialist training. Three patients commented that nursing and support staff did not have the necessary knowledge and skills relating to personality disorder to provide them with appropriate care, or a sound understanding of the model of treatment.

However:

Summary of findings

- The provider recognised that patients with a diagnosis of borderline personality disorder were at a particular risk of self-harm and suicide. This was reflected within the patient group receiving care and treatment on New Dawn ward at the time of our inspection, some of whom were at risk of fixing ligatures multiple times each day.
- Our discussions with staff and observation of handover showed that staff had a good understanding of patients' individual needs and projected a caring approach when discussing patients.
- Some patients had been involved in recent staff recruitment on the ward.
- Patients were able to access mobile phones supplied by the ward to make personal phone calls in private.
- Patients had unrestricted access to hot drinks and snacks.

Summary of findings

Contents

Requires improvement

Cygnet Hospital Beckton

Services we looked at

Acute wards for adults of working age and psychiatric intensive care units; Forensic inpatient/secure wards; Wards for people with learning disabilities or autism; Tier 4 personality disorder services;

Summary of this inspection

Background to Cygnet Hospital Beckton

Cygnet Health Care is an independent provider of mental health and social care services. Cygnet Hospital Beckton is one of 19 locations operated by Cygnet Health Care. Cygnet Hospital Beckton provides services for women with complex mental health needs. The hospital accepts emergency and planned pre-assessed admissions.

There are four wards at Cygnet Hospital Beckton. New Dawn Ward is an 18 bed personality disorder ward offering dialectic behaviour therapy (DBT) interventions in a locked environment. Bewick Ward, is a 15 bed low-secure unit for complex care and recovery, Hooper ward, is a 15 bed psychiatric intensive care unit (PICU) and Hansa ward is a 13 bed locked learning disability ward that provides care and treatment to detained and informal patients.

Cygnet Hospital Beckton is registered to provide assessment or medical treatment for persons detained under the Mental Health Act 1983 and treatment of disease, disorder or injury.

We have inspected the provider four times previously, most recently on 15 May 2013. At the time of the inspection, there were no outstanding areas of non-compliance.

Our inspection team

The team that inspected Cygnet Hospital Beckton consisted of six people, an inspection manager, an inspector, a Mental Health Act reviewer, a clinical psychologist specialist advisor, a nurse specialist advisor and an expert by experience. The expert by experience is a person who has developed expertise in relation to health services by using them.

Why we carried out this inspection

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

How we carried out this inspection

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

• Is it safe?

• Is it effective?

• Is it caring?

• Is it responsive to people's needs?

• Is it well-led?

Before the inspection visit we reviewed information that we held about the service and asked other organisations for information.

During the inspection visit the inspection team:

- spoke with 20 members of staff including the hospital manager, the safeguarding lead, the clinical services manager, the quality assurance lead, consultants, nursing staff, support workers, activity co-ordinators, and occupational therapists
- spoke with 17 patients
- observed a multidisciplinary team meeting
- observed a handover meeting
- observed how staff were caring for patients
- toured each ward and associated clinic room
- carried out a Mental Health Act monitoring visit on Hansa ward

Summary of this inspection

- examined the care and treatment records of 10 patients
- carried out specific checks relating to medication management on Hooper and New Dawn wards
- received feedback from four clinical commissioning groups (CCGs), NHS England, the local independent mental health advocate and local safeguarding leads
- reviewed a range of records relating to the running of the service.

What people who use the service say

- Most patients we spoke with were positive about their experience of care on the wards. They told us that staff were mostly caring, respectful and polite. However, a small number of patients told us that on occasion staff could be rude and inappropriate in the way they interacted with patients on Hansa, Hooper and New Dawn wards.
- Patients spoke positively about the range of activities provided during the week, but commented that there were only a few activities available at the weekend.
- Patients commented that it could be frightening when unwell patients were admitted to the ward. They also complained about the noise on some wards.
- Staff were a visible presence on wards. However, some patients felt that staff did not always acknowledge patients. Patients told us that staff based themselves in the nursing offices on wards, spoke to patients through closed office doors and did not sufficiently acknowledge patients when they approached the nursing office for support.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Requires improvement

We rated safe as **requires improvement** because:

- The provider had not identified all ligature anchor points in ligature risk assessments. Where works to address potential ligature anchor points were required, dates had not been set for these to be completed. On Hooper ward, there were blind spots on the ward, which meant that staff could not readily observe patients in all areas. No mirrors were in place to mitigate this potential risk.
- On Hooper ward, staff prevented patients from leaving de-escalation rooms and had not recognised this as a period of seclusion. Staff had not afforded patients the safeguards of the Mental Health Act code of practice relating to seclusion. Staff had not appropriately recorded all incidents of restraint, with details of the hold, the staff involved and the length of time the person was restrained for. The provider monitored the use of restraint but staff were not able to identify trends in the use of restraint.
- When some patients received rapid tranquilisation, staff did not appropriately monitor their physical health afterwards. New Dawn one and two shared an emergency grab bag, which would delay staff in the case of an emergency.
- Staff had not recognised a significant safeguarding concern and had not followed appropriate safeguarding procedures.
- Robust systems to share learning about incidents and complaints between wards were not in place. Whilst learning from incidents took place, the provider did not have systems to monitor changes identified into practice.

However:

- Wards were clean and well maintained. A suitably equipped clinic room was available on each ward.
- Staff had access to personal alarms and the provider maintained safe staffing levels.
- Staff completed appropriate mandatory training.

Are services effective?

Requires improvement

We rated effective as **requires improvement** because:

Summary of this inspection

- For two patients, not all pre-admission information was available. Staff had not considered this when developing initial risk assessments along with the measures required to manage or mitigate the risks.
- Some patients on Bewick and Hooper ward did not have care plans that addressed their holistic needs and contained their views.
- Not all staff understood how to apply the Mental Capacity Act (MCA) or the circumstances when a capacity assessment would be appropriate. The provider did not have robust systems in place to ensure the appropriateness of the MCA. Not all staff received training on specialist approaches such as dialectic behavioural therapy that were used on the wards where they worked. On New Dawn ward not all staff had an understanding of the needs of patients and the therapeutic treatment model they were involved in delivering.
- The provider had not administered all medicines appropriately and within the prescribed guidelines. For one patient, staff had exceeded the maximum dose of medication over a 24 hour period. For two other patients, staff used required medicines as night time sedation.
- Staff had not reviewed a patient who had self-harmed, by banging their head against the wall. Staff had identified another patient as having physical health care needs. The provider had not followed this up.
- Staff did not meet some patients' needs. Examples included staff that had not explained rights to three patients on a frequent basis and staff who had not met individually with patients.

However:

- Staff assessed patients appropriately on admission, including their physical healthcare needs.
- Patients were able to access a range of psychological therapies and the multidisciplinary team included an appropriate mix of disciplines.

Are services caring?

Good

We rated caring as **good** because:

- We observed positive interaction between patients and staff. Staff were caring and respectful of patients' needs.

Summary of this inspection

- Overall, patients spoke positively about staff and reported that staff were friendly.
- Staff had a good understanding of patients' individual needs and projected a caring approach when discussing patients.
- The provider developed buddying systems and information packs to orientate patients on admission.
- Staff held regular community meetings on each ward. Patients participated in staff recruitment and quality improvements within the hospital and gave feedback on the care and treatment they received.

However:

- Some patients on Hooper and Hansa wards were not able to access drinks and snacks without having to ask staff to open the dining room for them.
- On some wards, for example New Dawn, we saw that some staff based in the nursing office talked to patients without opening the door. On the same ward, some staff did not follow the provider's confidentiality policy and procedure as they discussed sensitive patient information in communal areas of the ward.

Are services responsive?

Good

We rated responsive as **good** because:

- There were few delayed discharges and patients always had a bed available when they returned from leave.
- Staff provided appropriate activities on the wards. The provider had a range of communal spaces on each ward. Patients had unrestricted access to outside areas. On long-stay wards, patients were able to personalise their bedrooms.
- A range of meals to meet patient's dietary requirements were in place. Staff could support patients to access spiritual support. Staff could access interpreters if required.

However:

- The provider fed back the outcome of individual complaints investigations to the staff concerned. However, the provider did not share learning with other staff.
- One patient on New Dawn ward was a wheelchair user. The environment had not been adapted so that the person could access their en suite bathroom. At the time of our inspection,

the person had to ask staff to give them access to the communal facilities. Staff told us that they had made a referral to obtain a wheelchair that would fit into the en suite facilities and that they were following this up.

Are services well-led?

Good

We rated well-led as **good** because:

- Staff were aware of the provider's values and vision and felt that their ward values reflected these. Line managers appropriately supported staff.
- Managers at different levels had oversight of incidents and complaints and also supervision and appraisal.
- The provider was meeting targets for range of key performance indicators. The provider regularly undertook audits, with actions identified and followed through where necessary.
- Sickness rates were generally low and overall staff morale was good. On a case by case basis, the hospital supported staff to undertake further education related to their role.
- The hospital had developed a values based recruitment process and recruitment to vacant posts was ongoing.
- The hospital was accredited for inpatient mental health services (AIMS) with the Royal College of Psychiatrists (Hooper, Bewick and Hansa wards) and was an "investor in people", an independent framework to promote leadership, support and good management of staff.

However:

- On New Dawn ward the provider did not monitor the deployment of bank staff over the two wards and was unable to respond to patients' concerns that bank staff were concentrated on New Dawn two, which patients felt impacted upon consistency of care.

Detailed findings from this inspection

Mental Health Act responsibilities

We do not rate responsibilities under the Mental Health Act 1983. We use our findings as a determiner in reaching an overall judgement about the Provider. During out inspection, a MHA reviewer conducted a support inspection and completed a separate report which is now available.

- The majority of staff (91%) had completed training relating to the Mental Health Act (MHA) and MHA Code of Practice as part of mandatory training. We were not able to obtain this figure at ward level. Staff recently received training addressing the need to use the least restrictive practice and were able to give examples of how their and the wards practice had developed as a result.
- Staff stored detention papers securely and completed them correctly. There was a Mental Health Act administrator on site to provide support to staff.
- There was regular access to an independent mental health advocacy service. The provider had weekly visits by a pharmacist who checked Mental Health Act compliance, prescription writing and patient details.
- Overall, patients had their rights regularly reviewed. However on Hansa and Hooper wards, some patients told us that they were not aware of their rights. The records we reviewed demonstrated that staff had not recently explained rights to patients.

Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff had completed Mental Capacity Act (MCA) training. However, staff could not describe the five statutory principles, or how they would implement the MCA while providing care and treatment for patients.
- Staff had not assessed capacity issues in the care records that we reviewed.
- Audits used by the provider were not adequately addressing issues relating to the MCA.
- The hospital manager and Mental Health Act administrator provided support around the MCA for staff. The provider had a policy and procedure relating to the MCA and Deprivation of Liberty Safeguards (DoLS).
- Staff had made a DoLS application once in the last 12 months. No patients were currently subject to DoLS.

Overview of ratings

Our ratings for this location are:

Detailed findings from this inspection

	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	Good	Requires improvement
Forensic inpatient/ secure wards	Requires improvement	Good	Good	Good	Good	Good
Wards for people with learning disabilities or autism	Requires improvement	Requires improvement	Good	Good	Good	Requires improvement
Tier 4 personality disorder services	Requires improvement	Requires improvement	Good	Good	Good	Requires improvement
Overall	Requires improvement	Requires improvement	Good	Good	Good	Requires improvement

Notes

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	Good

Are acute wards for adults of working age and psychiatric instensive care unit services safe?

Requires improvement

Safe and clean environment

- Staff could not readily observe patients in some areas as there were blind spots on Hooper ward. The ward did not have mirrors or other aids to address this. Staff mitigated the risk through regular observations depending on the level of risk which range from intermittent observations to one to one observations.
- CCTV was in operation on Hooper ward. Views from the cameras were not available on the ward, but were recorded and kept in the reception area and could be accessed when needed. Patients were aware that CCTV was in use.
- The provider had completed a ligature risk assessment on the ward dated November 2014. This identified that some fixings, for example showerheads, presented a ligature risk and required replacement. The provider did not give any timescales for completion of the work.
- Taps in patients' bedrooms and in the shared bathroom areas were of a standard type. The provider had identified works to replace them in September 2015 and this was included on the ligature risk assessment.
- At the time of our inspection, staff had local arrangements to manage and mitigate the potential risks presented by ligature points. This included daily environmental checks, locking bath and shower room doors, increased observations of individual patients and general observations.
- We identified potential ligature points in the quiet room. For example, the provider had not included picture frames in the ligature risk assessment, and no control measures were in place to mitigate. In the shower and bathrooms staff had identified the "door – door furniture" as a ligature point. We observed that the hinges, door and a hole in the door all presented ligature points, but it was unclear whether the description in the ligature risk assessment addressed all of these areas.
- Serious incidents had recently occurred on New Dawn (Personality Disorder) ward involving ligature points, some of which had happened at ligature points not previously identified as posing a potential risk. Our discussions with the ward manager and review of the Hooper ward ligature risk assessment showed that the document had not been reviewed and updated. This was of concern as the same ligature point was present on Hooper ward. The provider could not be sure that they had identified all ligature points on Hooper ward and that appropriate measures were in place to manage and mitigate them.
- The provider's corporate risk manager periodically reviewed the ligature risk assessment. However, staff had not annotated the risk assessment to reflect this, and did not show any re-assessment of ligatures since its production in November 2014. Hooper ward was a single sex ward (female) and did not have a seclusion room. A de-escalation room was available on the ward. Staff accompanied patients when they transferred to the

de-escalation room. Staff informed us that if patients wanted to leave the de-escalation room, staff might restrain them and detain them there. The Mental Health Act (MHA) code of practice states that patients prevented from leaving a room where they are isolated from other patients, constitutes seclusion. The code outlines a number of practices to protect patient rights when being nursed in seclusion, including recording of the time seclusion started, the reasons for the seclusion and regular checks during the period of seclusion. Staff did not afford this protection to patients prevented from leaving the de-escalation room.

- The ward included a clinic room and there was evidence of stickers for regular checks to equipment. Staff had completed regular checks of emergency medicines and equipment available on the ward. The clinic room was clean and well organised. Staff checked and maintained fridge temperatures on a daily basis. There was a treatment table in the room and a blood pressure monitor and scales.
- The ward area was well maintained with modern furnishings and visibly clean.
- Staff undertook environmental risk assessments regularly. Staff checked items such as cleaning materials and other potentially hazardous items to see they were stored safely.
- The ward had appropriate personal alarm systems for staff. The ward manager allocated staff members a personal alarm at the start of each shift. All personal items that posed a possible risk were stored in lockers at reception.

Safe Staffing

- The ward manager advised that a recent review of staffing levels had led to an increase in the staffing complement. The numbers of staff on shift had not increased, but the overall pool of staff had, lessening the need to call on bank and agency staff.
- During a day shift, the ward manager rostered three nurses and four support workers on duty. At night, two nurses and three support workers were on duty. Staffing rotas reflected these numbers. There were sufficient staff on duty to meet patient needs and maintain a safe environment.
- The establishment levels at the time of the inspection for qualified nurse's was 11.8 whole time equivalent and 21.7 for nursing assistants. At the time of the inspection, there were three nurse vacancies and three support worker vacancies. Recruitment to these posts was underway, with bank and agency staff covering vacant shifts in the interim. Bank and agency staff had recently covered 16 shifts on Hooper ward. A review of staffing rosters demonstrated that over the previous three months the ward had met its staffing establishment for each shift and there were enough staff to deliver safe care.
- The manager was able to adjust staffing levels as needed to meet patients' needs. An example of this would be when staff identified patients as requiring one to one observations. Discussions with staff and patients as well as examination of case records confirmed this.
- Staff rarely cancelled leave and patients told us that one to ones with named nurses happened regularly.
- A doctor was on the ward Monday to Friday from 9am to 5pm each day and an on call doctor was available at weekends and out of hours. We did not find any issues regarding medical cover during the inspection.
- Access to mandatory training was through e-learning and supplementary classroom training. The majority of permanent staff were up to date with their training. Some recently appointed staff had not yet completed the full range of mandatory training had arranged to do so.
- A dashboard that was updated daily, captured information around incomplete mandatory training. Ward managers reviewed this to understand which staff had not completed training. Mandatory training identified for staff included management of violence and aggression, life support, security awareness and the Mental Health Act. Staff also undertook training relating to the use of seclusion, physical health and safeguarding adults and children. In addition, nurses completed training addressing medicines management.
- Eighty-three percent of Bank workers had completed the mandatory e-learning package. 66.7% of Bank workers had completed supplementary classroom

training. Gaps were identified in relation to e-learning policy awareness training and some Bank workers were stopped from working until they met the required level of training compliance.

Assessing and managing risk to patients and staff

- Staff used the short term assessment of risk and treatability (START) tool to assess potential risks. Staff completed this risk assessment on admission for each patient. However, for one patient we reviewed, staff had not picked up information on admission at the point of referral. The patient had recently self-harmed through cutting, had made statements that they wanted to be dead, and had episodes of poor self-care with double incontinence. Staff did not include this in the patient's risk assessment. At the point of admission, staff had not considered all available information relating to risk and had not put appropriate measures put in place to address these.
- One patient's care records showed they had made allegations since admission that staff had sexually assaulted them. Staff had discussed the allegations in multidisciplinary ward reviews, and considered them unfounded and part of the person's presentation while unwell. Staff updated the patient's risk assessment to reflect the allegations made. However, they had not discussed this with the safeguarding lead as to how to address and manage the on-going allegations to ensure the safety of the patient and the staff caring for them.
- The ward had reviewed restrictive practises and did not have unjustified blanket restrictions. However, staff had locked the dining area where patients were able to access snacks and drinks outside of meal times and patients had to ask staff for access.
- The ward admission criteria required that patients referred were detained under an appropriate section of the Mental Health Act.
- The provider had an appropriate policy and procedure for observations that staff were aware of and followed. Staff nursed patients on one to one observations when required.
- Staff searched patients returning from community leave in accordance with the hospitals policy and procedure.
- From the 1 November 2014 to the 30 April 2015, there were 44 incidents of restraint recorded on Hooper ward. Eight of the restraints were in the prone position and resulted in the administration of rapid tranquilisation. Staff used restraint as a last resort, and did not plan it. Information regarding the number of restraints for the preceding six months was not available and the provider was not able to advise whether the use of restraint, particularly prone restraint had increased, remained stable or if the provider had plans to decrease.
- Staff had received training in managing violence and aggression and described in detail the techniques they used to de-escalate situations. They discussed violent or aggressive incidents in handover meetings and recorded them in an individual patient care plan.
- Staff recorded use of restraint and incident reports showed a record was maintained of the hold used, the staff involved, which points of the body each staff member restrained and the duration of the restraint. Staff debriefed patients after incidents of restraint.
- Staff received safeguarding training and gave us examples of safeguarding alerts they had either raised or been involved in. Staff knew the safeguarding lead for the provider. We reviewed a number of safeguarding records and these showed that safeguarding allegations were appropriately documented and appropriate action taken.
- The hospital had appointed a safeguarding lead who reviewed all safeguarding alerts and was available to give advice to staff regarding safeguarding matters. The lead had recently delivered some safeguarding training to a few patients at the hospital to improve knowledge around concern.
- The hospitals safeguarding lead met regularly with local authority safeguarding contacts to review and discuss safeguarding referrals. The safeguarding lead held information relating to safeguarding referrals and their investigation was available for us to review. Staff had recorded information relating to the referral including its investigation and outcome. However, on Hooper ward, a patient alleged staff had inappropriately restrained them. The provider's investigation upheld the complaint, and that the member of staff had not used a recognised restraint hold. Staff at all levels within the organisation had not recognised that this constituted a safeguarding concern, and had not raised a

safeguarding alert. We discussed this with the safeguarding lead who subsequently referred the matter to local authority safeguarding. The provider could not be sure that staff at all levels in the organisation recognised all safeguarding concerns and took appropriate action to safeguard patients.

- We saw appropriate arrangements were in place for obtaining medicines. Staff explained how they obtained medicines. We observed that supplies were available to enable patients to have their medicines when needed.
- Medication was stored securely. Staff stored medicines requiring cold storage appropriately and kept them at the correct temperature. Controlled medicines were stored and managed appropriately. It was the provider's policy to store and record the use of all benzodiazepines in its register of drugs liable for misuse.
- As part of this inspection, we looked at patients' medicine administration records. Appropriate arrangements were in place for recording the administration of medicines. These records were clear and fully completed .The records showed patients were getting their medicines when they needed them, there were no gaps on the administration record's and staff recorded any reasons for not giving patients their medicines.
- Patients detained under the MHA, had their medicines authorised by a second opinion appointed doctor if detained longer than three months. Based on a sample of 10 patient medicines records over Hooper and New Dawn wards, all of the supporting Mental Health Act documentation relating to medicines, were correctly completed.
- Some patients prescribed high doses of anti-psychotic medication required specific health checks. The provider had systems to ensure patients requiring these checks took place.
- The record of drugs liable for misuse register indicated that staff had given 10 doses of Lorazepam injections to patients on Hooper ward from 8 August until 25 August 2015. The rapid tranquilisation observation record indicated that staff had completed four charts within the same period. Of these four, two had been completed in line with provider's policy "The prevention and management of aggression". This policy stated that all patients administered rapid tranquilisation must have an observation chart completed at regular intervals post administration. This meant that on six occasions between 8 August and 25 August patients had not received appropriate checks. Staff had not appropriately recorded these checks. This was also contrary to national guidance (NICE NG10 p218).
- The provider had a policy and procedure in place for children's visits that staff were aware of. A children's visiting room was available off the ward. Staff supervised children's visits, which only took place after a multidisciplinary discussion had determined that they were in the child's best interests.

Track record on safety

- Ward and senior managers at a local level had investigated recent serious incidents. Staff identified learning from these incidents through handovers, staff meetings and clinical governance meetings. The provider shared learning from incidents on the hospitals intranet, which all staff could access.
- Some staff told us about specific learning from recent incidents that had occurred within the hospital. However, discussions with the ward manager and a review of the Hooper ward ligature risk assessment did not clearly show that as a result of a recent serious incident on New Dawn ward (Personality Disorder), staff had reviewed and updated ligature risk assessments on each of the other wards. This was of concern as a similar ligature anchor points were in place on Hooper ward. Staff had not updated the Hooper ward ligature risk assessment to clearly identify the potential anchor point or the measures in place to manage or mitigate it.

Reporting incidents and learning from when things go wrong

- Staff knew how to report an incident and displayed a good understanding around the process. Staff reported all incidents.
- Ward and senior managers identified that the majority of incidents reported related to patient on patient violence, or patient on staff violence. In response, the provider promoted a zero tolerance culture to violence. This resulted in the provider developing specific care plans with certain patients regarding violence and

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

Requires improvement

aggression and liaison with local police. As a result, the provider had experienced a recent downward trend in the number of incident reports relating to violence and aggression.

- Incident reports and discussions with patients showed that staff were open and transparent with patients and explained when things went wrong.
- The provider supported and debriefed patients and staff if they were involved in incidents.

Are acute wards for adults of working age and psychiatric intensive care unit services effective?

(for example, treatment is effective)

Requires improvement

Assessment of needs and planning of care

- Case records showed that a doctor and nurse initially assessed patients on the day of admission.
- Initial assessments on admission addressed patients' physical health and included an examination. From the care records we reviewed, staff had identified and followed up physical health needs. However, we found one patient that during a recent review was identified as requiring specialist medical follow up. Their care records did not indicate that this had happened.
- Each of the patient care and treatment records we examined included a range of care plans. However, for one patient we noted that while they had been receiving care and treatment on the ward for 14 weeks, only three areas of the care plan that addressed their mental health recovery, problematic behaviour and staying healthy were in place. Other areas of the care plan, which addressed their holistic needs such as life skills and relationships, were not in place. For this same patient we found little evidence of patient views in care plans, or reasons as to why this had not been possible to obtain.
- For one patient, the care plan stated that they should have one to one meetings with a female member of staff. However, their care records showed that on some days their allocated nurse, with whom they would have one to one meetings that day, was male.
- Staff had access to all records on the ward when needed, which were stored in paper format. For one patient admitted seven weeks previously, no initial referral information was on file. When we spoke with the ward staff and the ward manager, they informed us that they had archived this information. This meant that recent pre admission information relating to risk, was not readily available to staff.The provider could not be sure that all potential risks were identified and appropriate actions put in place to manage or mitigate these.

Best practice in treatment and care

- Weekly pharmacist visits ensured that medicines were reconciled, administered safely and the administration of medicines recorded correctly.
- Patients were able to access a range of psychological therapies.
- Ward doctors provided routine physical healthcare to patients. Out of hours, an on call doctor was available.
- Staff used recognised rating scales, for example, health of the nation outcome scales (HoNOS), to record severity of symptoms and measure outcomes for patients.
- Staff participated in a range of clinical audits, including a clinical notes audit. Staff identified actions through the audit and completed them by the following month. Additional audits included occupational therapy records, medication and explaining patients' rights.

Skilled staff to deliver care

- The multidisciplinary team consisted of an appropriate range of staff, including a consultant psychiatrist, occupational therapists, support workers, an activities co-ordinator, a psychologist, a specialist registrar and qualified nurses.

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

Requires improvement

- Ward staff spoke highly of the specialist training they had received relating to the development and use of de-escalation techniques. Some staff had also received specialist training in the management of self-harm, suicide and borderline personality disorder.
- Senior managers supervised staff monthly and appraised them annually. Staff told us they received supervision regularly.
- In the context of incidents that occurred across the hospital, senior managers spoke of a "few bad apples". The provider had taken appropriate disciplinary action where they had identified staff performance issues.

Multidisciplinary and inter-agency team work

- The ward had regular and effective multidisciplinary team meetings. Staff comprehensively recorded ward reviews and included patients' views.
- The handover we observed reviewed individual patients and included discussion around care plans, risk management, and a general update on the patient's well-being.
- Staff sent a detailed summary to the patient's GP on admission. Care and treatment records showed that staff had identified and made contact with patients' care co-ordinators. Staff kept care co-ordinators up to date and invited them to multidisciplinary team reviews and care programme approach (CPA) meetings**.**
- The provider gave commissioners regular updates on care pathways and discharge plans. Staff offered the local advocacy service access to the quiet room on the ward to meet privately with patients.
- The provider had made links with the local authority safeguarding lead and held regular monthly meetings to review safeguarding issues.

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

- The majority of staff (91%) had completed training relating to the Mental Health Act (MHA) and MHA Code of Practice as part of mandatory training. We were not able to obtain this figure at ward level. Staff recently received training addressing the need to use the least restrictive practice and were able to give examples of how their and the wards practice had developed as a result.
- Where required, staff had completed and attached consent (T2) or authorisation (T3) certificates to patients' medicine charts.
- The majority of patients we spoke with told us that they were aware of their rights. Staff regularly explained rights to patients. Staff met with patients to revisit their rights every two weeks. However, two patients we spoke with told us that they were not aware of their rights.
- The ward securely stored detention papers and completed them correctly. Staff were able to access a MHA administrator for support with issues relating to the MHA. The MHA administrator sent reminders of tribunals and reports to relevant staff. The MHA administrator reviewed consent to treatment and capacity forms as part of the MHA audit that took place once a week.
- Staff displayed information about independent mental health advocates (IMHA) on the ward and an advocate came to the ward on a weekly basis. Staff were complimentary of the advocate and said they knew how to contact them.
- Information leaflets produced by the provider were available in English only. The ward manager advised the leaflets were available in different languages.

Good practice in applying the MCA

- Some staff had recently completed Mental Capacity Act (MCA) training. Staff we spoke with were aware of the MCA but unable to describe the five statutory principles and could not tell us how they would implement the MCA while providing care and treatment for patients.
- Staff had made one deprivation of liberty safeguards (DoLS) application in the last 12 months. The hospital manager told us there were no patients currently subject to DoLS. The provider had developed a policy relating to MCA including DoLS. We were told by senior managers that the use of the MCA was monitored through the clinical notes audit. However, our sampling of records relating to patients care and treatment and review of the clinical notes audit did not show that use of the MCA was being monitored.

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

Requires improvement

Are acute wards for adults of working age and psychiatric intensive care unit services caring?

Good

Kindness, Dignity, respect and support

- We observed positive interaction between patients and staff. Staff were caring and respectful of patients' needs. Staff knocked on bedroom doors and waited for a response before opening the door.
- Patients spoke positively about staff and felt that staff were friendly. However, one patient commented that staff could be "a bit aggressive and tell you off for bad behaviour".
- Staff had a good understanding of patients' individual needs and projected a caring approach when discussing patients.
- A theme of poor staff attitude was evident from some incident and complaint records we reviewed. The provider was aware of this issue, with measures put in place including the launch of its values programme and review of staff training needs. Actions taken by the provider included the development of a new recruitment policy, shifting the focus away from skills, knowledge, and experience to focus on behavioural-based qualities. Interview questions incorporated values and the rewards of supporting others. Staff had also been supported with longer handover times, mid shift debriefs and ensuring that staff took appropriate breaks during their shift.

The involvement of people in the care they receive

- The ward had developed a welcome pack that orientated patients to the ward on admission. Staff provided patients with a copy of this. Occupational therapists completed an "interests" checklist with patients on admission, which informed the provision of activities on the ward.
- Patient views were included when developing and reviewing care plans. Ward review notes and discussions with patients indicated that they met with the multidisciplinary team during ward reviews and that their views were obtained and recorded. Staff provided timetables to patients, who were aware of their time for the ward rounds. Staff gave feedback to patients on progression from previous meetings and discussed the treatment plan.
- Patients had regular access to advocacy. An advocate visited the ward once a week. The ward displayed information about advocacy services.
- With the permission of patients, families were appropriately involved in their care and treatment.
- Staff held regular community meetings for patients on the ward. During these meetings, patients were able to express their views about the service provided and make suggestions. The ward had a "you said, we did" noticeboard. This outlined issues raised by patients and the action the hospital had taken in response. However, this was located outside of the ward entrance so was not readily accessible to all patients.
- Some patients had been involved in recent staff recruitment on the ward.

Are acute wards for adults of working age and psychiatric intensive care unit services responsive to people's needs? (for example, to feedback?)

Good

Access and discharge

- The ward accepted referrals nationwide.
- Patients were able to access escorted leave as agreed by the multidisciplinary team. There were no issues regarding beds being available upon return from leave.
- Staff did not move patients between wards during an admission for non-clinical reasons. When staff discharged or transferred patients, this happened at an appropriate time of day.
- As the PICU was a national resource, the provider had transferred patients from other parts of London and further away. For example, the provider regularly accepted patients from Bristol and Dorset. This meant

that some patients had difficulty in maintaining family and other close relationships during their admission. Staff did support patients to maintain contact with family through regular phone calls.

- At the time of our inspection, the ward manager identified that one patient on Hooper ward was subject to a delayed discharge because of difficulties experienced by the commissioners in identifying an appropriate placement for them. The ward was liaising closely with the commissioners and care co-ordinator to resolve the situation.

The facilities promote recovery, comfort and dignity and confidentiality

- The ward had a full range of rooms and equipment to support treatment and care. This included a communal lounge, quiet room and occupational therapy room. There was a clinical room on the ward where medicines were stored. However, clinic rooms did not contain a treatment couch, and patients did not have access to the clinic room. Where patients required physical health checks or monitoring, staff carried these out in patient bedrooms.
- Apart from patient bedrooms, there were no private spaces on the ward where patients could meet with family members. A room off the ward was available for patients to meet privately with visitors.
- Patients were able to access mobile phones supplied by the ward to make personal phone calls in private.
- Patients had unrestricted and direct access from the communal lounge to a garden area. Patients who wished to smoke could use this area at any time.
- The ward manager told us that since the appointment of the current chef the quality of the food had improved as had patient comments relating to the meals provided. The patients we spoke with felt the food was of good quality.
- Staff locked hot drinks and snacks in the dining room outside of mealtimes, meaning that patients did not have unrestricted access to these and had to request a hot drink or snack from a member of staff.
- Patients had lockable space to store possessions safely and securely. However, one patient told us "a lot of my things go missing from cupboards such as toiletries, clothing and food" and "I've had other patients wear my pyjamas."
- There was an activities co-ordinator and an activities programme in place, including some inter-ward activities. At weekends, ward staff took the lead in providing activities. Staff had appointed some patients to therapeutic jobs on the ward such as leading activities. Activities available on the ward included a relaxation group, a current affairs group, smoothie making and pampering groups. Occupational therapists assessed patients' daily living activities individually and they were able to access on site gym facilities.

Meeting the needs of all people who use the service

- The ward was located on the ground floor and was accessible to people with mobility difficulties and those using a wheelchair.
- The ward did not display information leaflets in other languages. The manager could request this from the provider when required.
- The ward had information on patients' rights, local services and how to make a complaint.
- Staff could access interpreting services and could book face to face interpreters for patient assessments, ward reviews and other meetings.
- The ward provided food that met cultural, religious and dietary requirements.
- Patients had access to a multi-faith room that had several religious texts. A chaplain visited the ward each week and patients with leave could attend a local mosque with which ward staff had made contact. When required, staff would address patients regarding their spiritual needs from other religions.

Listening to and learning from concerns and complaints

- Patients were aware of the complaints procedure. The ward manager discussed complaints in detail and reassured patients the complaint would be treated in confidence. Patients spoke highly of the approach of the ward manager who had dealt with their complaints. From June 2014 to April 2015 there were 36 complaints

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

Requires improvement

made on Hooper ward with 13 upheld, the highest number across the four wards on site. Patients told us that they had received responses to their complaints, and that where they were upheld, an apology.

- The provider upheld complaints on Hooper ward related to staff attitude, administrative errors, medication errors and the quality of care.
- Staff were aware of the complaints procedure, and were able to describe the process to follow if patients wished to make a complaint.
- The provider fed back upheld complaints and investigations to the staff involved and measures such as additional training provided. We saw evidence that the provider shared learning from individual complaints with staff who were not directly involved.

Are acute wards for adults of working age and psychiatric intensive care unit services well-led?

Good

Vision and values

- The ward staff were aware of the organisations' values; empathy, caring, respect and honesty and felt they reflected the ethos of the ward.
- Staff told us that they felt well supported by their immediate line manager, and that the hospital manager visited their ward regularly. Some staff commented that the chief executive of the organisation had visited the ward, while others commented that there was little visibility of senior executives at ward level.

Good governance

- At a local level, there were effective systems in place to ensure that ward managers had appropriate oversight of incidents, restraints and complaints that had occurred on their ward. Senior managers had an oversight of this information at ward and hospital level.
- While the provider had systems in place to share learning from incidents there was evidence that these systems were not always effective as learning from some incidents and complaints was not shared across wards.
- Staff appropriately investigated serious incidents and shared findings with senior managers and ward managers. The provider benchmarked serious incidents requiring investigation against other hospitals run by the provider, but were not at ward level. A breakdown of the London region by hospital was not available for us to look at.
- Staff audited record keeping and documentation through the clinical notes audit. However, from the audits we reviewed, there was no evidence that staff monitored the MCA. Staff conducted the audits regularly but there was no cross-ward audit process to check the validity of audit results.
- Permanent staff had completed the majority (91%) of mandatory training. The provider monitored mandatory training uptake by bank staff. They did not give work to bank staff who failed to complete their training. Ward managers regularly supervised and appraised staff.
- An appropriate number of staff of the right grades and experience covered shifts. Staff maximised the time they spent on the ward in direct care activities.
- The provider collected data on performance through a range of audits and other measures and uploaded this onto the providers' quality dashboard. The provider measured key performance indicators (KPIs) that included average length of stay for those who completed treatment, the number of service users who received a healthcare assessment and delayed discharges. The provider monitored the majority of KPIs at a regional (London Area), local (Cygnet Hospital Beckton) or service (such as low-secure) level.
- The quality service report monitored key performance indicators on a quarterly basis and benchmarked against other hospitals run by the provider. There was no benchmarking against services of a similar nature outside the Cygnet organisation meaning that comparison was unavailable.
- The provider was meeting its key performance indicator targets. Senior managers discussed key performance

indicators and other governance issues at monthly clinical meetings. Ward managers regularly attended additional governance meetings where they reviewed key performance indicators.

- The provider monitored risk levels through the risk register. The register highlighted the length of time the risk had been open, the owners for each action with a rating in relation to the seriousness of the risk. Ward managers had the opportunity to submit items to the risk register through the clinical services manager. The clinical services manager made the decision to add the item to the risk register. The ward manager felt that risks could be elevated and considered for the risk register and was satisfied with the process despite needing approval.
- The local risk register fed into a corporate risk register. The highest risks identified by the corporate risk register were management of serious untoward incidents, medication administration and MHA errors, vacancies and the use of bank and agency workers. Senior staff highlighted staff attitude as a consistent theme in incident and complaints reports but this did not appear on the risk register.
- Staff vacancy rates had been on the local Cygnet risk register since October 2014 and there had been a reduction in the use of bank and agency. The high rate of cancellations by bank and agency workers put pressure on permanent members of staff. On-going recruitment drives had filled the majority of outstanding vacancies and quarterly staffing key performance indicators monitoring vacancies, turnover and bank and agency usage were in place.

Leadership, morale and staff engagement

- Staff were complimentary of the ward manager and were happy with the management of the ward.
- For Hooper ward, the percentage of permanent staff sickness overall was low and stood at 3% (as at April 2015).
- There were no concerns raised over bullying or harassment across the ward.
- Staff described the whistleblowing process to us, although none we spoke with had had cause to use it. Staff told us they would be comfortable raising a concern without the fear of reprisal or victimisation.
- The majority of staff we spoke with enjoyed their job and felt valued. Staff admitted to feeling stressed at times but felt that it was part of the job.
- The provider gave staff opportunities to undertake additional training for leadership development and encouraged them to apply for other roles. The provider on a case-by-case basis supported staff with some areas of continuous professional development, relating to higher education.
- The complaints investigations showed that staff were open and transparent and apologised to patients if something went wrong.
- The provider had a staff survey and staff had participated in the development of the providers values. There had been a recent “dragons den” style project where staff were able to present projects within the hospital and make a case for why this should be taken forward.

Commitment to quality improvement and innovation

- The hospital achieved an Investors in people Bronze award in February 2015. This was an independent framework to promote leadership, support and good management of staff.
- The ward is a member of the national association of psychiatric intensive care and low secure units (NAPICU). Staff attended annual general meetings and conferences and undertook annual accreditation.

Examples of innovative practice or involvement in research.

- The provider had a quality improvement project that focused on five key areas and encouraged staff to develop initiatives in their respective areas that supported the overall aim of the quality improvement plan.

Good

Forensic inpatient/secure wards

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

Are forensic inpatient/secure wards safe?

Requires improvement

Safe and clean environment

- Bewick ward had no blind spots and staff could observe patients. Staff used mirrors to see around corners and the nursing office was centrally located.
- CCTV was in operation on Bewick ward. Views from the cameras' were not available on the ward, but were recorded and kept in the reception area and could be accessed when needed. Patients were aware that CCTV was in use on the ward.
- The provider had completed a ligature risk assessment for the ward. Taps in patient bedrooms were of a standard type. The ward had recorded this on the ligature risk assessment. Work to address potential ligature points in patient bedrooms would be complete by August 2016.
- At the time of our inspection, staff had local arrangements to manage and mitigate the potential risks presented by ligature points. This included daily environmental checks, locking bath and shower room doors, increased observations of individual patients and general observations.
- The audit listed rooms and identified ligature risks within these areas. The audit did not give a detailed and accurate description of all risks. The ligature risk assessment gave a brief description and the location of the ligature point. For some ligature points a plan to address the risk was not in place, for example, where works may be required to remove ligature anchor points there were no planned works with dates.
- Serious incidents had recently occurred on New Dawn ward involving ligature points, some of which had occurred at ligature points not previously identified as posing a potential risk. Our discussions with the ward manager and review of the Bewick ward ligature risk assessment did not clearly show that the response to the serious incident had prompted the review and update of the Bewick ward ligature risk assessment. This was of concern as the same ligature point was present on Bewick ward. The provider could not be sure that they had identified all ligature points on Bewick ward and that appropriate measures were in place to manage and mitigate them.
- Bewick ward was a single sex ward (female) and did not have a seclusion room. The ward used a de-escalation room appropriately.
- The ward included a clinic room and there was evidence of stickers showing regular checks on equipment. Staff had completed regular checks of emergency medicines and equipment available on the ward. The clinic room was clean and well organised. Staff checked and maintained fridge temperatures on a daily basis. There was a treatment table in the room and a blood pressure monitor and scales.
- The ward area was visibly clean and well maintained with modern furnishings.

- Staff undertook environmental risk assessments regularly. Staff checked items such as cleaning materials and other potentially hazardous items to see they were stored safely.
- Appropriate personal alarm systems for staff were in place. The ward manager allocated staff members a personal alarm at the start of each shift. All personal items that posed a possible risk were stored in lockers at reception.

Safe Staffing

- The ward manager maintained appropriate staffing levels on Bewick Ward. Staff felt safe working on the ward and commented that staffing levels were enough to keep patients safe. Patients we spoke with felt safe on the ward and had not experienced low levels of staff.
- At the time of the inspection, the ward had 22 substantive staff with two leavers within the last 12 months. There were no vacancies although one staff member was on maternity leave. The ward used existing staff and bank workers to cover the absence.
- The ward manager used a matrix for planning shifts to ensure the correct number of staff were available on the rota. There had been no instances of staffing being below the required level.
- The provider had calculated staffing levels on a ratio of three patients to one staff member. The day shift compromised of two qualified nurses and three support workers. Four staff were on duty each night, which consisted of two qualified nurses and two support workers. The ward manager increased staffing levels dependent upon patients' leave arrangements or the need to provide increased support through one to one observations. The ward manager stated that the staffing establishment was sufficient and was planned according to patients' needs.
- The establishment levels at the time of the inspection for qualified nurses whole time equivalent was 9.5 with establishment levels for nursing assistants 11.8. Bank and agency staff had covered 10 shifts in the previous three months. The ward used regular bank staff familiar with the ward from a list approved by the hospital manager.
- Staff rarely cancelled patient leave and patients told us that one to one meetings with named nurses happened regularly.
- A doctor was on the ward Monday to Friday from 9am to 5pm each day and an on call doctor was available at weekends and out of hours. We did not find any issues regarding medical cover during the inspection.
- Access to mandatory training was through e-learning and supplementary classroom training. The majority of permanent staff were up to date with their training. Some recently appointed staff had not yet completed the full range of mandatory training but had arranged to do so.
- A dashboard that was updated daily, captured information around incomplete mandatory training. Ward managers reviewed this to understand which staff had not completed training. Mandatory training identified for staff included management of violence and aggression, life support, security awareness and the Mental Health Act. Staff also undertook training relating to the use of seclusion, physical health and safeguarding adults and children.
- All doctors, permanent and bank nurses completed mandatory training relating to medication. For newly qualified nursing staff, the provider embedded a medication management assessment in the preceptorship programme. Staff must have completed this within six months of starting employment.
- Eighty-three percent of Bank workers had completed the mandatory e-learning package. 66.7% of Bank workers had completed supplementary classroom training. Gaps were identified in relation to e-learning policy awareness training and some Bank workers were stopped from working until they met the required level of training compliance.

Assessing and managing risk to patients and staff

- Staff used the short term assessment of risk and treatability (START) tool to assess potential individual risks to patients. Staff completed a risk assessment on admission for each patient. Staff also used the historical clinical risk (HCR-20) assessment tool. Staff addressed identified risks in patient care plans.
- The ward did not permit some items and had a policy for this. Staff conducted a search using a metal detector

when patients returned from escorted leave, in the quiet room. Staff took items such as plastic bags and stored food securely. Staff referred to the risk assessment when searches were undertaken. Patients were aware of the provider's search policy that addressed the searching of patients, rooms, communal areas, and visitors.

- The ward imposed a blanket restriction on visitors from bringing phones with cameras into the hospital, including the visitor's room. This was consistent with the Department of Health low secure service Good Practice Commissioning guidance (2012). The hospital provided mobile phones without cameras to patients. The ward encouraged family members to use alternative methods for example printing photos or sharing pictures via the internet. When appropriate patients were given leave outside the low secure parameter where they had free access to mobile phones with cameras with family
- The ward displayed information relating to patient rights and informal patients were aware of their right to leave the ward.
- The provider had an appropriate policy and procedure for observations and staff were aware of this. Staff nursed patients on one to one observations when required.
- Staff used restraint infrequently on Bewick ward. For the six months from November 2014 to April 2015, there were six incidents of restraint, of which one was in the prone position. Staff used restraint as a last resort and did not plan it. Information regarding the number of restraints for the preceding six months was not available and the provider was not able to advise whether the use of restraint, particularly prone restraint had increased, remained stable or had decreased.
- Staff had received training in and used verbal de-escalation techniques. They were able to describe in detail the techniques they used to de-escalate situations. Staff discussed instances of potentially violent or aggressive behaviour in handover meetings, along with the de-escalation techniques they used. Patients assessed as being at risk of violent or aggressive behaviour had a specific care plan to address this area.
- There were no incidents of rapid tranquilisation on the ward from November 2014 to the time of our inspection. The ward manager attributed this to the successful use of de-escalation methods.
- Staff demonstrated a good understanding of safeguarding and could identify events that should trigger a safeguarding alert and how to make the alert. Staff completed mandatory training in safeguarding and explained different types of safeguarding concerns. Staff knew the safeguarding lead for the provider. Safeguarding allegations were appropriately documented and action taken.
- The hospital had appointed a safeguarding lead who reviewed all safeguarding alerts and was available to give advice to staff regarding safeguarding matters. The lead had recently delivered some safeguarding training to patients at the hospital to improve knowledge around concern. The hospital safeguarding lead met regularly with local authority safeguarding contacts to review and discuss safeguarding referrals. The safeguarding lead held information relating to safeguarding referrals and their investigation, which was available for us to review. Staff had recorded information relating to the referral including its investigation and outcome.
- We saw appropriate arrangements were in place for obtaining medicines. Staff explained how they obtained medicines. We observed that supplies were available to enable patients to have their medicines when they needed them.
- Medication was stored securely. Staff stored medicines requiring cold storage appropriately and kept them at the correct temperature. Controlled medicines were stored and managed appropriately. It was the provider's policy to store and record the use of all benzodiazepines in its register of drugs liable for misuse.
- Patients detained more than three months under the Mental Health Act (MHA) had medicines authorised by a second opinion appointed doctor (SOAD). Staff completed and attached consent (T2) or authorisation (T3) certificates to medicine charts.
- As part of this inspection we reviewed patients' medicine administration records (MAR). We observed that appropriate arrangements were in place for recording the administration of medicines. These

records were accurate and fully completed. MAR sheets indicated that patients received their medications promptly. Staff had recorded reasons if patients were not given medication and there were no gaps on the administration records.

- Staff were required to complete health checks for patients who were prescribed high doses of anti-psychotic medication. The provider had systems to ensure patients requiring these checks took place.
- The provider had a policy and procedure in place for children's visits that staff were aware of. A children's visiting room was available off the ward. Staff supervised children's visits, which only took place after a multidisciplinary discussion had determined that they were in the child's best interests.

Track record on safety

- There had been no recent serious incidents on Bewick ward.

Reporting incidents and learning from when things go wrong

- Staff knew how to report an incident and displayed a good understanding around the process. Staff reported all incidents.
- Ward and senior managers identified that the majority of incidents reported related to patient on patient violence, or patient on staff violence. In response, the provider promoted a zero tolerance culture to violence. This resulted in the provider developing specific care plans with certain patients regarding violence and aggression and liaison with local police. As a result, the provider had experienced a recent downward trend in the number of incident reports relating to violence and aggression.
- Incident reports and discussions with patients showed that staff were open and transparent with patients and explained when things went wrong.
- The provider supported and debriefed patients and staff if they were involved in incidents.
- Some systems were in place to learn from incidents across the hospital and organisation. These included discussions at staff and clinical governance meetings. The provider shared learning from incidents on the hospitals intranet, which all staff could access. However, there had been a recent serious incident on New Dawn ward, but Bewick ward had not reviewed and updated the ligature risk assessment. This was of concern as similar ligature anchor points were in place on Bewick ward.

Are forensic inpatient/secure wards effective?

(for example, treatment is effective)

Good

Assessment of needs and planning of care

- We reviewed two case records which showed that a doctor and nurse initially assessed patients on the day of admission. Assessments on admission addressed the patients' physical health and included an examination. From the care records we reviewed, staff had identified physical health needs and followed these up. An example of this was a patient who had a history of chest infections. The ward doctor was aware and highlighted the risk in the care plan.
- Staff reviewed care plans regularly and they were recovery orientated and ran in conjunction with eight outcome areas; my mental health recovery, stopping my problem behaviours, getting insight, recovery from drug and alcohol problems, making feasible plans, staying healthy, my life skills and my relationships. The clinician and patient rated each of the eight outcome areas against a series of outcome statements.
- Patients could adapt and personalise outcome statements to make them meaningful. Staff gave patients copies of care plans and details of the care pathway known as "my shared pathway".
- The provider stored information needed to deliver care on paper records. On Bewick ward an electronic record system ran in tandem with the paper record.

Best practice in treatment and care

- Bewick ward used the recovery star tool as it best supported the "my shared pathway" framework. A member of the multidisciplinary team and the patient

completed the recovery star collaboratively, within three months of admission. Patients were able to select three areas of the recovery star they would prefer to address. Recovery star goals related to patient care plans.

- Patients had access to a range of psychological interventions and the ward was recovery focused. Staff supported patients to develop their skills with a view to moving to independent living.
- A pharmacist visited the ward weekly and conducted medication audits. Staff also conducted a weekly drug chart audit and the clinical service manager immediately followed up gaps identified. Some medication errors had previously occurred on the ward. As a result, two members of staff administered all medication. Senior managers monitored the management of medicines via the local risk register.
- Ward doctors provided routine physical healthcare to patients. Out of hours, an on call doctor was available. In addition, the provider registered patients with a local GP practice.
- Staff used recognised rating scales, such as health of the nation outcome scales (HoNOS) measure outcomes for patients.
- Staff participated in a range of clinical audits, including a clinical notes audit. Staff identified actions through the audit and completed them by the following month. Additional audits included occupational therapy records, medication and explaining patients' rights.

Skilled staff to deliver care

- The multidisciplinary team consisted of an appropriate range of staff, including a consultant psychiatrist, occupational therapists, support workers, an activities co-ordinator, a psychologist, a specialist registrar and qualified nurses.
- Staff felt supported and encouraged to access specialised training for their roles. Some staff had awareness training in dialectical behaviour therapy (DBT), START risk assessment and cognitive behavioural therapy (CBT) training. Ward staff spoke highly of the specialist training they had received relating to the use of de-escalation techniques.
- Senior managers supervised staff monthly and appraised them annually. Staff told us they received supervision regularly. The ward manager also encouraged informal supervision and staff used this to discuss issues as they arose.
- In the context of incidents that occurred across the hospital, senior managers spoke of a "few bad apples". The provider had taken appropriate disciplinary action where they had identified staff performance issues.

Multidisciplinary and inter-agency team work

- The ward had regular and effective multidisciplinary team meetings. Staff comprehensively recorded ward reviews and included patients' views.
- Staff used handovers between shifts to look at lessons learned, briefings on safety, incidents, complaints and other operational issues and what staff could do differently. Each shift generated a handover document, detailing any changes in patients' mental state. Staff highlighted and recorded visits, appointments and significant events in the ward diary.
- The provider gave commissioners regular updates on care pathways and discharge plans. Staff offered the local advocacy service access to the quiet room on the ward to meet privately with patients.
- The provider had made links with the local authority safeguarding lead and held regular monthly meetings to review safeguarding issues.

Adherence to the MHA and the MHA Code of Practice

- The majority of staff (91%) completed training relating to the Mental Health Act (MHA) and MHA Code of Practice as part of mandatory training. We were not able to obtain this figure at ward level. Staff recently received training addressing the need to use the least restrictive practice and were able to give examples of how their and ward practice had developed as a result.
- Staff had completed and attached consent (T2) or authorisation (T3) certificates to medicines charts where required.
- Patients we spoke with said they had their rights read to them on admission and that this was repeated to them once a month. The records we reviewed confirmed this.

Good

Forensic inpatient/secure wards

- The ward securely stored detention papers and completed them correctly. Staff were able to access a MHA administrator for support with issues relating to the MHA. The MHA administrator sent reminders of tribunals and reports to relevant staff. The MHA administrator reviewed consent to treatment and capacity forms as part of the MHA audit that took place once a week. On admission, the senior nurse on duty, who had received specific training to scrutinise these documents and report any anomalies to the hospital manager, checked MHA documentation.
- Staff displayed information about independent mental health advocates (IMHA) on the ward and an advocate came to the ward on a weekly basis. Staff were complimentary of the advocate and said they knew how to contact them.
- The IMHA service visited the ward each week. Patients could contact the service between visits and were appreciate of the service.
- The ward had information leaflets in English only. The ward manager advised the leaflets were available in different languages when needed.

Good practice in applying the MCA

- Some staff had recently completed Mental Capacity Act (MCA) training. Staff we spoke with were aware of the MCA but were unable to describe the five statutory principles and could not tell us how they would implement the MCA while providing care and treatment for patients.
- The hospital manager told us that while no patients were currently subject to deprivation of liberty safeguards (DoLS), they had made an application for a patient within the last 12 months. The provider had developed a policy relating to MCA including DoLS. Senior managers told us they monitored the use of the MCA through the clinical notes audit. However, our sampling of records relating to patients care and treatment and review of the clinical notes audit, did not show monitoring of the use of the MCA.

Are forensic inpatient/secure wards caring?

Good

Kindness, Dignity, respect and support

- We observed high levels of positive interaction between patients and staff. The staff and patient "social lunch" was an example of this, with staff and patients engaging with each other in a relaxed atmosphere. We observed that staff were caring and respectful of patients' needs and actively supported patients. Staff knocked on bedroom doors and waited for a response before opening the door.
- All patients spoke positively about the support they received from staff. They said the staff were always willing to talk and felt that staff went out of their way to help them. When patients became anxious or aggressive, staff responded promptly and de-escalated situations by speaking calmly and giving reassurance.
- The majority of patients we spoke with felt safe on the ward but some commented that they occasionally felt unsafe due to violent outbursts from other patients. Some patients also felt uncomfortable about the level of noise heard on the ward while using the quiet room.
- Staff had a good understanding of patients' individual needs and projected a caring approach when discussing patient's needs.
- A theme of poor staff attitude was evident from some incident and complaint records we reviewed. The provider was aware of this issue, with measures put in place including the launch of its values programme and review of staff training needs. Actions taken by the provider included the development of a new recruitment policy that shifted the focus away from skills, knowledge and experience towards a focus on behavioural-based qualities. Interview questions incorporated values and the rewards of supporting others. Staff had also been supported with longer handover times, mid shift debriefs and ensuring that staff took appropriate breaks during shift.

The involvement of people in the care they receive

- The ward had developed a welcome pack that orientated patients to the ward on admission. Staff

provided patients with a copy of this. Occupational therapists completed an "interests" checklist with patients on admission, which informed the provision of activities on the ward.

- The ward operated a buddy system for orientation and each new patient was 'buddied' with another for support.
- Most patients we spoke with said they were involved in care planning and had received a copy of their care plan. The care plans we reviewed were individualised, and comprehensive. However, in the majority of care plans we looked at, staff had not recorded patients views in relation to their objectives.
- Staff provided patients with personal folders (my shared pathway) which included documentation relating to the care programme approach (CPA). My shared pathway was patient orientated and based on a recovery and strength based approach.
- Patients had regular access to advocacy. An advocate visited the ward once a week. Wards displayed information about advocacy services.
- With the permission of patients, families were appropriately involved in their care and treatment. Staff knew patients' families, how to contact them and any family issues, such as housing and potential safeguarding concerns. Many patients' families did not live locally and did not have a large amount of involvement in their care.
- Patients held planning meetings every morning and had the opportunity to feed back on the service provided. There was also a community meeting every week, which involved the ward manager, staff, patients and an advocate.
- The provider had established a recovery outcome group (ROG) at the regional level (London), throughout the South East and at a national level. A patient co-chaired the group and senior management made up the rest of the group. The group looked at what actions hospitals had taken around patient feedback and their experiences. The ROG scrutinised actions taken by the provider regarding patient experience. The ROG had recently considered issues of quality improvement, smoking cessation and the management of violence and aggression. The ROG met each quarter locally and nationally every six months.
- Service users were actively involved in the recruitment process and participated in interviews as part of the recruitment panel.
- Service users had undertaken collaborative risk assessment training and trained with staff on how to conduct a risk assessment.
- The "you see, we did" boards showed what actions staff has taken in light of feedback and suggestions from patients. The board was informative but not displayed within the ward. It was outside the entrance, which meant that not all patients had access to it.
- We did not see evidence of any patients having advanced decisions in place.

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

Good

Access and discharge

- The ward accepted referrals nationally. Staff completed a gatekeeping assessment and checked the patient met admission criteria. Average bed occupancy from November 2014 to April 2015 was just over 99%. At the time of our inspection, the majority of patients were admissions from outside London.
- Patients were able to access escorted and unescorted leave as agreed by the multidisciplinary team. There were no issues regarding beds being available upon return from leave.
- Staff did not move patients between wards during an admission for non-clinical reasons. When staff discharged or transferred patients, this happened at an appropriate time of day.
- At the time of our inspection, the ward manager identified that one patient on Bewick ward was subject

to a delayed discharge as they had declined the placements identified by their care co-ordinator. The ward was working with the care co-ordinator to identify a suitable placement.

The facilities promote recovery, comfort and dignity and confidentiality

- The ward was open and spacious and offered a full range of rooms available for activities or treatment. These included a communal lounge, quiet room and occupational therapy room.
- Patients we spoke with felt the ward was comfortable and relaxing.
- The quiet room was located away from patients' bedrooms at the entrance of the ward. Patients used the quiet room as an area where patients could speak with visitors. Some patients complained noise could be heard from the communal lounge and that it was not quiet enough.
- The ward had access to a garden area, which patients could use at any time.
- Patients had supervised internet access in the group room on the ward. Patients were able to access mobile phones supplied by the ward to make personal phone calls in private.
- The majority of patients told us that the quality of food was good or okay. Patients did not have unrestricted access to hot drinks and snacks in between meals and had to request these from a member of staff.
- Patients were encouraged to bring personal items to the hospital and make their bedrooms more homely. Restricted items not allowed on the ward were stored securely in a locked cupboard.
- Patients had daily planning meetings with an activity co-ordinator to choose activities in which they wished to participate. Occupational therapists and activities co-ordinators supervised patients in the gym and had recently received training to do this. Other activities included yoga and baking clubs.
- Patients spoke positively about the frequency and quality of activities available. However, some patients told us that there was a lack of activities at the weekend.
- The ward displayed boards with information for patients. Allocation boards detailed each patient's allocated nurse and staffing as well as photos of staff members. Welcome boards displayed information about the ward manager, visiting and protected meal times and patient advice and liaison services.

Meeting the needs of all people who use the service

- The ward was located on the first floor and access was via a lift. The ward manager informed us they had requested an evacuation wheelchair. People with a disability had access to a specifically modified gym.
- The ward did not display information leaflets in other languages. The manager could request these from the provider when needed.
- Information on patients' rights, local services and how to make a complaint were all available on the ward.
- Interpreting services were available to staff, and face to face interpreters could be booked for patient assessments, ward reviews and other meetings.
- The provider ensured meals were available to meet cultural, religious or dietary requirements. Some patients complained of weight gain on the ward. When necessary, patients had a nutrition plan to work towards losing weight and eating balanced meals.
- There was a multi-faith room available for all patients that had several religious texts. A chaplain visited the ward each week and patients with leave could attend a local mosque with which ward staff had made contact. When required, staff would address patients regarding their spiritual needs from other religions.

Listening to and learning from concerns and complaints

- The patients we spoke with knew how to make a complaint. Patients discussed complaints in detail with the ward manager and staff assured their complaint would be in confidence. From June 2014 to April 2015 patients made 11 complaints on Bewick ward, four were upheld. Patients who had made complaints told us that they had received feedback and were satisfied with the handling of their complaint. Staff demonstrated a good understanding of how to deal with complaints.

Good

Forensic inpatient/secure wards

- Staff received feedback for complaints that were upheld. Ward managers provided measures such as additional training. There was no evidence that the provider shared learning from individual complaints with staff who were not directly involved.

Are forensic inpatient/secure wards well-led?

Good

Vision and values

- The ward staff were aware of the organisations' values; empathy, caring, respect and honesty and felt they reflected the ethos of the ward.
- Staff told us that they felt well supported by their immediate line manager, and that the hospital manager visited their ward regularly. Some staff commented that the chief executive of the organisation had visited the ward, while others commented that there was little visibility of senior executives at ward level.

Good governance

- At a local level, the ward manager had effective systems in place to ensure appropriate oversight of incidents, restraints and complaints that had occurred on their ward. Senior managers had an oversight of this information at ward and hospital level.
- While the provider had systems in place to share learning from incidents, there was evidence that these systems were not always effective as they had not shared learning from some incidents and complaints across wards.
- The ward appropriately investigated serious incidents and findings were shared with senior and ward managers. The provider benchmarked serious incidents requiring investigation against other hospitals run by the provider, but were not benchmarked at ward level. A breakdown of the London region by hospital was not available for us to look at.
- Staff audited record keeping and documentation through the clinical notes audit. However, from the audits we reviewed, there was no evidence that staff monitored the MCA. Staff conducted the audits regularly but there was no cross-ward audit process to check the validity of audit results.
- Permanent staff had completed the majority (91%) of mandatory training. The provider monitored mandatory training uptake by bank staff. They did not give work to bank staff who failed to complete their training. Ward managers regularly supervised and appraised staff.
- An appropriate number of staff of the right grades and experience covered shifts. Staff maximised the time they spent on the ward in direct care activities.
- The provider collected data on performance through a range of audits and other measures and uploaded this onto the providers' quality dashboard. The provider measured key performance indicators (KPI) that included average length of stay for those who completed treatment, the number of service users who received a healthcare assessment and delayed discharges. The majority of KPIs were monitored at regional (London Area), local (Cygnet Hospital Beckton) or service (such as low-secure) level.
- The quality service report monitored key performance indicators on a quarterly basis and benchmarked against other hospitals run by the provider. There was no benchmarking against services of a similar nature outside the Cygnet organisation meaning that comparison was unavailable.
- The provider was meeting its key performance indicator targets. Senior managers discussed key performance indicators and other governance issues at monthly clinical meetings. Ward managers regularly attended additional governance meetings where they reviewed key performance indicators.
- The provider monitored risk levels through the risk register. The register highlighted the length of time the risk had been open, the owners for each action with a rating in relation to the seriousness of the risk. Ward managers had the opportunity to submit items to the risk register through the clinical services manager. The clinical services manager made the decision to add the item to the risk register. The ward manager felt that risks could be elevated and considered for the risk register and was satisfied with the process despite needing approval.

Good

Forensic inpatient/secure wards

- The local risk register fed into a corporate risk register. The highest risks identified by the corporate risk register were management of serious untoward incidents, medication administration and MHA errors, vacancies and the use of bank and agency workers. Senior staff highlighted staff attitude as a consistent theme in incident and complaints reports but this did not appear on the risk register.
- Staff vacancy rates had been on the local Cygnet risk register since October 2014 and there had been a reduction in the use of bank and agency. The high rate of cancellations by bank and agency workers put pressure on permanent members of staff. On-going recruitment drives had filled the majority of outstanding vacancies and quarterly staffing key performance indicators monitoring vacancies, turnover and bank and agency usage were in place.

Leadership, morale and staff engagement

- Staff were complimentary of the ward manager and were happy with the management of the ward.
- For Bewick ward, the percentage of permanent staff sickness was low at 2% (as at 30 April 2015).
- There were no concerns raised over bullying or harassment across the ward.
- Staff described the whistleblowing process to us, although none we spoke with had had cause to use it. Staff told us they would be comfortable raising a concern without the fear of reprisal or victimisation.
- The majority of staff we spoke with enjoyed their job and felt valued. Staff admitted to feeling stressed at times but felt that it was part of the job.
- The provider gave staff opportunities to undertake additional training for leadership development and encouraged them to apply for other roles. The provider on a case-by-case basis supported staff with some areas of continuous professional development, relating to higher education.
- The complaints investigations records we reviewed showed that staff were open and transparent and apologised to patients if something went wrong.
- The provider conducted a staff survey and recently asked staff to participate in the development of the provider's values. There had been a recent "dragons den" style project where staff were able to present projects within the hospital and make a case for why this should be taken forward.

Commitment to quality improvement and innovation

- The hospital achieved an Investors in people Bronze award in February 2015. This was an independent framework to promote leadership, support and good management of staff.

Examples of innovative practice or involvement in research.

- The provider had a quality improvement project that focused on five key areas and encouraged staff to develop initiatives in their respective areas that supported the overall aim of the quality improvement plan.

Requires improvement

Wards for people with learning disabilities or autism

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

Are wards for people with learning disabilities or autism safe?

Requires improvement

Safe and clean environment

- Hansa ward had no blind spots and staff could readily observe patients. The ward had identified two bedrooms as being appropriate for patients with higher dependency needs.
- CCTV was in operation on Hansa ward. Views from the cameras' were not available on the ward, but were recorded and kept in the reception area and could be accessed when needed. Patients were aware that CCTV was in use.
- The provider had completed a ligature risk assessment for the ward. Taps in patient bedrooms were of a standard type. Staff had recorded these ligature points on the ligature risk assessment. The ward manager told us that works to address potential ligature points in patients' bedrooms would be complete within 12 months.
- At the time of our inspection, staff had local arrangements to manage and mitigate the potential risks presented by ligature points. This included daily environmental checks, locking bath and shower room doors, increased observations of individual patients and general observations.
- The audit listed rooms and identified ligature risks. The audit did not give a detailed and accurate description of all risks. The ligature risk assessment gave a description of the ligature risk and its location with a risk rating for the room. However, staff had not clearly documented the follow up actions for removing or fixing ligatures.
- Serious incidents had recently occurred on New Dawn (Personality Disorder) ward involving ligature points, some of which had occurred at ligature points not previously identified as posing a potential risk. Our discussions with the ward manager and review of the Hansa ward ligature risk assessment did not clearly show that the response to the serious incident had prompted the review and update of the Hansa ward ligature risk assessment. This was of concern, as the same ligature point was present on Hansa ward. The provider could not be sure that they had identified all ligature points on Hansa ward and that appropriate measures were in place to manage and mitigate them.
- Hansa ward was a single sex ward (female) and did not have a seclusion room. The ward had a de-escalation room that staff used appropriately.
- The ward included a clinic room and there was evidence of stickers showing regular checks to equipment. Staff had completed regular checks of emergency medicines and equipment available. The clinic room was clean and well organised. Staff checked and maintained fridge temperatures on a daily basis. There was a treatment table in the room and a blood pressure monitor and weighing scales.
- The ward area was visibly clean and well maintained with modern furnishings.

- Staff undertook environmental risk assessments regularly. Staff checked items such as cleaning materials and other potentially hazardous items to see they were stored safely.
- Appropriate personal alarm systems for staff were in place. The ward manager allocated staff members a personal alarm at the start of each shift. All personal items that posed a possible risk were stored in lockers at reception.

Safe Staffing

- The ward manager maintained appropriate staffing levels on Hansa Ward. Staff felt safe working on the ward and commented that staffing levels were adequate. Patients we spoke with felt safe on the ward and had not experienced low levels of staff.
- At the time of the inspection, the ward had 24 substantive staff. There had been three leavers within the last 12 months and there were four vacancies on the ward. The ward used existing staff and bank workers to cover the vacant posts.
- The ward used a matrix for planning shifts to ensure the correct number of staff were available on the rota. There had been no instances of staffing being below the required level.
- The provider calculated staffing levels on a ratio of three patients to one staff member. The day shift compromised of two qualified nurses and three support workers. Four staff were on duty each night, two qualified nurses and two support workers. The ward manager increased staffing levels dependent upon patients' leave arrangements or the need to provide increased support through one to one observations. The ward manager could adjust staffing levels to patients' needs and stated that the staffing establishment was sufficient.
- The establishment levels at the time of the inspection for qualified nurses whole time equivalent was 11.8 with established levels for nursing assistants 16.3. Bank and agency staff covered 24 shifts in the previous three months. Agency staff covered four shifts within the current financial year. The ward used regular bank staff familiar with the ward from a list approved by the hospital manager.
- Staff rarely cancelled leave and patients told us that one to one meetings with named nurses happened regularly.
- A doctor was on the ward Monday to Friday from 9am to 5pm each day and an on call doctor was available at weekends and out of hours. We did not find any issues regarding medical cover during the inspection.
- Access to mandatory training was through e-learning and supplementary classroom training. The majority of permanent staff were up to date with their training. Some recently appointed staff had not yet completed the full range of mandatory training but had arranged to do so.
- A dashboard that was updated daily, captured information about incomplete mandatory training. Ward managers reviewed this to understand which staff had not completed training. Mandatory training identified for staff included management of violence and aggression, life support, security awareness and the Mental Health Act. Staff also undertook training relating to the use of seclusion, physical health and safeguarding adults and children. In addition, nurses completed training addressing medicines management.
- Eighty-three percent of bank staff had completed the mandatory e-learning package. 66.7% of Bank staff had completed supplementary classroom training. Gaps were identified in relation to e-learning policy awareness training and some Bank staff were stopped from working until they met the required level of training compliance.

Assessing and managing risk to patients and staff

- Staff used the short term assessment of risk and treatability (START) tool to assess potential risks. Staff completed this risk assessment on admission for each patient. Staff also used the historical clinical risk (HCR-20) assessment tool. Staff addressed risks in patient care plans and recorded impulsive and unpredictable behaviour in behavioural management plans.
- The ward had reviewed restrictive practises and did not have unjustified blanket restrictions in place.
- The ward displayed information relating to patient rights and informal patients were aware of their right to leave the ward.

- The provider had an appropriate policy and procedure for observation that staff were aware of. Staff nursed patients on one to one observations when required.
- For the six months from November 2014 to April 2015 there were 46 incidents of restraint recorded, five of theses in the prone position. Staff used restraint as a last resort, and did not plan it. Information regarding the number of restraints for the preceding six months was not available and the provider was not able to advise whether the use of restraint, particularly prone restraint had increased, remained stable or had decreased.
- Staff had received training in managing violence and aggression and described in detail the techniques they used to de-escalate situations. They discussed violent or aggressive incidents in handover meetings and recorded them in individual patient care plans.
- The ward manager told us that the majority of restraints occurred while escorting patients and involved staff using a forearm lock. We examined a sample of recent incident reports and found that in some instances where a patient had been subject to restraint, staff had not completed the appropriate reporting form. This meant that there was no record of the staff involved in the restraint, with which parts of the patient's body they had been in contact, and how long the hold had been maintained. The provider could not confirm that patients had adequate protection when staff used restraint. This meant the provider had not recorded debriefing of patients and staff after incidents of prone restraint.
- Four incidents of prone restraint resulted in rapid tranquilisation. The ward doctor monitored patients appropriately afterwards when staff used rapid tranquilisation on the ward.
- Staff displayed a good understanding of safeguarding and could identify events that should trigger a safeguarding alert and how to make one. Staff completed mandatory training in safeguarding and explained different types of safeguarding concerns. Staff knew the safeguarding lead for the provider. Safeguarding allegations were appropriately documented and action taken.
- The hospital had appointed a safeguarding lead who reviewed all safeguarding alerts and was available to give advice to staff regarding safeguarding matters. The lead had recently delivered some safeguarding training to patients at the hospital to improve knowledge around concern. The hospital safeguarding lead met regularly with local authority safeguarding contacts to review and discuss safeguarding referrals. The safeguarding lead held information relating to safeguarding referrals and their investigation was available for us to review. Staff had recorded information relating to the referral including its investigation and outcome.
- The ward had appropriate arrangements in place for obtaining medicines. Staff explained how they obtained medicines. We observed that supplies were available to enable patients to have their medicines when needed.
- Staff stored medication securely. Staff stored medicines requiring cold storage appropriately and kept them at the correct temperature. Controlled medicines were stored and managed appropriately. It was the provider's policy to store and record the use of all benzodiazepines in its register of drugs liable for misuse.
- As part of this inspection we reviewed patients' medicine administration records (MAR). We observed that appropriate arrangements were in place for recording the administration of medicines. These records were accurate and fully completed. MAR sheets indicated that patients received their medications promptly. The ward had recorded reasons for staff not giving patients medicines and there were no gaps on the administration records.
- Some patients who were prescribed high doses of anti-psychotic medication required specific health checks. The provider had systems to ensure that patients requiring these checks had them.
- The provider had a policy and procedure in place for children's visits that staff were aware of. A children's visiting room was available off the ward. Staff supervised children's visits, which only took place after a multidisciplinary discussion had determined that they were in the child's best interests.

Track record on safety

- There had been no recent serious incidents on Hansa ward.

Reporting incidents and learning from when things go wrong

Requires improvement

Wards for people with learning disabilities or autism

- Staff knew how to report an incident and displayed a good understanding around the process. Staff reported all incidents.
- Ward and senior managers identified that the majority of incidents reported related to patient on patient violence, or patient on staff violence. In response, the provider promoted a zero tolerance culture to violence. This resulted in the provider developing specific care plans with certain patients regarding violence and aggression and liaison with local police. As a result, the provider had experienced a recent downward trend in the number of incident reports relating to violence and aggression.
- Incident reports and discussions with patients showed that staff were open and transparent with patients and explained when things went wrong.
- The provider supported and debriefed patients and staff if they were involved in incidents.
- The provider had some systems in place to learn from incidents across the hospital. This included discussions at staff and clinical governance meetings. The provider shared learning from incidents on the hospital's intranet, which all staff could access. However, in spite of a recent serious incident on New Dawn ward, staff on Hansa ward had not reviewed and updated the ligature assessment. This was of concern as similar ligature anchor points were in place on Hansa ward.

Are wards for people with learning disabilities or autism effective?

(for example, treatment is effective)

Requires improvement

Assessment of needs and planning of care

- All of the case records we saw showed that a doctor and nurse initially assessed patients on the day of admission.
- Staff addressed patients' physical health and included an examination in initial assessments. From the care records we reviewed, staff had identified and followed up on physical health. Staff registered patients with a local GP, who visited the ward every two weeks.
- Each of the patient care and treatment records we reviewed included a range of care plans that were person centred and holistic. However, we were unable to locate evidence that patients' views in relation to their care and treatment had been included the two care plans we reviewed. A column headed 'service user agrees' with a yes/no response was frequently used to show patient involvement in care planning.
- Staff had given patients copies of their care plans and details of "my shared pathway".
- Staff had access to all records on the ward which were stored in paper format.

Best practice in treatment and care

- Hansa ward used an adapted version of the dialectical behavioural therapy (DBT) programme with the majority of patients having a diagnosis of emotionally unstable personality disorder (EUPD) or traits associated with this. An assistant psychologist co-facilitated the DBT skills group with the clinical psychologist. This involved skills coaching sessions as and when requested by the patients.
- The treatment approach was similar to the structure, positive (approaches and expectations), empathy, low arousal, link (SPELL) framework. Activities and occupation were a key feature of the programme, along with a positive acceptance approach and low stimulus environment that tried to avoid triggers.
- The ward used a symptom checklist (SCL-90) assessment tool on admission and measured specific DBT outcomes every three months. In addition, they used the health of the nation outcome scales (HoNOS).
- We saw the provider had regular visits from a pharmacist, who checked that staff gave medicines safely to patients and the administration of medicines recorded correctly. We observed that staff had prescribed one patient Haloperidol 5 -10 mg every four to six hours with a maximum of 10 mg in 24 hours. On the 24 August 2015, we saw staff had given 20 mg in a 24-hour period exceeding the maximum dose prescribed. The records we reviewed did not show what action staff had taken to address this. We highlighted this to the ward manager.
- Staff participated in a range of clinical audits, including a clinical notes audit. Staff identified actions through

the audit and completed them by the following month. Additional audits included occupational therapy records, medication and explaining patients' rights. In July 2015 staff conducted the quality of person centred care audit of behavioural management in care plans against NICE guidance on prevention and interventions for people with learning disabilities whose behaviour challenges.

Skilled staff to deliver care

- The multidisciplinary team was made up of an appropriate range of staff, including a consultant psychiatrist, occupational therapists, support workers, an activities co-ordinator, a psychologist, a specialist registrar and qualified nurses.
- Ward staff spoke highly of the specialist training they had received relating to the development and use of de-escalation techniques. Psychologists and some other staff had completed specialist DBT training as well as autistic spectrum disorder training. We did not see evidence of specialist positive behavioural support training.
- Senior managers supervised staff monthly and appraised them annually. Staff told us they were receiving supervision regularly.
- In the context of incidents that occurred across the hospital, senior managers spoke of a "few bad apples". The provider had taken appropriate disciplinary action where they had identified staff performance issues.

Multidisciplinary and inter-agency team work

- There were regular and effective multidisciplinary team meetings. Staff comprehensively recorded ward reviews and included the patients' views.
- The handover we observed reviewed individual patients and included discussion around care plans, risk management and a general update on the patient's wellbeing.
- Care and treatment records showed that staff had identified and made contact with patients' care co-ordinators. Staff kept them up to date, invited them to multidisciplinary team reviews and care programme approach (CPA) meetings.
- The provider gave commissioners regular updates on care pathways and discharge plans. Staff offered the local advocacy service access to the quiet room on the ward to meet privately with patients.
- The provider had made links with the local authority safeguarding lead and held regular monthly meetings to review safeguarding issues.

Adherence to the MHA and the MHA Code of Practice

- The majority of staff (91%) completed training relating to the Mental Health Act (MHA) and MHA Code of Practice as part of mandatory training. We were not able to obtain this figure at ward level. Staff recently received training addressing the need to use the least restrictive practice and were able to give examples of how their and the ward's practice had developed as a result.
- Staff completed and attached consent (T2) or authorisation (T3) certificates to medicines charts where required.
- The majority of patients we spoke with told us that they were aware of their rights. Staff regularly explained rights to patients. In one patient's records, it had been recorded that that a discussion of the patient's rights had been completed and that the patient had understood. However, the patient told us that they could not recall their rights being discussed with them and did not know what section of the Mental Health Act they were detained under, and could not recall having a discussion with staff regarding their rights.
- Staff securely stored and correctly completed detention papers. Staff were able to access a MHA administrator for support with issues relating to the MHA. The MHA administrator sent reminders of tribunals and reports to relevant staff. The MHA administrator reviewed consent to treatment and capacity forms as part of the MHA audit that took place once a week. On admission, the senior nurse on duty, who had received specific training to scrutinise these documents and report any anomalies to the hospital manager, checked MHA documentation.
- Staff displayed information about independent mental health advocates (IMHA) on the ward and an advocate came to the ward on a weekly basis. Staff were complimentary of the advocate and said they knew how to contact them.

Requires improvement

Wards for people with learning disabilities or autism

Good practice in applying the MCA

- Some staff had recently completed Mental Capacity Act (MCA) training. Staff we spoke with were aware of the MCA but unable to describe the five statutory principles and could not tell us how they would implement the MCA while providing care and treatment for patients.
- Staff had made one deprivation of liberty safeguards (DoLS) application in the last 12 months. The hospital manager told us there were no patients were currently subject to DoLS. The provider had developed a policy relating to MCA including DoLS. We were told by senior managers that use of the MCA was monitored through the clinical notes audit. However, the sample of records relating to patient care and treatment and clinical notes audit we reviewed did not show that use of the MCA was being monitored.

Are wards for people with learning disabilities or autism caring?

Good

Kindness, Dignity, respect and support

- We observed positive interaction between patients and staff. We observed that staff were caring and respectful of patients' needs and actively supported them. Staff knocked on bedroom doors and waited for a response before opening the door.
- Patients we met in private spoke positively about the ward and staff in general. Most patients said that staff were caring and kind and listened to them. Two patients commented that they did not feel listened to and that the ward was very noisy.
- The majority of patients we spoke with felt safe on the ward but some did comment that they occasionally felt unsafe due to violent outbursts from other patients.
- Staff had a good understanding of patients' individual needs and projected a caring approach when discussing patients.
- A theme of poor staff attitude was evident from some incident and complaint records we reviewed. The provider was aware of this issue, with measures put in place including the launch of its values programme and review of staff training needs. Actions taken by the provider included the development of a new recruitment policy, shifting the focus away from skills, knowledge and experience to focus on behavioural based qualities. Interview questions incorporated values and the rewards of supporting others. Staff had also been supported with longer handover times, mid shift debriefs and ensuring that staff took appropriate breaks during shift.

The involvement of people in the care they receive

- The ward had developed a welcome pack that orientated patients to the ward on admission. Staff provided patients with a copy of this. Occupational therapists completed an "interests" checklist with patients on admission, which informed the provision of activities on the ward.
- Patients' views were included when developing and reviewing care plans. Ward review notes and discussions with patients indicated that they met with the MDT during ward reviews and that their views were obtained and recorded. Staff provided timetables to patients, who were aware of their time for the ward rounds. Staff gave feedback to the patient on progression from the last meeting and their treatment plan discussed.
- Most patients told us that staff had given them a copy of their care plan. Some patients said that they did not know if staff had given them a copy of their care plan. Most patients felt that staff took their views into account in relation to their care and treatment, but some felt staff did not always listen.
- Patients were given personal folders (my shared pathway) which included the documentation relating to the care programme approach (CPA), this was patient orientated and included a recovery and strength based approach.
- Patients had undertaken collaborative risk assessment training and with staff around risk assessment.
- Patients had regular access to advocacy. An advocate visited the ward once a week. Wards displayed information about advocacy services.
- With the permission of patients, families were appropriately involved in their care and treatment.

Requires improvement

Wards for people with learning disabilities or autism

- The ward held daily planning meetings. Staff and patients held regular community meetings. During these meetings, patients were able to express their views about the service provided and make suggestions. The ward displayed a "you said we did" noticeboard. This outlined issues such as quality of food and activities raised by patients and the action the hospital had taken in response. However, this was located outside of the ward entrance so was not accessible to all patients.
- The ward had planned patient focus groups to discuss new ideas for the next financial quarter. This included reviewing existing groups and activities and planning new ones.
- The provider had established a recovery outcome group (ROG) locally, at the regional level (London), throughout the South East and at a national level. The group looked at what actions staff had taken around patient feedback and their experiences. The ROG scrutinised actions taken by the provider regarding patient experience. The ROG has recently considered issues of quality improvement, smoking cessation and the management of violence and aggression. The ROG met each quarter locally and nationally every six months.
- Some patients had been involved in recent staff recruitment on the ward.

Are wards for people with learning disabilities or autism responsive to people's needs?

(for example, to feedback?)

Good

Access and discharge

- The ward accepted referrals nationally. Staff admitted patients after a gatekeeping assessment meeting referral criteria. Average bed occupancy from November 2014 to April 2015 was 93%.
- Staff engaged with commissioners, providers and patients families in discharge planning. Staff completed a community placement profile with patients to plan discharges. This included where they wished to move, what accommodation they wished to have and what area they wished to be discharged. This was passed on to care co-ordinators and staff liaised with identified placements to identify availability and discuss appropriate handover arrangements. Staff encouraged patients to take leave and visit the placement and encouraged family to view with them.
- Patients were able to access escorted and unescorted leave as agreed by the multi disciplinary team. There were no issues regarding beds being unavailable upon return from leave.
- Staff did not move patients between wards during an admission for non-clinical reasons. When staff discharged or transferred patients, this happened at an appropriate time of day.
- There were plans to separate Hansa ward into two units, to provide an acute admission unit to meet the needs of patients with high dependency need and a step down unit providing a therapeutic setting where they could deliver DBT.
- At the time of our inspection, there were no patients on Hansa ward subject to delayed discharge. From November 2014 to 30 April 2015 the ward reported two delayed discharges.

The facilities promote recovery, comfort and dignity and confidentiality

- A full range of rooms and equipment to support treatment care were available on the ward. These included a communal lounge, quiet room and occupational therapy room. A sensory room and activities of daily living kitchen were also available on the ward.
- With the exception of patient bedrooms, there were no private spaces on the ward where patients could meet with family members. A room off the ward was available for patients to meet privately with visitors.
- Patients were encouraged to personalise their bedrooms.
- Patients were able to access mobile phones supplied by the ward to make personal phone calls in private.
- There was direct access from the communal lounge to a garden area, which patients had unrestricted access to. Patients who wished to smoke could use this area at any time.

Requires improvement

Wards for people with learning disabilities or autism

- The manager told us that since the appointment of the current chef the quality of the food had improved as had patient comments relating to the meals provided. The patients we spoke with felt the food was overall of good quality. Patients were able to access hot drinks and snacks freely.
- Patients had lockable space to store their possessions safely and securely.
- Patients had daily planning meetings with an activities co-ordinator and chose activities they wished to participate in. The provider had recently trained occupational therapists and activities co-ordinators to give inductions for the gym. Other activities available included yoga and baking clubs.
- Patients spoke positively about the frequency and quality of activities available. However, some patients told us that there was a lack of activities at the weekend.
- The ward displayed boards with information for patients. Allocation boards detailed each patients' allocated nurse and staffing as well as photos of staff members. Welcome boards displayed information about the ward manager, visiting and protected times and patient advice and liaison services.

Meeting the needs of all people who use the service

- The ward was located on the ground floor and was accessible to people with disabilities.
- The ward did not display information leaflets in other languages. The manager could request this from the provider when required.
- Information on patients' rights, local services and how to make a complaint were all available on the ward.
- Staff could book interpreting services and face to face interpreters could be booked for patient assessments, ward reviews and other meetings.
- The ward adapted meals to meet cultural, religious or dietary requirements. Some patients complained of weight gain on the ward. When necessary, a nutrition plan to work towards losing weight and eating balanced meals had subsequently been included in patient care records.
- Patients had access to a multi-faith room that had several religious texts. A chaplain visited the ward each week and patients with leave could attend a local mosque with which ward staff had made contact. When required, staff would address patients regarding their spiritual needs from other religions.

Listening to and learning from concerns and complaints

- The patients we spoke with knew how to make a complaint. Complaints were discussed in detail with the ward manager and patients were reassured the complaint would be treated in confidence. Patients spoke highly of the approach of the ward manager who had dealt with their complaints. From June 2014 to April 2015 there were seven complaints made on Hansa ward, with three being upheld. Patients told us that they had received responses to their complaints, and that where they were upheld, an apology.
- The provider upheld complaints on Hansa ward related to staff attitude, administrative errors, medication errors and the quality of care.
- Staff were aware of the complaints procedure, and were able to describe the process to follow if patients wished to make a complaint.
- The provider fed back upheld complaints and investigations to the staff involved and measures such as additional training provided. However, there was no evidence that the provider shared learning from individual complaints with staff who were not directly involved.

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

Good

Vision and values

- The ward staff were aware of the organisations' values; empathy, caring, respect and honesty and felt they reflected the ethos of the ward. Hansa ward implemented a core philosophy that included a treatment programme that facilitated skills development, MDT and multi-agency approaches, increasing pro-social behaviours, supporting patient re-integration into the community and close partnership working with referral teams.

Requires improvement

Wards for people with learning disabilities or autism

- Staff told us that they felt well supported by their immediate line manager, and that the hospital manager visited their ward regularly. Some staff commented that the chief executive of the organisation had visited the ward, while others commented that there was little visibility of senior executives at ward level.

Good governance

- The ward manager had effective systems in place at a local level to ensure appropriate oversight of incidents, restraints and complaints that had occurred on the ward. Senior managers had an oversight of this information at ward and hospital level.
- The provider had systems in place to share learning from incidents. However, there was not always evidence that these systems were effective as the provider had not shared learning from some complaints and incidents across wards.
- Serious incidents were appropriately investigated and their findings shared with senior and ward managers. The provider benchmarked serious Incidents requiring investigation against other hospitals run by the provider, but were not benchmarked at ward level. A breakdown of the London region by hospital was not available for us to look at.
- Staff audited record keeping and documentation through the clinical notes audit. However, from the audits we reviewed, there was no evidence that staff monitored the MCA. Staff conducted the audits regularly but there was no cross-ward audit process to check the validity of audit results.
- Permanent staff had completed the majority (91%) of mandatory training. The provider monitored mandatory training uptake by bank staff. They did not give work to bank staff who failed to complete their training. Ward managers regularly supervised and appraised staff.
- An appropriate number of staff of the right grades and experience covered shifts. Staff maximised the time they spent on the ward in direct care activities.
- The provider collected data on performance through a range of audits and other measures and uploaded this onto the providers' quality dashboard. The provider measures key performance indicators (KPIs) that included average length of stay for those who completed treatment, the number of service users who received a healthcare assessment and delayed discharges. The provider monitored the majority of KPIs at regional (London Area), local (Cygnet Hospital Beckton) or service (such as low-secure) level.
- The quality service report monitored key performance indicators on a quarterly basis and benchmarked against other hospitals run by the provider. There was no benchmarking against services of a similar nature outside the Cygnet organisation meaning that comparison was unavailable.
- The provider was meeting its key performance indicator targets. Senior managers discussed key performance indicators and other governance issues at monthly clinical meetings. Ward managers regularly attended additional governance meetings where they reviewed key performance indicators.
- The provider monitored risk levels through the risk register. The register highlighted the length of time the risk had been open, the owners for each action with a rating in relation to the seriousness of the risk. Ward managers had the opportunity to submit items to the risk register through the clinical services manager. The clinical services manager made the decision to add the item to the risk register. The ward manager felt that risks could be elevated and considered for the risk register and was satisfied with the process despite needing approval.
- The local risk register fed into a corporate risk register. The corporate risk register identified the highest risks as management of serious untoward incidents, medication administration and MHA errors, vacancies and the use of bank and agency workers. Senior staff highlighted staff attitude as a consistent theme in incident and complaints reports but this did not appear on the risk register.
- Staff vacancy rates had been on the local Cygnet risk register since October 2014 and there had been a reduction in the use of bank and agency. The high rate of cancellations by bank and agency workers put pressure on permanent members of staff. On-going recruitment drives had filled the majority of outstanding vacancies and quarterly staffing key performance indicators monitoring vacancies, turnover and bank and agency usage were in place.

Leadership, morale and staff engagement

Requires improvement

Wards for people with learning disabilities or autism

- Staff were complimentary of the ward manager and were happy with the management of the ward.
- For Hansa ward, the percentage of permanent staff sickness overall was low at 3% as of April 2015.
- There were no concerns raised over bullying or harassment across the ward.
- Staff described the whistleblowing process to us, although none we spoke with had had cause to use it. Staff told us they would be comfortable raising a concern without the fear of reprisal or victimisation.
- The majority of staff we spoke with enjoyed their job and felt valued. Staff admitted to feeling stressed at times but felt that it was part of the job.
- The provider gave staff opportunities to undertake additional training for leadership development and encouraged them to apply for other roles. The provider on a case-by-case basis supported staff with some areas of continuous professional development, relating to higher education.
- The complaints investigations records we reviewed showed that staff were open and transparent and apologised to patients if something went wrong.
- The provider conducted a staff survey and recently asked staff to participate in the development of the providers values. There had been a recent "dragons den" style project where staff were able to present projects within the hospital and make a case for why this should be taken forward.

Commitment to quality improvement and innovation

- The hospital achieved an Investors in people Bronze award in February 2015. This was an independent framework to promote leadership, support and good management of staff.

Examples of innovative practice or involvement in research.

- The provider had a quality improvement project that focused on five key areas and encouraged staff to develop initiatives in their respective areas that supported the overall aim of the quality improvement plan.

Requires improvement

Tier 4 personality disorder services

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

Are tier 4 personality disorder services safe?

Requires improvement

Safe and clean environment

- Staff could readily observe patients on New Dawn ward and there were no blind spots. Staff were present in the communal areas and nurse's offices were located so that staff could view corridor areas.
- CCTV was in operation on New Dawn ward. Views from the cameras were not available on the ward, but were recorded and kept in the reception area and could be accessed when needed. Patients were aware of the use of CCTV.
- The provider had completed a ligature risk assessment for the ward in November 2014. The provider identified that some ligature risks, for example showerheads and all the upright taps in shower rooms, bathroom and en suites presented a ligature risk that should be replaced. The provider should have costed works but did not give any timescales for completion of the work. Staff noted other ligature points, for example the pipe work in the quiet room on New Dawn one as "protect/cover", but no date for the completion of works had been identified.
- The provider identified the shower and bathrooms the "door – door furniture" as a ligature point. We identified that the hinges and the actual door all presented ligature points, but it was unclear whether the description in the ligature risk assessment addressed all of these areas.
- The provider recognised that patients with a diagnosis of borderline personality disorder were at a particular risk of self-harm and suicide. This was reflected within the patient group receiving care and treatment on New Dawn ward at the time of our inspection, some of whom were at risk of fixing ligatures multiple times each day.
- At the time of our inspection, staff had made local arrangements to manage and mitigate the potential risks presented by ligature points. These included daily environmental checks, locking bath and shower room doors, increased observations of individual patients, use of anti-ligature bedding, locating of patients assessed at being at high risk in bedrooms close to the nursing office and general observations.
- Staff had assessed some patients on New Dawn ward as being at such high risk of fixing ligatures that they were subject to continuous one to one observations. This meant that staff might observe them while they used their en suite facilities. While staff described measures to do this in ways that maximised privacy and dignity, they had identified numerous ligature points in en suite toilets that the provider had not yet scheduled works for. This increased the need for intrusive observations of some patients that infringed their privacy and dignity.
- Two serious incidents had recently occurred on the ward that involved the fixing of ligatures. As a result, the ward had made some modifications to en suite toilet doors across the hospital. The ward had identified these doors as a ligature point on the ligature risk assessment but had not identified a timescale for replacement. Similarly, a patient had used a light fitting in an en suite toilet to fix a ligature. While the hospital had changed one light to an anti-ligature fitting because of this incident, the other en suite toilets on the ward and

throughout the hospital still contained the original light fitting. Staff had not clearly identified the light fittings in the en suite toilets on the ligature risk assessment as presenting a ligature risk and no control measures were identified.

- The ward manager told us that the provider's corporate risk manager regularly reviewed the ligature risk assessment. However, the provider had not annotated the New Dawn ligature risk assessment to show this and did not indicate any reassessment of ligatures across the ward since its production in November 2014. The provider could not clearly show that since the recent serious incidents a ward wide review of all potential ligature points had taken place, and that there were appropriate measures to manage and mitigate these.
- New Dawn ward is single female sex ward for women who experience emotional trauma with a diagnosis of PD. There are not de-escalation or seclusion room on this ward as service users are supported in crisis through psychological interventions. Access to the de-escalation facility on Hooper is available if required and this arrangement is structured and managed with the wards protocol.
- The ward included a clinic room and there was evidence of stickers for regular checks to equipment. Staff completed regular checks of emergency medicines and equipment available. The clinic room was clean and well organised. Staff checked and maintained fridge temperatures on a daily basis. There was a treatment table in the room and a blood pressure monitor and scales.
- However, there was only one emergency grab bag to cover New Dawn one and New Dawn two. As there was a locked door between the two units, there could be a delay in staff accessing the emergency bag in the event a patient collapsed.
- The ward area was visibly clean and well maintained with modern furnishings.
- Staff undertook environmental risk assessments regularly. Staff checked items such as cleaning materials and other potentially hazardous items to see they were stored safely.
- Appropriate personal alarm systems for staff were in place. The ward manager allocated staff members a personal alarm at the start of each shift. All personal items that posed a possible risk were stored in lockers at reception.

Safe Staffing

- The ward manager had recently reviewed staffing levels. The day shift comprised of three qualified nurses and five support workers. The ward manager deployed one nurse and two support workers from this complement onto New Dawn two. The ward manager could adjust staffing levels depending on patient numbers or if staff were nursing a patient on one to one observations. Staffing rotas showed that the required number of staff were rostered on duty. There were sufficient staff on duty to meet their needs and maintain a safe environment.
- The establishment levels at the time of the inspection for qualified nurses whole time equivalent was 14.2 with established levels of nursing assistants 18.9. At the time of the inspection, the ward had 27 substantive staff with three leavers within the last 12 months. There were three nursing vacancies and one support worker vacancy. Recruitment was underway for these posts and regular bank and agency staff were covering them. Bank and agency staff had covered 22 shifts in the previous three months. The ward used regular bank staff familiar with the ward from a list approved by the hospital manager.
- Patients on New Dawn two raised the issue that bank staff tended to be deployed to New Dawn two, and their view was that this affected upon the quality of care. The provider did not keep a record for each shift showing the deployment of bank and agency staff over New Dawn one and New Dawn two to monitor bank and agency deployment and ensure consistency of care.
- Staff rarely cancelled leave and patients told us that one to one meetings with named nurses happened regularly.
- There was a ward doctor during working hours an on call doctor was available out of hours. Some patients were at risk of self-harm through the insertion of objects. Some patients preferred to receive treatment to remove these objects from a female doctor. The ward's therapeutic approach stated that medical staff within

the hospital would not remove these objects, and that staff should refer the patient to the local GP or A&E. As a female doctor was not always available at A&E, the provider had an arrangement with the local GP and a female GP was available each Friday to provide this treatment. This meant that in non-urgent cases patients might have to wait several days to receive medical treatment to remove inserted items by a female doctor. Whilst this did not compromise their safety, some patients told us that they found it distressing.

- Staff accessed mandatory training through e-learning and supplementary classroom training. The majority of permanent staff were up to date with their training. Some recently appointed staff had not yet completed the full range of mandatory training had arranged to do so.
- A dashboard that was updated daily, captured information around incomplete mandatory training. Ward managers reviewed this to understand which staff had not completed training. Mandatory training identified for staff included management of violence and aggression, life support, security awareness and the Mental Health Act. Staff also undertook training relating to the use of seclusion, physical health and safeguarding adults and children. In addition, nurses completed training addressing medicines management.
- Eighty-three percent of Bank workers had completed the mandatory e-learning package. 66.7% of Bank workers had completed supplementary classroom training. Gaps were identified in relation to e-learning policy awareness training and some Bank workers were stopped from working until they met the required level of training compliance.

Assessing and managing risk to patients and staff

- Staff used the short term assessment of risk and treatability (START) tool to assess potential risks. They undertook and completed risk assessments for each patient upon admission and updated this regularly after each incident. The risk assessment did not include an indication of the seriousness of the risk and only had a brief summary. A patient whose case records we examined had recently been involved in a serious incident and while staff had updated their risk assessment to include this, they had not reflected the seriousness of the incident in the recording.
- The ward had reviewed restrictive practices and did not have unjustified blanket restrictions in place.
- The ward displayed information relating to patient rights and informal patients were aware of their right to leave the ward.
- There was an appropriate policy and procedure for observations that staff were aware of and followed. Staff nursed patients on one to one observations when required.
- Staff searched patients returning from community leave in accordance with the hospitals policy and procedure.
- For the six months from November 2014 to the April 2015, there were 13 incidents of restraint on New Dawn ward, of which one was a restraint in the prone position. Staff told us that the use of restraint was a last resort, and never planned it. Information regarding the number of restraints for the preceding six months was not available and the provider was not able to advise whether the use of restraint, particularly prone restraint had increased, remained stable or had decreased.
- Staff had received training in managing violence and aggression and described in detail the techniques they used to de-escalate situations. They discussed violent or aggressive incidents in handover meetings and recorded them in an individual patient care plan.
- We examined four recent incident reports relating to restraint and found that in two instances where a patient had been subject to prone restraint, staff had not completed a restraint form. This meant that there was no record of the staff involved in the restraint, at which points on the patient's body they had been in contact, and for how long staff had maintained the hold. There was also no record of doctors reviewing patients held in the prone restraint position or monitoring of their vital observations. There was also no record of the debriefing for patient and staff after incidents of prone restraint.
- Staff completed mandatory training in safeguarding and explained different types of safeguarding concerns. Staff knew the safeguarding lead for the provider. Safeguarding allegations were appropriately documented and action taken.
- The hospital had appointed a safeguarding lead who reviewed all safeguarding alerts and was available to

give advice to staff regarding safeguarding matters. The lead had recently delivered some safeguarding training to patients at the hospital to improve knowledge around concern.

- The hospitals safeguarding lead met regularly with local authority safeguarding contacts to review and discuss safeguarding referrals. The safeguarding lead held information relating to safeguarding referrals and their investigation was available for us to review. Staff had recorded information relating to the referral including its investigation and outcome.
- The provider had appropriate arrangements in place for obtaining medicines. Staff explained how they obtained medicines. We observed that supplies were available to enable patients to have their medicines when they needed them.
- The ward stored medication securely. Staff stored medicines requiring cold storage appropriately and kept them at the correct temperature. Controlled medicines were stored and managed appropriately. It was the provider's policy to store and record the use of all benzodiazepines in its register of drugs liable for misuse.
- As part of this inspection, we looked at patients' medicine administration records. Appropriate arrangements were in place for recording the administration of medicines. These records were clear and fully completed .The records showed patients were getting their medicines when they needed them, there were no gaps on the administration records and any reasons for not giving patients their medicines were recorded.
- Staff had prescribed some patients with high doses of anti-psychotic medication and they required specific health checks. The provider had systems to ensure patients requiring these checks had them.
- The provider had a policy and procedure in place for children's visits that staff were aware of. A children's visiting room was available off the ward. Staff supervised children's visits, which only took place after a multidisciplinary discussion had determined that they were in the child's best interests.

Track record on safety

- Two recent serious incidents had recently occurred on New Dawn ward. The ward and senior managers at a local level had investigated each.
- Each of the incidents had involved the fixing of ligatures in either patient bedrooms or en suites. In response to the incident that involved the en suite door, the hospital made modifications to all en suite doors across the hospital.
- For the second incident, the ward had made environmental changes to the bedroom and en suite of the patient involved in the incident, but the provider had not carried out changes in other patient bedrooms either on New Dawn or on other wards in the hospital. This meant that while the hospital was aware of the potential to fix a ligature to an identified anchor point, the ligature risk assessment on each ward had not been updated to include this anchor point and no control measures were identified as to how the potential risks associated with this anchor point would be managed in other patient bedrooms on New Dawn ward, or in patient bedrooms on other wards.

Reporting incidents and learning from when things go wrong

- Staff knew how to report an incident and displayed a good understanding around the process. Staff reported all incidents.
- Ward and senior managers identified that the majority of incidents reported related to patient on patient violence, or patient on staff violence. In response, the provider promoted a zero tolerance culture to violence. This resulted in the provider developing specific care plans with certain patients regarding violence and aggression and liaison with local police. As a result, the provider has experienced a recent downward trend in the number of incident reports relating to violence and aggression.
- Incident reports and discussions with patients showed that staff were open and transparent with patients and explained when things went wrong.
- The provider supported and debriefed patients and staff if they were involved in incidents.

Requires improvement

Tier 4 personality disorder services

Are tier 4 personality disorder services effective?

(for example, treatment is effective)

Requires improvement

Assessment of needs and planning of care

- The case records we reviewed howed that a doctor and nurse initially assessed patients on the day of admission.
- Staff addressed the patients' physical health and included an examination in initial assessments on admission. Staff had identified and followed up physical health needs in care records. However, we identified one patient whose care records showed they had recently self-harmed through deliberately banging their head. Examination of the patient's care records did not show that the doctor had reviewed the patient after these incidents.
- Each of the patient care records we looked at included a range of care plans in place that were up to date, personalised, holistic and recovery orientated. Patients' views were included in the development and review of care plans.
- Staff had access when needed to all records on the ward which were stored in paper format.

Best practice in treatment and care

- The provider had weekly visits by a pharmacist who checked that staff gave medicines safely to patients and the administration of medicines recorded correctly. However, our review of a sample of medication administration records indicated that two patients, who were prescribed promethazine medication for agitation when required, were being administered this medication regularly each evening. This meant that for these two patients, staff inappropriately administered their "as required" medicines as night sedation. We brought this to the attention of the ward manager.
- New Dawn ward provides tier 4 treatment for patient with personality disorder. The ward used a range of psychological interventions including (DBT) and an adaptive DBT approach to work with patients.
- Ward doctors provided routine physical healthcare to patients. Out of hours, an on call doctor was available. The provider registered patients with a local GP on admission to the hospital.
- Recognised rating scales, for example health of the nation outcome scales (HoNOS) were being used to measure patient outcomes.
- Staff participated in a range of clinical audits, including a clinical notes audit. Staff identified actions through the audit and completed them by the following month. Additional audits included occupational therapy records, medication and explaining patients' rights.

Skilled staff to deliver care

- The multidisciplinary team was made up of an appropriate range of staff, including a consultant psychiatrist, occupational therapists, support workers, an activities co-ordinator, a psychologist, a specialist registrar and qualified nurses.
- Ward staff spoke highly of the specialist training they had received relating to the development and use of de-escalation techniques. Medical and psychological staff had received specialist training in the use of dialectical behavioural therapy (DBT) and adaptive DBT. Some nurses had also completed comprehensive training in this approach. Other nurses and support workers had completed an introductory days training in DBT and had not completed comprehensive DBT Training. Other nurses and HCAs had not completed any training in relation to DBT or CBT. Training records showing the numbers of nurses and HCAs on New Dawn ward who had completed any specialist DBT or CBT training were not available. Three patients commented that nursing and support staff did not have the necessary knowledge and skills relating to personality disorder to provide them with appropriate care, or a sound understanding of the model of treatment. The provider was not able to show that sufficient numbers of nurses and support workers had completed appropriate training or had a sound understanding of the specialist models of treatment provided on New Dawn ward.
- Senior managers supervised staff monthly and appraised them annually. Staff told us they were receiving supervision regularly.
- From the incident and complaint records we reviewed, a theme of poor staff attitude was evident. The provider was aware of this issue, with measures put in place

including the launch of its values programme and review of staff training needs. Actions taken by the provider included the development of a new recruitment policy, shifting the focus away from skills, knowledge and experience to focus on behavioural based qualities. Interview questions incorporated values and the rewards of supporting others. Staff had also been supported with longer handover times, mid shift debriefs and ensuring that staff took appropriate breaks during shift.

- In the context of incidents that occurred across the hospital, senior managers spoke of a "few bad apples". The provider had taken appropriate disciplinary action where they had identified staff performance issues.

Multidisciplinary and inter-agency team work

- There were regular and effective daily multidisciplinary team meetings. Staff comprehensively recorded ward reviews and included patients' views.
- Staff handovers occurred four times each day on New Dawn ward. The handover we observed reviewed individual patients and included discussion around care plans, risk management and a general update on the patient's wellbeing.
- On admission, staff sent a detailed summary to the patients GP. From care and treatment records we observed that staff had identified and made contact with patients' care co-ordinators. Staff kept them up to date and invited them to multidisciplinary team reviews and care programme approach (CPA) meetings.
- The provider gave commissioners regular updates on care pathways and discharge plans. Staff offered the local advocacy service access to the quiet room on the ward to meet privately with patients.
- The provider had made links with the local authority safeguarding lead and held regular monthly meetings to review safeguarding issues.

Adherence to the MHA and the MHA Code of Practice

- The majority of staff (91%) had completed training relating to the Mental Health Act (MHA) and MHA Code of Practice as part of mandatory training. We were not able to obtain this figure at ward level. Staff recently received training addressing the need to use the least restrictive practice and were able to give examples of how their and the wards practice had developed as a result.
- Staff had completed and attached consent (T2) or authorisation (T3) certificates to medicines charts.
- A second opinion appointed doctor (SOAD) authorised patients' medicines if they were detained longer than three months under the Mental Health Act 1983. Based on a sample of 10 patient medicines records over New Dawn and Hooper wards, staff had correctly completed all of the supporting Mental Health Act documents relating to medicines.
- The majority of patients we spoke with told us that they were aware of their rights. Staff regularly explained rights to patients. Staff met with patients to revisit their rights every month.
- Staff securely stored and completed detention papers correctly. Staff were able to access a MHA administrator for support with issues relating to the MHA. The MHA administrator sent reminders of tribunals and reports to relevant staff. The MHA administrator reviewed consent to treatment and capacity forms as part of the MHA audit that took place once a week.
- Staff displayed information about independent mental health advocates (IMHA) on the ward and an advocate came to the ward on a weekly basis. Staff were complimentary of the advocate and said they knew how to contact them.
- The provider produced information leaflets in English only. The ward manager advised the leaflets were available in different languages when needed.

Good practice in applying the MCA

- Some staff had recently completed Mental Capacity Act (MCA) training. Staff we spoke with were aware of the MCA but unable to describe the five statutory principles and could not tell us how they would implement the MCA while providing care and treatment for patients.
- Staff had made one deprivation of liberty safeguards (DoLS) application in the last 12 months. The hospital manager told us there were no patients were currently subject to DoLS. The provider had developed a policy relating to MCA including DoLS. We were told by senior

managers that use of the MCA was monitored through the clinical notes audit, however our sampling of records relating to patients care and treatment and review of the clinical notes audit did not show that use of the MCA was being monitored.

Are tier 4 personality disorder services caring?

Good

Kindness, Dignity, respect and support

- We observed positive interaction between patients and staff. Staff were caring and respectful of patients' needs. Staff knocked on bedroom doors and waited for a response before opening the door.
- Some patients reported that while on one to one observations, staff handed over to the person taking on the duty in communal spaces and had disclosed confidential information. We raised this with the ward manager who advised that a policy was in place and they would remind staff of the procedure to follow when discussing sensitive information to preserve patient confidentiality.
- Patients we spoke with expressed mixed feedback in regards to their treatment by staff. The majority felt that there were no serious attitude problems but they can sometimes "wind you up". Patients often felt often ignored at the office and they have to try to talk through doors, as staff are "too busy".
- A qualified nurse was available in the communal area or visible in the nursing office at all times. Some patients and staff commented that on occasion nurses were only available in the nursing office, and that when approached by patients they talked to them through the door. This was also something that we observed when we were on the ward.
- Our discussions with staff and observation of handover showed that overall staff had a good understanding of patients' individual needs and projected a caring approach when discussing patients.
- A theme of poor staff attitude was evident from some incident and complaint records we reviewed. The provider was aware of this issue, with measures put in place including the launch of its values programme and review of staff training needs. Actions taken by the provider included the development of a new recruitment policy, shifting the focus away from skills, knowledge and experience to focus on behavioural based qualities. Interview questions incorporated values and the rewards of supporting others. Staff had also been supported with longer handover times, mid shift debriefs and ensuring that staff took appropriate breaks during shift.

The involvement of people in the care they receive

- The ward had developed a welcome pack that orientated patients to the ward on admission. Staff provided patients with a copy of this. Occupational therapists completed an "interests" checklist with patients on admission, which informed the provision of activities on the ward.
- The ward operated a buddy system and paired new patients with those who had been their longer to help orientate them to the ward and for peer support.
- Patients underwent a three month assessment on admission to the ward to assess their suitability for the DBT programme.
- Patient views were included when developing and reviewing care plans. Ward review notes and discussions with patients indicated that they met with the MDT during ward reviews and that their views were obtained and recorded.
- Patients had regular access to advocacy. An advocate visited the ward once a week. Wards displayed information about advocacy services.
- With the permission of patients, families were appropriately involved in their care and treatment. A patient we spoke with told us how, with their permission, the ward manager would call specific family members to provide updates on their care and treatment.
- Staff held regular community meetings for patients on the ward. During these meetings, patients were able to express their views about the service provided and make suggestions. The ward had a "you said, we did" noticeboard. This outlined issues raised by patients

such as quality of food and activities and the action the hospital had taken in response. However, this was located outside of the ward entrance so was not readily accessible to all patients.

- The provider had established a recovery outcome group (ROG) locally, at the regional level (London), throughout the South East and at a national level. Senior management attend and have patients as co-chairs and they scrutinise actions taken regarding patient experience. The group challenged Cygnet and gave guidance on matters such as CQUINs, weight gain, smoking cessation and violence against staff. The meeting took place quarterly at the local level with the national ROG meeting every six months. The group looked at what actions staff had taken around patient feedback and their experiences. The ROG scrutinised actions taken by the provider regarding patient experience. The ROG had recently considered issues of quality improvement, smoking cessation and the management of violence and aggression. The ROG met each quarter locally and nationally every six months.
- Some patients had been involved in recent staff recruitment on the ward.

Are tier 4 personality disorder services responsive to people's needs?

(for example, to feedback?)

Good

Access and discharge

- New Dawn ward accepted referrals nationwide. The ward admitted patients after completion of a gatekeeping assessment that confirmed that patients met admission criteria. Average bed occupancy from November 2014 to April 2015 was 99%. The majority of patients were admissions from out of London.
- Patients were able to access escorted and unescorted leave as agreed by the MDT. There were no concerns about beds being unavailable upon return from leave.
- Staff did not move patients between wards during an admission for non-clinical reasons. When staff discharged or transferred patients, this happened at an appropriate time of day.
- Patients from New Dawn ward, on occasion, used the de-escalation room on the PICU ward. The hospital had developed a protocol for staff to follow when transferring and using the de-escalation room on another ward within the hospital.
- At the time of our inspection the ward manager identified that one patient on New Dawn ward was subject to a delayed discharge because of difficulties experienced by the commissioners in identifying an appropriate placement for them. The ward was liaising closely with the commissioners and care co-ordinator to resolve the situation.

The facilities promote recovery, comfort and dignity and confidentiality

- A full range of rooms and equipment to support treatment care were available on the ward. These included a communal lounge, quiet room and occupational therapy room. There was a clinical room on the ward where medicines were stored. However, clinic rooms did not contain a treatment couch, and patients did not have access to the clinic room. Where patients required physical health checks or monitoring, staff carried these out in patient bedrooms.
- With the exception of patient bedrooms, there were no private spaces on the ward where patients could meet with family members. A room off the ward was available for patients to meet privately with visitors.
- Patients were able to access mobile phones supplied by the ward to make personal phone calls in private.
- Patients had unrestricted access from the communal lounge to a garden area. Patients who wished to smoke could use this area at any time.
- Patients gave mixed reviews of the meals provided. Some patients said the ward could improve the food, whilst others said the food was really good. Patients had unrestricted access to hot drinks and snacks.
- Patients were encouraged to personalise their bedrooms and there were facilities for patients to secure their possessions safely and securely.

Requires improvement

Tier 4 personality disorder services

- A structured individual and group DBT programme was in place on the ward. Patients spoke positively about the frequency and quality of activities available. However, some patients commented that there was a lack of activities at the weekend.

Meeting the needs of all people who use the service

- The ward was located on the first floor with lift access. At the time of our inspection, one patient who was receiving treatment was a wheelchair user. The en suite facilities in their bedroom could not accommodate their wheelchair, which meant that they were using the communal toilet. The ward locked the toilet, which meant that to use it the patient had to ask a member of staff to unlock it for them. Staff told us that they had made a referral to obtain a wheelchair that would fit into the en suite facilities and that staff were chasing this up.
- The ward did not display information leaflets in other languages. The manager could request this from the provider when required.
- The ward had information on patients' rights, local services and how to make a complaint.
- Staff had access to interpreting services and face to face interpreters could be booked for patient assessments, ward reviews and other meetings.
- The ward adapted meals to meet cultural, religious or dietary requirements.
- The service had a holistic approach when considering patients' identities and several patients who identified as transgender had their view respected and staff appropriately supported them.
- Patients had access to a multi-faith room available that had several religious texts. A chaplain visited the ward each week and patients with leave could attend a local mosque with whom ward staff had made contact. When required, staff would address patients regarding their spiritual needs from other religions.

Listening to and learning from concerns and complaints

- The patients we spoke with knew how to make a complaint. Complaints were discussed in detail with the ward manager and patients were reassured the complaint would be treated in confidence. Patients spoke highly of the approach of the ward manager who had dealt with their complaints. From June 2014 to April 2015 there were 21 complaints made on New Dawn ward, with six being upheld, the highest number across the four wards on site. Patients told us that they had received responses to their complaints, and that where they were upheld an apology.
- Staff were aware of the complaints procedure, and were able to describe the process to follow if patients wished to make a complaint.
- The ward had investigated a complaint in May 2015 by a patient and had found that a member of staff had inappropriately restrained a patient. It was not clear from the evidence that the provider had shared learning from this complaint with other staff.

Are tier 4 personality disorder services well-led?

Good

Vision and values

- The ward staff were aware of the organisations' values; empathy, caring, respect and honesty and felt they reflected the ethos of the ward.
- Staff told us that they felt well supported by their immediate line manager, and that the hospital manager visited their ward regularly. Some staff commented that the chief executive of the organisation had visited the ward, while others commented that there was little visibility of senior executives at ward level.

Good governance

- Ward managers had effective systems in place at a local level to ensure appropriate oversight of incidents, restraints and complaints that had occurred on their ward. Senior managers had an oversight of this information at ward and hospital level.
- While the provider had systems in place to share learning from incidents, there was evidence that these systems were not always effective as they had not shared learning from some incidents and across wards.
- Staff appropriately investigated serious incidents and shared their findings senior and ward managers. The

provider benchmarked serious Incidents requiring investigation against other hospitals run by the provider, but not at ward level. A breakdown of the London region by hospital was not available for us to look at.

- Staff audited record keeping and documentation through the clinical notes audit. However, from the audits we reviewed, there was no evidence that staff monitored the MCA. Staff conducted the audits regularly but there was no cross-ward audit process to check the validity of audit results.
- Permanent staff had completed the majority (91%) of mandatory training. The provider monitored mandatory training uptake by bank staff. They did not give work to bank staff who failed to complete their training. Ward managers regularly supervised and appraised staff.
- An appropriate number of staff of the right grades and experience covered shifts. Staff maximised the time they spent on the ward in direct care activities.
- The provider collected data on performance through a range of audits and other measures and uploaded this onto the providers' quality dashboard. The provider measured key performance indicators (KPIs) which included average length of stay for those who completed treatment, the number of service users who received a healthcare assessment and delayed discharges. The majority of KPIs were monitored at regional (London Area), local (Cygnet Hospital Beckton) or service (such as low-secure) level.
- The quality service report monitored key performance indicators on a quarterly basis and benchmarked against other hospitals run by the provider. There was no benchmarking against services of a similar nature outside the Cygnet organisation meaning that comparison was unavailable.
- The provider was meeting its key performance indicator targets. Senior managers discussed key performance indicators and other governance issues at monthly clinical meetings. Ward managers regularly attended additional governance meetings where they reviewed key performance indicators.
- The provider monitored risk levels through the risk register. The register highlighted the length of time the risk had been open, the owners for each action with a rating in relation to the seriousness of the risk. Ward managers had the opportunity to submit items to the risk register through the clinical services manager. The clinical services manager made the decision to add the item to the risk register. The ward manager felt that risks could be elevated and considered for the risk register and was satisfied with the process despite needing approval.
- The local risk register fed into a corporate risk register. The corporate risk register identified the highest risks as management of serious untoward incidents, medication administration and MHA errors, vacancies and the use of bank and agency workers. Senior staff highlighted staff attitude as a consistent theme in incident and complaints reports but this did not appear on the risk register.
- Staff vacancy rates had been on the local Cygnet risk register since October 2014 and there had been a reduction in the use of bank and agency. The high rate of cancellations by bank and agency workers put pressure on permanent members of staff. On-going recruitment drives had filled the majority of outstanding vacancies and quarterly staffing key performance indicators monitoring vacancies, turnover and bank and agency usage were in place.

Leadership, morale and staff engagement

- Staff were complimentary of the ward manager and were happy with the management of the ward.
- For New Dawn ward the percentage of permanent staff sickness was low at 2% (as at 30 April 2015).
- There were no concerns raised over bullying or harassment across the ward.
- Staff described the whistleblowing process to us, although none we spoke with had had cause to use it. Staff told us they would be comfortable raising a concern without the fear of reprisal or victimisation.
- The majority of staff we spoke with enjoyed their job and felt valued. Staff admitted to feeling stressed at times but felt that it was part of the job.
- The provider gave staff opportunities to undertake additional training for leadership development and

encouraged them to apply for other roles. The provider on a case-by-case basis supported staff with some areas of continuous professional development, relating to higher education.

- The complaints investigations records we reviewed showed that staff were open and transparent and apologised to patients if something went wrong.
- The provider had a staff survey and recently asked staff to participate in the development of the providers values. There had been a recent "dragons den" style project where staff were able to present projects within the hospital and make a case for why this should be taken forward.

Commitment to quality improvement and innovation

- The hospital achieved an Investors in people Bronze award in February 2015. This was an independent framework to promote leadership, support and good management of staff.

Examples of innovative practice or involvement in research.

- The provider had a quality improvement project that focused on five key areas and encouraged staff to develop initiatives in their respective areas that supported the overall aim of the quality improvement plan.

Outstanding practice and areas for improvement

Outstanding practice

- The providers safeguarding lead had delivered safeguarding training to some patients to improve knowledge about concerns. Patients had participated in staff training addressing risk assessment.
- The provider had established a recovery outcome group (ROG) locally, at the regional level (London), throughout the South East and at a national level. A patient co-chaired the meeting and senior management made up the rest of the members. The group looked at what actions staff had taken around patient feedback and their experiences.

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that sufficient emergency medical equipment is available on New Dawn ward, so that patients can receive prompt emergency medical treatment whether located on New Dawn 1 or New Dawn 2.
- The provider must ensure that all ligature anchor points are clearly identified in the ligature risk assessment. Where works to address potential ligature anchor points are required, a date for the completion of these works must be identified. The provider must also ensure that where there are blind spots on the ward (for example Hooper) appropriate steps are taken to address these.
- The provider must ensure that where patients are prevented from leaving de-escalation rooms this is recognised as a period of seclusion and that the appropriate safeguards for patients nursed in seclusion, as outlined in the Mental Health Act Code of Practice are followed.
- The provider must ensure that where patients are administered rapid tranquilisation they receive appropriate health checks afterwards.
- The provider must ensure that where patients are restrained, these incidents are appropriately recorded, including the hold, the staff involved and the length of time that the restraint hold was maintained. The provider must ensure that it uses available data to identify any trends or themes in the use of restraint.
- The provider must ensure that all staff are trained to recognise safeguarding concerns and that appropriate actions are taken to address safeguarding concerns.
- The provider must ensure that all medicines are administered appropriately and within the prescribed guidelines. The provider must ensure that maximum doses of medication over 24 hour periods are not exceeded and that as required medicines are not used as night time sedation.
- The provider must ensure that all relevant pre-admission assessment information is available to staff and included in the initial risk assessment along with the measures to manage and mitigate these risks.
- The provider must ensure that on specialist wards such as New Dawn, nursing staff and health care support workers receive specialist training in DBT and CBT approaches to better understand patients' needs and support the delivery of the therapeutic programme.

Action the provider SHOULD take to improve

- The provider should ensure that consistency of care is provided on New Dawn 1 and New Dawn 2 ward by monitoring the deployment of bank staff over the unit.
- The provider should ensure all care plans are holistic and contain patients' views on their care and treatment.
- The provider should ensure that staff understand how to apply the MCA to their role and that robust systems are in place to monitor the use of the MCA.

Outstanding practice and areas for improvement

- The provider should ensure that patients are able to access drinks and snacks on all wards without having to ask staff to open the dining room for them.
- The provider should ensure that all staff follow the provider's confidentiality policy and procedure and do not discuss sensitive patient information in communal areas of the ward.
- The provider should ensure that staff do not talk to patients through a closed door when they based in the nursing office.
- The provider should ensure that learning from complaints is shared with all staff.
- The provider should ensure that following incidents of self-harm a doctor reviews the patient.

The provider should ensure that robust systems are in place to share learning from incidents and complaints between staff and across wards.

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 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Care and treatment was not always provided in in a safe way. The provider had not ensured that sufficient emergency medical equipment was available on New Dawn ward, so that patients can receive prompt emergency medical treatment whether located on New Dawn 1 or New Dawn 2. **This is a breach of Regulation 12(2)(b)** The provider had not ensured that all ligature anchor points were clearly identified in the ligature risk assessment along with the measures to manage or mitigate these. Where works to address potential ligature anchor points were required a date for the completion of these works had not been identified. On Hooper ward there were blind spots on the ward with no mirrors in place to mitigate the potential risk this posed. **This is a breach of Regulation 12(2)(d)** The provider had not ensured that where patients were administered rapid tranquilisation they received appropriate health checks afterwards. **This is a breach of Regulation 12(2)(a)(b)** The provider had not ensured that all medicines were administered appropriately and within the prescribed guidelines.. **This is a breach of Regulation 12(2)(g)** The provider had not ensured that robust systems were in place to share learning from incidents and complaints between staff and across wards. **This is a breach of Regulation 12(2)(a)(b)**

This section is primarily information for the provider

Requirement notices

The provider had not ensured that all relevant pre-admission assessment information was available to staff and included in the initial risk assessment along with the measures to manage and mitigate these risks.

This is a breach of regulation 12(1)(2)(a)(b)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment Patients were not always protected from abuse and improper treatment. The provider had not ensured that where patients were prevented from leaving de-escalation rooms this was recognised as a period of seclusion and that the appropriate safeguards for patients nursed in seclusion, as outlined in the Mental Health Act Code of Practice were followed. **This is a breach of Regulation 13(1)** The provider had not ensured that all staff were able to recognise safeguarding concerns and that appropriate actions were taken to address safeguarding concerns. **This is a breach of Regulation 13(3)**

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Systems or processes to assess, monitor and improve the quality and safety of the service were not always effective. The provider had not ensured that where patients were restrained, these incidents were appropriately recorded, including the hold, the staff involved and the length of time that the restraint hold was maintained. **This is a breach of Regulation 17(2)(c)**

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing Suitably qualified, competent, skilled and experienced staff were not always deployed on the wards. The provider had not ensured that staff on New Dawn ward, received specialist training in DBT and CBT approaches to better understand patient needs and support the delivery of the therapeutic programme. **This is a breach of regulation18(2)(a)(b)**

The provider did not use available restraint data to identify any trends or themes in the use of restraint and thus improve the safety of the service.

This is a breach of Regulation 17(1)(a)(b)

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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