Cygnet Behavioural Health Limited

Cygnet Aspen Clinic

Inspection report

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

Ratings

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

Summary of findings

Overall summary

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

- The ward environments were not consistently safe and clean. The ligature risk assessment had not been updated following identification of an additional risk following a serious incident, rooms within the ward were cluttered with patient belongings due to a lack of formal storage, and oxygen was not safely and securely stored.
- Prescriptions were not always signed by a doctor in a timely manner as per the provider's policy.
- Whilst staff received supervision and had access to team meetings, supervision was sometimes on a team rather than one to one basis and meetings were not taking place regularly.
- Due to lack of space and storage within the building, patient's privacy and dignity was not always maintained when they were given their medications.
- It was not clear whether all patients had their physical health reviewed effectively during their time on the ward.
- Whilst we could see that staff actively involved patients in care decisions, we could not see that families and carers were equally involved, where the patient requested this. Families and carers told us they were unsure how to provide feedback, and felt visiting facilities were not adequate for children visiting the service.
- The governance of the service did not always ensure the delivery of high-quality care and audits did not always identify areas of concern found.

However:

- The wards had enough nurses and doctors. Staff assessed and managed risk well. They minimised the use of restrictive practices and followed good practice with respect to safeguarding.
- Staff developed holistic, recovery-oriented care plans informed by a comprehensive assessment. They provided a range of treatments suitable to the needs of the patients cared for in a mental health rehabilitation ward and in line with national guidance about best practice. Staff engaged in clinical audit to evaluate the quality of care they provided.
- The ward teams included or had access to the full range of specialists required to meet the needs of patients on the wards. The ward staff worked well together as a multidisciplinary team and with those outside the ward who would have a role in providing aftercare.
- Staff understood and discharged their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005.
- Staff treated patients with compassion and kindness, respected their privacy, and understood the individual needs of patients.
- Staff planned and managed discharge well and liaised well with services that would provide aftercare.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Long stay or rehabilitation mental health wards for working age adults	Requires Improvement 	

Summary of findings

Contents

Summary of this inspection

Background to Cygnet Aspen Clinic

Cygnet Aspen Clinic is a 16-bed locked rehabilitation service providing assessment, treatment and rehabilitation for women with personality disorder and complex needs. At the time of our inspection, there were 16 patients staying in the hospital.

Cygnet Aspen Clinic has been registered with the Care Quality Commission since 17 November 2010 and is registered to provide the following regulated activities;

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

-Treatment of disease, disorder or injury.

The hospital provides care and treatment to informal and detained patients. There was a registered manager in place at the time of inspection.

The last time the Care Quality Commission inspected Cygnet Aspen Clinic was in November 2017 when we rated the service as good overall. We rated the safe domain as requires improvement and all remaining domains as good.

Following this inspection, we told the provider they must take the following actions;

-Staff must ensure they record the current temperature of the medication fridge, not just the maximum and minimum temperatures

-Staff must ensure they practice good infection control precautions when carrying out clinical procedures

-Staff must ensure they store controlled drugs securely prior to disposal

What people who use the service say

During inspection we spoke with six patients and four family members of patients.

Most patients told us staff were caring and appeared interested in their wellbeing. We observed positive interactions between patients and staff and staff were observed to speak respectfully about patients during handover and multidisciplinary team meetings. However, patients told us they often had to wait for staff to be available as they were too busy with other tasks such as patient observations.

Patients told us they could speak to staff if they had any questions and most patients knew what was in their care plan. Patients engaged in daily planning meetings and could make requests for activities of interest but did tell us there were no activities on weekends which could be difficult for patients unable to leave the hospital.

Patients were able to give feedback in several ways and told us they knew how to raise formal complaints. However, family members we spoke with were unclear on how they could give feedback or raise a complaint.

Summary of this inspection

How we carried out this inspection

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

• Is it safe?

• Is it effective?

• Is it caring?

• Is it responsive to people's needs?

• Is it well-led?

Before the inspection visit, we reviewed information that we held about the location and asked another organisation for information. The inspection was unannounced.

During the inspection visit, the inspection team:

• toured the ward, looked at the quality of the ward environment and observed how staff were caring for patients;

• spoke with six patients who were using the service and four family members of patients

• spoke with the registered manager and the head of care at the hospital

• spoke with 9 other staff members; including doctors, nurses, occupational therapists, psychologists and support workers

• attended and observed a hand-over meeting and a multi-disciplinary meeting

• looked at the care and treatment records for six current patients

• carried out a specific check of the medication management

• looked at a range of policies, procedures and other documents relating to the running of the service

You can find information about how we carry out our inspections on our website: https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

Areas for improvement

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

Summary of this inspection

Action the service MUST take to improve:

- The service must ensure that the ligature risk assessment is kept up to date with all identified risks. (Reg 12)
- The service must ensure oxygen is safely and securely stored. (Reg 12)
- The service must ensure medicines are signed for by a doctor in a timely manner, as per policy, when transcribed. (Reg 12)
- The service must ensure that the environment is suitable for use by patients. Including private and dignified spaces for medication administration, comfortable and appropriate visiting spaces and that rooms are suitable for their designated use. (Reg 15)
- The service must ensure that governance processes are effective. (Reg 17)

Action the service SHOULD take to improve:

- The service should ensure that all patients have their physical health reviewed effectively during their time on the ward.
- The service should ensure their infection prevention control policy is clear as to what is expected of staff, and should ensure staff follow this appropriately.
- The service should ensure it is clear how all patient concerns are actioned and responded to.
- The service should ensure families are supported, informed and involved where appropriate.
- The service should ensure families know how to give feedback and raise complaints.
- The service should ensure patients can always make hot drinks and snacks.
- The service should ensure there is enough food provided for patients that is of good quality, and there should be enough options to support patients to live healthier lives and those with additional dietary requirements.
- The service should ensure staff are fully completing forms when patients utilise section 17 leave.
- The service should ensure staff can attend regular team meetings.
- The service should ensure supervision is appropriate to staff needs.
- The service should ensure the risk register is updated in a timely manner or when changes occur.
- The service should ensure all staff understand and implement the provider's search policy.
- The service should consider monitoring any cancellation of section 17 leave.
- The service should consider provision of structured activities on a weekend for those patients unable to leave the ward.

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Long stay or rehabilitation mental health wards for working age adults	Requires Improvement	Good	Good	Good	Requires Improvement	Requires Improvement
Overall	Requires Improvement	Good	Good	Good	Requires Improvement	Requires Improvement

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

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

Is the service safe?

Requires Improvement

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

Safe and clean care environments

Not all wards were safe, clean well equipped, well furnished, well maintained and fit for purpose.

Safety of the ward layout

Staff did not complete and regularly update thorough risk assessments of all ward areas. There were several potential ligature anchor points in the service, the majority of which were identified and mitigated against within the provider's ligature risk assessment. However, we were concerned that not all risks had been addressed in patient bedrooms.

The service had identified in governance documents from April 2022, reviewing incidents across the service, that 'the area of highest risk for self-harm incidents remained the patients' bedroom'.

There had been a serious incident at the hospital in November 2021 where a patient had tied a fixed ligature. This risk was not detailed on the service's ligature risk assessment. Staff had done some work to mitigate this risk by assessing each patient against the risk of ligaturing, and had removed items where necessary, but some items remained in rooms of patients not deemed a risk, and these were not detailed on the service's ligature risk assessment. Following feedback during the inspection, managers amended the ligature risk assessment to include this risk.

The service did have up to date building and fire risk assessments and we saw that they carried out regular checks of relevant equipment and fittings, as well as conducting regular fire drills. Where actions were established from fire drills staff had signed the relevant form to indicate they had read and understood these actions. CCTV installation was taking place at the service during inspection and a contractor's policy and guidance notes document were in place to ensure this was done safely.

Staff could not observe patients in all parts of the wards as there were a number of blind spots and the ward was based over two floors with the majority of patient bedrooms on the first floor and staff offices on the ground floor. Staff utilised individual patient observations to keep patients safe and were in the process of installing CCTV. A member of staff was always allocated to observe the garden due to historical incidents of patients attempting to leave the ward using the fences.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

The ward complied with guidance and there was no mixed sex accommodation as the service was open to female patients only.

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

Maintenance, cleanliness and infection control

Ward areas were generally clean and well-furnished. However, the physical health suite and gym rooms were cluttered with patient belongings being stored in the space. Managers told us that storage was an issue at the service and this had been escalated to senior managers within the organisation, but a solution was yet to be agreed.

Additionally, patients sometimes had to queue up outside the clinic room for their medicines due to the lack of space in the clinic room and physical health suite. Following inspection, managers shared plans for reconfiguring several rooms within the service to allow for formal storage areas.

Staff did not always follow national guidance in infection control. We observed staff wearing rings and nail varnish; covering these with plastic gloves rather than removing them.

Clinic room and equipment

Clinic rooms were fully equipped, with accessible resuscitation equipment and emergency drugs and equipment that staff checked and maintained regularly. However, excess oxygen was not stored as per the provider's policy and was stored in the staff office on the ward. It was not stored securely and there was no signage to indicate that was where it was stored. Following our inspection managers told us they were taking action to ensure this was stored safely and securely.

Safe staffing

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

Nursing staff

The service had enough nursing and support staff to keep patients safe. Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants for each shift. Minimum numbers were always two qualified nurses as well at six healthcare support workers during the day and five support workers during the night. The ward manager could adjust staffing levels according to the needs of the patients. We reviewed staffing rotas from 25 April to 17 May 2022 and found that there were always higher levels of staff on duty.

The service had low vacancy rates. At the time of inspection there was only one vacancy for a kitchen assistant. Vacancies and retention were reviewed at monthly governance meetings so action could be taken quickly to fill any posts.

The service had low rates of bank and agency nurses and healthcare support workers. Between 01 December 2021 and 17 May 2022, the service had only used agency staff to cover one night shift. There was usage of agency healthcare support workers, but managers told us they mainly used agency workers to increase staffing numbers above basic levels when individual patients required increased levels of observation to keep them safe.

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

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

The service had a low turnover rate which was reducing. In the 12 months prior to inspection the all staff turnover rate was 17% with 11 staff having left the service and 16 having started.

Levels of sickness were reducing. The average sickness rate of the 12 months prior to inspection was 11.8% and in April 2022 was 5.9%. Managers supported staff who needed time off for ill health and could access support and advise from the organisation's human resources department.

Patients had regular one- to-one sessions with their named nurse. Some patients told us that staff were not always available when they wanted someone to talk to, but we saw evidence in patient's notes that one-to-ones were regularly facilitated.

Patients rarely had their escorted leave or activities cancelled, even when the service was short staffed. We asked the service to provide figures detailing how often leave was cancelled but the service told us they did not record this. Managers told us they intended to rectify this going forwards and review and discuss data at monthly governance meetings. Staff, patients and their family members did not raise concerns about leave being cancelled.

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

Staff shared key information to keep patients safe when handing over their care to others. We observed a handover meeting whereby staff discussed each individual patient in terms of risks, recent incidents and any safeguarding concerns. They also discussed observation levels and any individual restrictions.

Medical staff

The service had enough daytime and night-time medical cover, but it was not clear whether there was a doctor available to go to the ward quickly in an emergency. The service had an on-call policy for doctors and a monthly rota was displayed in staff areas. However, on the service's risk register it was highlighted as a concern that doctors could sometimes be up to two hours away and not able to attend quickly in a psychiatric emergency. The policy in place had recently been reviewed but it was still not clear whether this had been addressed as it was stated that timeliness of attendance was at the medical director's discretion. Following inspection, the provider reviewed this policy and made it clear that a doctor would attend within 30 minutes of a psychiatric emergency.

Managers could call locums when they needed additional medical cover and they made sure all locum staff had a full induction and understood the service before starting their shift.

Mandatory training

Staff had completed and kept up to date with their mandatory training. At the time of inspection overall training compliance was 84%.

The mandatory training programme was comprehensive and met the needs of patients and staff. Managers monitored mandatory training and alerted staff when they needed to update their training. Training compliance was reviewed as part of monthly governance meetings attended by managers and heads of therapy departments and actions required were detailed, such as new starters being booked onto courses.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

Assessing and managing risk to patients and staff

Staff assessed and managed risks to patients and themselves well. Staff followed best practice in anticipating, de-escalating and managing challenging behaviour. As a result, they used restraint only after attempts at de-escalation had failed. Staff achieved the right balance between maintaining safety and providing the least restrictive environment possible in order to facilitate patients' recovery the majority of the time.

Assessment of patient risk

Staff completed risk assessments for each patient on admission, using a recognised tool, and reviewed this regularly, including after any incident. Staff completed the Short-Term Assessment of Risk and Treatability (START) for all patients and reviewed these every eight weeks as a minimum. Staff also completed a daily risk assessment whereby patients risk level was colour coded as red, amber or green.

Management of patient risk

Staff knew about any risks to each patient and acted to prevent or reduce risks. Daily risk assessments supported staff in understanding which patients may be at greater risk and may need additional support. We observed risk coding and specific incidents being discussed at staff handover and multidisciplinary team meetings.

Staff identified and responded to any changes in risks to, or posed by, patients. Each patient had a behaviour support plan which detailed triggers and warning signs that they may be deteriorating or need additional support, and also detailed ways in which patients liked to be supported in these moments, such as with specific music, opportunities to be with staff, or activities. Staff utilised observations to support patients and there was a policy in place which detailed how these should be undertaken.

Staff always followed policies and procedures when they needed to search patients or their bedrooms to keep them safe from harm. The service had an up to date policy which detailed searching for patients, visitors, property and the environment. However, the policy referred to 'random search selection procedures' but did not elaborate on what this meant, and some staff were unclear on the what 'random' meant.

Use of restrictive interventions

Levels of restrictive interventions were low. In the six months prior to inspection there were 81 recorded incidents of restraint. Most of these involved low-level holds and none involved the use of prone restraint. Staff made every attempt to avoid using restraint by using de-escalation techniques and restrained patients only when these failed and when necessary to keep the patient or others safe. Patients told us staff were good at using de-escalation techniques and felt there was not much restraint on the ward. Patients were asked to give any feedback on restrictive interventions at monthly community meetings. Staff participated in the provider's restrictive interventions reduction programme. The service had a log in place detailing blanket restrictions on the ward. Restrictions were reviewed at least every three months to ensure they were still necessary.

Staff understood the Mental Capacity Act definition of restraint and worked within it. There were no recorded incidents of the us of rapid tranquilisation in the six months prior to inspection but the service had an up to date policy relating to the use of rapid tranquilisation should it be required.

The service did not have a seclusion room and there were no recorded incidents of the use of seclusion or long-term segregation in the six months prior to inspection.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

Safeguarding

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

Staff received training on how to recognise and report abuse, appropriate for their role. At the time of inspection 90% of staff were up to date with their safeguarding individuals at risk training which included information pertinent to both adults and children. The service had an up to date safeguarding policy in place for staff to refer to.

Staff could give clear examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. Staff knew how to recognise adults and children at risk of or suffering harm and worked with other agencies to protect them. In the 12 months prior to inspection the service had made 94 safeguarding referrals.

Staff followed clear procedures to keep children visiting the ward safe as visits were planned in advance and took place in a room off the ward.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. There was a safeguarding lead within the team whom staff could approach for internal advice, and contact details for external teams was displayed.

Staff access to essential information

Staff had easy access to clinical information and it was easy for them to maintain high quality clinical records – whether paper-based or electronic.

Patient notes were comprehensive, and all staff could access them easily and although the service used a combination of electronic and paper records, staff made sure they were up-to-date and complete. Staff did reflect that it wasn't ideal having some notes in electronic format and some in paper, but managers explained that the electronic system used was not set up to accommodate all files electronically.

Records were stored securely and when patients transferred to a new team, there were no delays in staff accessing their records.

Medicines management

The service used systems and processes to safely prescribe, administer, and store medicines but did not ensure record. Staff regularly reviewed the effects of medications on each patient's mental and physical health.

Staff followed systems and processes to prescribe and administer medicines safely. The service had an up to date medicines management policy as well as a transcribing policy which allowed nurses to transcribe prescriptions to allow medicines to be administered without delay, if for example they were prescribed by a doctor on a weekend when doctors were not typically available on-site. However, the transcribing policy stated medicines transcribed onto prescription cards should be followed up by a signature on the chart by a doctor within 24hours, or within a maximum of 72 hours over weekends. We reviewed six patient prescription cards and found several prescriptions without a doctor signature for five of these patients. One patient had five prescriptions without signatures. Managers told us that the service's doctor was unavailable due to annual leave, and another doctor had been covering but only visiting the service a couple of times a week, hence the delay in signing transcribed prescriptions. We observed the covering doctor reviewing and signing prescriptions during inspection.

Staff reviewed each patient's medicines regularly and provided advice to patients about their medicines. Patients told us they could discuss any queries or concerns regarding medicines with the nurses or doctor.

Staff stored and managed all medicines and prescribing documents safely.

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

Staff learned from safety alerts and incidents to improve practice. The registered manager was also the controlled drugs accountable officer and we saw evidence of safety alerts received externally and shared with those in the service.

The service ensured people's behaviour was not controlled by excessive and inappropriate use of medicines. We observed discussions in a multidisciplinary meeting relating to the use of PRN (as required) medicines and saw from prescription cards that antipsychotics were not prescribed above British National Formulary (BNF) limits. Staff reviewed the effects of each patient's medicines on their physical health according to NICE guidance and managers audited this monthly.

Track record on safety

The service had a good track record on safety.

Reporting incidents and learning from when things go wrong

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

Staff knew what incidents to report and how to report them and reported serious incidents clearly and in line with trust policy. Managers investigated incidents thoroughly. Patients and their families were involved in these investigations where appropriate.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong. We saw examples of letters being sent to patients offering an apology, and patients told us staff engaged them in debriefs following incidents.

Managers debriefed and supported staff after any serious incident. Staff told us that debriefs would be informal following most incidents but felt that they had good support from the team and managers. Staff had access to debrief forms to guide discussion. The service's electronic incident reporting system prompted managers to ensure debriefs were offered to both staff and patients involved.

Staff received feedback from investigation of incidents, both internal and external to the service via emails and team meetings. We observed incidents being discussed in handover meetings, and what this meant in terms of risk management.

Staff met to discuss the feedback and look at improvements to patient care. Lessons learned were cascaded down from management and staff received these via email and team meetings.

There was evidence that changes had been made as a result of feedback such as environmental changes to the ward.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

Is the service effective?

Good

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

Assessment of needs and planning of care

Staff assessed the physical and mental health of all patients on admission but did not always ensure care plans were followed. Staff developed individual care plans which were reviewed regularly through multidisciplinary discussion and updated as needed. Care plans reflected patients' assessed needs, and were personalised, holistic and recovery-oriented.

Staff completed a comprehensive mental and physical health assessment of each patient either on admission or soon after and developed comprehensive care plans for each patient that met their needs.

Not all patients had their physical health reviewed in line with their care plans during their time on the ward. We reviewed six patient's care plans and found that within two there were references to management plans for physical health concerns that were not always followed. For example, one patient's care plan indicated their weight should be measured twice a month, but records showed this was only being attempted once per month. Additionally, the care plan indicated a dietician was involved to support the patient, but we could not see that there had been any contact with a dietician since June 2021 and it was unclear how else staff were mitigating any relating physical health risks. However, weights that were recorded indicated a healthy body mass index. Another patient care plan also referenced support from a dietician for an eating disorder, but we could see no evidence of a dietician being involved or any further management around this.

Staff regularly reviewed and updated care plans when patients' needs changed. Care plans were reviewed every four weeks in review meetings and patients were involved in any changes.

Care plans were personalised, holistic and recovery orientated. All patients had discharge care plans which indicated clear individual plans for working towards discharge, such as self-medicating, and included the patient's view of where they were hoping to be discharged to, such as wanting to live independently or in support living accommodation. Patients also had care plans and goals specific to their individual circumstances, for example some patients had plans relating to contact with family, and specific goals set such as around wanting to learn cooking skills.

Best practice in treatment and care

Staff provided a range of treatment and care for patients based on national guidance and best practice. This included access to psychological therapies, support for self-care and the development of everyday living skills and meaningful occupation. Staff used recognised rating scales to assess and record severity and outcomes. They also participated in clinical audit, benchmarking and quality improvement initiatives. Staff took some actions to encourage patients to live healthier lives.

Staff provided a range of care and treatment suitable for the patients in the service in line with best practice and national guidance. The model of care for the service was made up of five stages from pre-admission through to discharge. Patients could attend a variety of group-based psycho-education groups, including dialectical behaviour therapy skills, as well as individual therapy sessions, with the aim of working their way through the model of care.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

Staff identified patients' physical health needs and recorded them in their care plans. All patients were assessed against risks associated with choking, venous thromboembolism (VTE) and pressure sores on admission and relevant care plans were created if required. Known pre-existing physical health conditions were also care planned. However, it was not clear whether staff made sure patients had access to physical health care, including specialists as required. For example, we saw reference to the requirement for support from a dietician in two patient's care plans but could not see evidence from notes that a dietician was involved in the patient's care.

Staff had made some attempts to help patients live healthier lives but there were still some areas for improvement. Daily menus were displayed in the dining area with meals being colour coded to indicate nutritional content. However, on one of the days we visited the only options for dinner were 'red' indicating low nutritional content. Two of the six patients we spoke with also felt the food could be healthier with one telling us too much food was fried. There was a gym available for patients to use, but it was cluttered with patient belongings as dedicated storage facilities in the hospital were full. The hospital had a takeaway night once a week but explained all patients had capacity to understand the health implications of this and stated that an alternative would be provided for patients not wishing to purchase a takeaway. The hospital still allowed smoking in the communal garden, but managers did tell us that they were working towards becoming a non-smoking site by October 2022.

Staff used recognised rating scales to assess and record the severity of patients' conditions and care and treatment outcomes. For example, they used the Health of The Nation Outcome Scales (HoNOS), a tool to measure the health and social functioning of people with severe mental illness, and the Model of Human Occupation Screening Tool (MoHOST), to gain an overview of each patient's occupational functioning.

Staff took part in clinical audits, benchmarking and quality improvement initiatives and managers used results from audits to make improvements, but audits were not always effective in identifying areas of concern. The service had an audit tracker which detailed audits that required completing along with frequency. For example, staff completed monthly audits of patient files looking at quality of care planning and documentation, with any actions being assigned to relevant staff. Staff also received results of monthly audits completed by the providing pharmacy. We reviewed an audit completed 12 May 2022 and saw that there were 51 errors noted related to 14 different patients. Many of these errors related to information being required from a doctor, such as a date or signature. It was explained that the service's doctor had been on leave, but we were concerned that the responsibility for medicines had not been picked up by another doctor in their absence. We did see that by the next audit on 18 May 2022 these errors had been rectified, showing action had been taken, and only three errors relating to two patients had been identified on this visit. Additionally, patient file audits did not identify concerns we found with regards to physical health, and there no audit found which reviewed use, or cancellation, of section 17 leave.

Skilled staff to deliver care

The ward team included or had access to the full range of specialists required to meet the needs of patients on the ward. Managers made sure they had staff with the range of skills needed to provide high quality care. They supported staff with appraisals, supervision and opportunities to update and further develop their skills. Managers provided an induction programme for new staff.

The service had access to a full range of specialists to meet the needs of the patients on the ward. This included a psychologist, assistant psychologist, occupational therapist, activity coordinators, doctor, nurses and support staff.

Managers ensured staff had the right skills, qualifications and experience to meet the needs of the patients in their care, including bank and agency staff. Staff had training in areas such as working with patients with personality disorders, and autism spectrum disorders, and the service had trained two staff members in delivering dialectical behaviour therapy.

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

Managers supported staff through regular, constructive appraisals of their work. At the time of inspection 100% of staff who required one had received an appraisal within the last 12 months.

Managers supported staff through regular, constructive clinical supervision of their work as per the provider's own policy. At the time of inspection managers told us 100% of staff were up to date with required supervision. The service's policy stated that staff should receive managerial supervision every three months on a one to one basis and clinical supervision every month on a one to one or group basis. However, managers told us they combined managerial and clinical supervision and undertook them both on a monthly basis. Some of the staff we spoke to told us that they had only been offered group supervision in the last few months and they shared they did not feel like this was entirely appropriate for ongoing supervision as they were unable to share personal aspects related to development. Figures provided only showed whether supervision was undertaken and not whether this was one to one or group based.

Managers made sure staff could attend team meetings, but these varied in terms of regularity and content. In the six months prior to inspection there had been two nurses' meetings and three support workers' meetings. Staff told us they felt the ability to attend team meetings was impacted by the acuity on the ward which they felt was currently high. Minutes from team meetings were made available for those who could not attend but it was not always clear in minutes from support worker meetings who was responsible for any actions required. Managers told us they were looking to implement additional reflective practice sessions for staff and were considering when the best time to conduct sessions was to encourage as many staff as possible to attend.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Staff talked positively about the internal opportunities for development, for example staff were being supported through nursing training and to complete professional courses in wound management and non-medical prescribing.

Managers recognised poor performance, could identify the reasons and dealt with these. Managers could access support from human resources if required and we saw evidence that performance was discuss at team level to encourage staff to meet requirements, such as discussing staff tardiness within team meetings.

Multi-disciplinary and interagency teamwork

Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care. They had effective working relationships with staff from services providing care following a patient's discharge.

Staff held regular multidisciplinary meetings to discuss patients and improve their care. Staff including the head of care, doctor and representatives from the nursing, psychology and occupational therapy teams attended daily multidisciplinary meetings during the week. Staff engaged in detailed discussion in relation to each individual patient's presentation in the preceding 24-hours, including consideration of risk, observation levels, incidents and medication concerns.

Staff made sure they shared clear information about patients and any changes in their care, including during handover meetings. Nursing and support staff attended a handover prior to starting a shift. We observed staff holding open discussion about patients and their current risks and needs. Staff spoke respectfully about patients and appeared to know them well. Staff were also allocated duties for the shift at these handover meetings to ensure essential duties were covered, including staffing of patient observations, fire marshalling and supervising the ward garden.

Ward teams had effective working relationships with other teams in the organisation. For example, occupational therapists working in personality disorder services across the wider organisation met every two months to discuss best practice and to share learning.

Ward teams had effective working relationships with external teams and organisations. We saw in patient care plans and through discussions in handover and multidisciplinary team meetings that the team engaged with external teams to support patients, particularly those approaching discharge.

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

Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice and discharged these well. Managers made sure that staff could explain patients' rights to them.

Staff received and kept up-to-date with training on the Mental Health Act and the Mental Health Act Code of Practice and could describe the Code of Practice guiding principles. At the time of inspection 94% of staff were compliant with training in Mental Health Act awareness.

Staff had access to support and advice on implementing the Mental Health Act and its Code of Practice through the service's Mental Health Act administrator.

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

Patients had easy access to information about independent mental health advocacy and patients who lacked capacity were automatically referred to the service. The service was in a transition period between advocates and the new advocate had not yet visited the ward at the time of inspection, but their contact details were displayed in patient areas.

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

Staff made sure patients could take section 17 leave (permission to leave the hospital) when this was agreed with the Responsible Clinician and/or with the Ministry of Justice. However, staff did not always accurately record important details on the provider's 'section 17 leave utilisation record' including where the patient was going, the time they left, or for how long they would be out. We were concerned that because of this staff may not be aware when patients should be returning and so may not escalate this in a timely manner if there were concerns. Additionally, other than in daily notes the service did not record when section 17 leave had to be cancelled. This made it difficult for managers to understand how often, and for what reasons leave was cancelled. Managers told us they planned to make changes to discuss this in monthly governance meetings going forwards.

Staff requested an opinion from a Second Opinion Appointed Doctor (SOAD) when they needed to.

Staff stored copies of patients' detention papers and associated records correctly and staff could access them when needed.

Informal patients knew that they could leave the ward freely and the service displayed posters to tell them this.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

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

Managers and staff made sure the service applied the Mental Health Act correctly by completing audits and discussing the findings.

Good practice in applying the Mental Capacity Act

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

Staff received and kept up to date with training in the Mental Capacity Act and had a good understanding of at least the five principles. At the time of inspection 92% of staff were compliant with training in the Mental Capacity Act and Deprivation of Liberty Safeguards.

There were no Deprivation of Liberty Safeguards applications made in the last 12 months.

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

Staff gave patients all possible support to make specific decisions for themselves before deciding a patient did not have the capacity to do so. We observed staff discussing concerns relating to a patient's capacity to make a specific decision and making plans to formally assess this.

Staff assessed and recorded capacity to consent clearly each time a patient needed to make an important decision. When staff assessed patients as not having capacity, they made decisions in the best interest of patients and considered the patient's wishes, feelings, culture and history.

The service monitored how well it followed the Mental Capacity Act and acted when they needed to make changes to improve.

Is the service caring?

Good

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

Kindness, privacy, dignity, respect, compassion and support

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

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

Staff were discreet, respectful, and responsive when caring for patients. We observed positive interactions between patients and staff and staff were observed to speak respectfully about patients during handover and multidisciplinary team meetings.

Staff gave patients help, emotional support and advice during regular one to one's. However, most patients we spoke with told us they often had to wait for staff to be available as they were too busy with other tasks such as patient observations. Patients we spoke with felt the environment was not support of rehabilitation due to the acuity of other patient's and felt this was having a negative impact on staff's ability to provide appropriate care and support.

Staff supported patients to understand and manage their own care treatment or condition. Patients told us they were given information leaflets and could speak to the nursing staff if they had any questions. Patients were positive about the medical provision, stating their medications were explained to them, including side effects. We saw records pertaining to patients who were risk assessed to manage their own medications.

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

Patients said staff treated them well and behaved kindly and most said staff were caring and interested in patient's wellbeing.

Staff understood and respected the individual needs of each patient.

Staff felt that they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards patients. Patients were positive about staff abilities to use de-escalation to diffuse situations and reported low levels of physical interventions.

Staff followed policy to keep patient information confidential most of the time. However, one patient showed us a copy of their care plan which contained the names of two other patients.

Involvement in care

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

Involvement of patients

Staff introduced patients to the ward and the services as part of their admission. Patients told us they were given information leaflets on admission to orient them to the ward.

Staff involved patients and gave them access to their care planning and risk assessments. Most patients we spoke with knew what was in their care plan and told us they would discuss any changes with their named nurse when plans were reviewed every four weeks.

Staff involved patients in decisions about the service, when appropriate. Patients engaged in planning meetings where they could request different activities to take place on and off the ward. However, most patients we spoke with told us that there were no activities on weekends as therapy staff did not work weekends and ward staff were too busy to facilitate. Staff told us that physical materials for activities, such as crafts, were made available at all times.

Patients could give feedback on the service and their treatment and staff supported them to do this. Patients were last given the opportunity to feedback via a 'service user satisfaction survey' in August 2021. The survey asked for feedback

in areas such as food, accommodation, staffing, and care planning and feedback was largely positive. Patients could also give feedback in community meetings which took place monthly on the ward. However, it was unclear whether all actions were followed up from these meetings as action plans were developed with actions assigned to relevant persons, but not all concerns raised were identified in these action plans. For example, patients had raised a concern about noisy pipes in the building at two consecutive meetings and it was unclear if this was being followed up and by whom.

Staff supported patients to make decisions on their care and made sure patients could access advocacy services. The service was in the process of introducing a new advocate to the ward at the time of inspection and we saw posters displayed with contact details.

Involvement of families and carers

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

Staff did not always support, inform and involve families or carers. We spoke with four family members who told us they had to push for information relating to patients as it was not readily provided. None of the family members we spoke with had been involved in any care planning. One of the family members we spoke with shared concerns that they had not been involved in discussions about a patient's overnight leave from the ward even though they would be staying with that family member. From reviewing patient care records and talking with staff it was evident that it could be difficult to always involve families and carers in patient's care as patients often did not agree to this or had asked that some information was not shared. Where appropriate patients did have care plans in relation to family contact.

Families felt that the environment for visiting was not suitable as it was a meeting room without comfy seating or any facilities to make drinks or purchase snacks. One family member felt that visiting facilities could be improved for children visiting the service. Managers told us this room had been designated as it allowed entry to the building directly from outside, and allowed socially distanced visits, both of which supported in the reduction of any spread of COVID-19.

Staff did not always help families to give feedback on the service. Managers issued a family and friends survey in August 2021 to 14 family members or carers but only one family member responded to give feedback, which was largely positive. Due to the low number of respondents the survey was re-issued, and this resulted in seven respondents who gave largely positive responses in relation to sharing of information. However, all four family members we spoke with told us they had not been asked to provide feedback and were disappointed there was no easy method for providing feedback such as a box in reception. One family member shared that they had raised concerns to a member of staff about another staff member's conduct but did not feel any action had been taken and they did not receive any feedback. This demonstrated clarity around the process of family members giving and receiving feedback was required.

We did not see any evidence that staff gave carers information on how to find the carer's assessment.

Is the service responsive?

Good

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

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

Access and discharge

Staff planned and managed patient discharge well. They worked well with services providing aftercare and managed patients' move out of hospital. As a result, patients did not have to stay in hospital when they were well enough to leave.

Bed occupancy regularly exceeded 85%. At the time of inspection all beds were occupied. Managers told us they carefully considered all new admissions and would only admit patients they felt were appropriate for the service who were ready to engage with rehabilitation. At the time of inspection, most staff and patients told us they felt the ward acuity was very high due to several patients who they felt were not appropriate for the service and were requiring a lot of staff time including four patients on one to one observations at all times. Managers told us they were aware they did not always get it right in terms of admissions and were looking at how to address this going forwards, such as visiting potential new admissions in their current placement to gain a better understanding of their needs before agreeing to an admission. Managers gave examples of where they had moved patients on to other services when it became apparent they were not suitable for rehabilitation at the time.

Managers regularly reviewed length of stay for patients to ensure they did not stay longer than they needed to. Discharge plans were reviewed every four weeks as part of care plan review meetings.

The service had low out-of-area placements. Where patients were admitted from out-of-area managers told us this was an agreed decision with the patient and was planned carefully to ensure it was appropriate.

Managers and staff worked to make sure they did not discharge patients before they were ready.

When patients went on leave there was always a bed available when they returned. The multidisciplinary team worked together with patients to identify appropriate onwards placements.

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

Managers told us it could be difficult to access beds elsewhere quickly, but we did see evidence that a patient was transferred to a psychiatric intensive care unit in a timely manner when they needed more intensive care.

Discharge and transfers of care

Managers monitored the number of patients whose discharge was delayed and took action to reduce them. In the 12 months prior to inspection there were six patients whose discharge had been delayed. Delays ranged from one to six months in duration and were largely attributed to awaiting appropriate onward placements.

Staff carefully planned patients' discharge and worked with care managers and coordinators to make sure this went well. During a multidisciplinary meeting we observed staff to discuss individual discharge plans and agree actions for liaison with external teams as appropriate.

Staff supported patients when they were referred or transferred between services. We observed discussions related to a patient awaiting transfer having visited their new placement to familiarise themselves with the new setting to reduce anxiety about the move.

The service followed national standards for transfer.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

Facilities that promote comfort, dignity and privacy

The design, layout, and furnishings of the ward supported patients' treatment, privacy and dignity, although some areas were cluttered making them difficult to access. Each patient had their own bedroom with an en-suite bathroom and could keep their personal belongings safe. There were quiet areas for privacy. When clinically appropriate, staff supported patients to self-cater. However, the food was not always of good quality and patients could not always make hot drinks and snacks at any time.

Each patient had their own bedroom, which they could personalise. Patients had a secure place within their bedroom to store personal possessions but could also ask staff to store items for them.

Staff used a full range of rooms and equipment to support treatment and care. Patients had access to a gym, laundry, sensory room, activity room, and two lounge areas. Since our last inspection the service had created a physical health suite containing an examination couch for patients to utilise when having physical health examinations and treatment. However, this room, and the patient gym, were cluttered with patient belongings as the service did not have enough storage elsewhere. Following feedback during inspection managers told us they were looking to relocate the physical health suite to make it more usable. There were also plans to install a salon room at the request of patients and move patient belongings out of the gym.

The service had quiet areas and patients could meet with visitors in private in a meeting room off the ward. During our last inspection we received feedback that this meeting room was not child-friendly, and managers reported they would identify actions around this. However, during this current inspection we received similar feedback and could not identify that managers had taken any action.

Patients could make phone calls in private and the service had an outside space that patients could access easily containing a variety of seating, planting and exercise areas.

Patients could make their own hot drinks and snacks in the therapy kitchen and were not dependent on staff. However, the kettle and toaster occasionally had to be removed if any patients were presenting as a risk so in this situation would have to ask staff to make drinks and snacks for them. Managers told us they tried to limit taking such action where possible, and had also made a fridge available in the dining room which contained food for patients to access at all times.

The service did not always offer a variety of good quality food. Daily menus were displayed in the dining area with meals being colour coded to indicate nutritional content. However, on one of the days we visited the only options for dinner were 'red' indicating low nutritional content. We could also see from community meeting minutes that patients had requested more food to be provided at weekends and had raised concerns about a lack of hot food in the evenings. Two of the six patients we spoke with felt the food could be healthier with one telling us too much food was fried.

Patients' engagement with the wider community

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

Staff made sure patients had access to opportunities for education and work, and supported patients. At the time of inspection one patient was accessing a college course and another was due to start a course shortly.

Staff helped patients to stay in contact with families and carers. Patients had access to their own mobile phones but could also access a ward electronic tablet if required. Where appropriate patients had care plans in relation to family contact.

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

Meeting the needs of all people who use the service

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

The service could support and make adjustments for disabled people and those with communication needs or other specific needs. The service had a lift and all en-suites were wet rooms. Managers told us they were assess patient's needs before admission to establish if they were able to provide support needed.

Staff made sure patients could access information on treatment, local service, their rights and how to complain. Noticeboards throughout the ward contained a variety of information.

The service did not display information leaflets in languages other than English, but staff confirmed they could access these if required. Managers made sure staff and patients could get help from interpreters or signers when needed.

The service provided a variety of food to meet the dietary and cultural needs of individual patients but were not able to produce vegan meals. Staff told us this was because they were only able to bulk order vegan food which was not feasible for one patient, meaning staff shopped for individual microwave meals for this patient instead.

Managers told us that patients could access spiritual, religious and cultural support if this was something they requested. Prior to the COVID-19 pandemic a pastor had visited the service regularly, but this had not re-started. There were religious texts available within the service for patients to access and managers gave examples of patients being supported to attend external religious services.

Listening to and learning from concerns and complaints

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

The service clearly displayed information about how to raise a concern in patient areas and patients we spoke with knew how to complain or raise concerns. However, we spoke with four family members of patients, all of whom told us they did not know, or had not been given any information on, how to complain.

Staff understood the policy on complaints and knew how to handle them and managers investigated complaints and identified themes. In the 12 months prior to inspection there were 14 complaints made to/about the service. Of these one was upheld, eight were partially upheld, four were not upheld and one was withdrawn. Patients received feedback from managers after the investigation into their complaint and apologies were provided where appropriate.

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

Managers shared feedback from complaints with staff and learning was used to improve the service, for example we saw evidence of staff and patient mediation following a complaint being raised.

The service used compliments to learn, celebrate success and improve the quality of care. In the 12 months prior to inspection the service received 22 compliments which were shared with staff via email where appropriate. We saw that patients who had given compliments were asked to share their story with other Cygnet locations.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

Is the service well-led?

Requires Improvement

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

Leadership

Leaders had the skills, knowledge and experience to perform their roles. The Registered Manager of the service was supported by a Head of Care, both of whom had a good understanding of the service and were passionate about the service. Managers were visible in the service and approachable for patients and staff. The managers' office was based on the ward and there was an open-door policy for patients and staff who had any queries or concerns. Staff spoke highly of managers and felt they were supportive. However, some staff raised concerns that when the Registered Manager was unavailable for periods of time, the support available to them diminished as the Head of Care took on extra responsibilities and was not as available. Staff were not aware of any additional support being put in place by the wider organisation in the periods of absence of the Registered Manager.

Vision and strategy

Staff knew and understood the provider's vision and values of integrity, trust, empower, respect and care, and how they were applied to the work of their team. Visions and values were displayed in staff areas and formed part of staff interviews and appraisals and we saw these values demonstrated in staff interactions with patients and in handover and multidisciplinary meetings.

Culture

Staff felt respected, supported and valued. Staff spoke highly of the teams in which they worked. However, most staff told us they had felt increasingly stressed due to acuity on the ward. Staff said the service promoted equality and diversity in daily work and provided opportunities for development and career progression. Staff gave examples of how the company was supporting them through additional qualifications and training courses. Managers were aware of the importance of this in terms of retaining staff. Most staff told us they could raise any concerns without fear. Some staff told us that whilst they would always raise concerns related to patient care, they may not raise concerns about something personal as they did not feel this would be well managed.

Governance

Our findings from the other key questions demonstrated that governance processes operated effectively at team level and that performance and risk were not always managed well.

We found areas of the ward, including the gym and physical health room, were cluttered with patient belongings due to a lack of formal storage. This had been highlighted as a concern in a health and safety compliance audit completed in October 2021 and we saw evidence that this had been escalated to senior managers within the organisation. However, at the time of inspection there was no identified solution to this issue. Following inspection, managers demonstrated that plans were being discussed to reconfigure existing rooms to allow for appropriate storage.

We also found that the ligature risk assessment for the service had not been updated following a serious incident. However, managers were aware of the risk and had taken remedial action to make bedrooms safe for those identified as at risk. The service was also due to undergo work this year to replace all bedroom furniture.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

Managers maintained an audit schedule and ensured audits took place regularly to allow them to monitor and evaluate the quality of care provided. Where actions were identified as a result of audits, these were clearly assigned and completed in a timely manner. However, audits did not identify some of the concerns found, for example in relation to infection prevention control, staff following physical health care plans, and monitoring of section 17 leave.

We saw that managers sought feedback from staff, patients and family members. However, family members we spoke to told us they were unclear on how they could provide feedback, demonstrating clarity around this process was required. Additionally, it was not clear that all patient concerns raised were actioned and responded to.

Staff told us they felt happy in their roles and well supported by the teams and managers ensured there were always enough staff on duty. However, team meetings were not taking place regularly and staff supervision was not always available on a one to one basis.

However, there were systems in place to ensure pertinent information including incidents, staffing, training, safeguarding and lessons learnt were discussed and shared with the wider team. Local and regional governance meetings allowed managers to review the quality and effectiveness of the service and compare this to other relevant services within the organisation.

Management of risk, issues and performance

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

We found that the service's ligature risk assessment had not been updated following an incident of a patient tying a fixed ligature in their bedroom, but we could see that the service had mitigated the risk by assessing patients individually and taking action to remove doors where a risk or potential risk was identified. We also saw that the service regularly reviewed incidents and identified themes and trends relating to self-harm and ligaturing and identified plans of action where possible to minimise risks. Incidents were discussed daily during handover and multidisciplinary team meetings and clear plans were in place for each individual patient to manage risk, for example with access to specific items, observation levels and section 17 leave.

The service had a risk registered in place which detailed current risks within the service. However, this had not been recently updated, as a risk relating to installation of CCTV was identified and the action taken was to review quotes, but we saw that this work was beginning to take place during inspection. The service did have a contractors' policy and guidance notes document in place to ensure works were undertaken safely.

Information management

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

Managers attended quarterly regional governance meetings where they shared data relevant to the service with other Cygnet services in the North region. Data included incidents, medicines management concerns, restrictive interventions, safeguarding, training, effectiveness of interventions, and themes and trends from patient and staff feedback and complaints. This enabled managers to compare the service to others and identify areas for development or further investigation.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

Engagement

Managers engaged actively other local health and social care providers to ensure that an integrated health and care system was commissioned and provided to meet the needs of the local population. Those involved in patient's care were invited to relevant meetings and kept informed of their progress with treatment and plans for discharge. We asked for feedback from commissioners of the service and feedback received was largely positive, with comments received regarding the ability of the multidisciplinary team to manage a complex cohort of patients.

Learning, continuous improvement and innovation

Managers told us about their plans to work towards the Royal College of Psychiatrists Enabling Environments Award with the aim of creating a positive and rewarding place to live, work and study. They were seeking advice from other personality disorder services within the organisation who were already engaging with this.

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 -

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment -

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 -