Cygnet Oaks

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 Oaks as requires improvement because:

- The hospital did not always provide safe care. We identified issues with the safe and proper management of medicines and equipment. Doctors on call out of hours could not attend the hospital quickly if required. Although the provider's policy stated that remote prescribing should only take place in exceptional circumstances, this happened routinely and the prescribing doctors did not often know patients and their needs. Doctors did not attend the hospital afterwards to sign the prescription. One medication chart reviewed did not contain the route and dose and had not been signed. There were issues with staff not following the as and when required medication protocol for another patient and at the House, the electrocardiogram pads had expired in May 2018.
- We found gaps in the care planning of three patients with physical health needs. This included records not containing information about when blood glucose monitoring should be completed. Where patients had a physical health need, involving skin integrity and bowel activity, there was no care plan in place for staff to follow.
- We also observed that the blood glucose monitoring for two patients with diabetes was completed after they had eaten breakfast.
- In a safeguarding incident, staff had not acted and intervened as soon as they could to protect a patient from abuse.
- Mandatory and compliance training rates for five courses fell below 75%. This included training to ensure that staff had the skills and knowledge to keep people safe.
- The hospital building design limited the accessibility for patients with disabilities and reduced mobility to move around independently without staff support.

However:

- Staff assessed and managed risks well. They balanced risk management against providing a least restrictive environment. The hospital had involved patients in the reviewing of blanket restrictions and had reduced these.
- Patients had access to a full range of professions from multiple disciplines who provided a range of therapies and activities to support patients to get better and develop their skills.
- Staff understood the needs of patients well and treated patients with kindness, respect and compassion.
- Staff managed and planned discharge well. They worked with external services assertively to ensure that discharges were not delayed and patients had aftercare services.
- Leaders were visible and approachable within the service to staff and patients.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Long stay/ rehabilitation mental health wards for working-age adults	Requires improvement 	

Summary of findings

Contents

Requires improvement

Cygnet Oaks

Services we looked at

Long stay/rehabilitation mental health wards for working-age adults

Summary of this inspection

Background to Cygnet Oaks

Cygnet Oaks is an independent mental health hospital situated in Barnsley, South Yorkshire. From May 2018, Cygnet Behavioural Health Limited became the registered parent provider. The hospital has previously been owned and operated by other independent providers since it was first registered with the CQC on 17 August 2011.

Cygnet Oaks is a 36-bed high dependency rehabilitation service for male patients with mental illness. It accepts both informal patients, who voluntarily consent to stay and receive treatment, and patients detained under the Mental Health Act 1983. The hospital consists of the House and the Lodge providing two separate units. At the time of our inspection, 31 patients were staying at the hospital.

The hospital had a registered manager in position and an accountable controlled drugs officer. Cygnet Oaks is registered to provide the regulated activities: assessment or medical treatment of persons detained under the Mental Health Act 1983 and treatment of disease, disorder or injury.

We have inspected Cygnet Oaks seven times previously. Our last comprehensive inspection of this location took place in March 2016, at that inspection we rated the location as 'good' overall and all the key questions apart from 'effective' as good. We rated effective as 'requires improvement'. We last inspected this location in March 2017, at that inspection, we found that the hospital had made improvements in relation to the concerns we identified at our previous inspection. However, we identified other issues within the key question 'effective' and so this key question remained rated as 'requires improvement'.

Following that inspection, we issued the provider with one requirement notice in relation to a breach of Regulation 17 Good governance of the Health and Social Care Act (Regulated Activity) Regulations 2014.

We told the provider they must ensure that all documentation in relation to each patient's care and treatment is accurate, complete and contains relevant information including any decisions or changes to care. This includes records of any assessments which may be undertaken. Where there are errors and omissions in information, the provider must have systems in place

to identify and address these accordingly.

We told the provider they should ensure that the service continues to work towards and embed the implementation of positive behaviour support plans for patients who may require these.

Our inspection team

The team that inspected the service comprised of three CQC inspectors, one CQC deputy chief inspector and two specialist advisors: one who worked as a registered mental health nurse and one occupational therapist.

Why we carried out this inspection

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

Summary of this inspection

How we carried out this inspection

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

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

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

During the inspection visit, the inspection team:

- visited both the House and the Lodge, looked at the quality of the ward environments and observed how staff were caring for patients;
- spoke with seven patients who were using the service;
- spoke to one carer;
- spoke with the registered manager who was the regional operations director, interim hospital manager and two heads of care;
- spoke with 15 other staff members; including doctors, nurses, occupational therapists, a forensic psychologist, an assistant psychologist and support workers;
- attended and observed seven meetings and sessions including: a community meeting, a planning meeting, an occupational therapy drop in, a morning meeting and a risk assessment review meeting;
- collected feedback from five patients using comment cards;
- looked at six care and treatment records of patients:
- carried out a specific check of the medication management on the wards
- looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the service say

Patients and the carer that we spoke with provided positive feedback about the service. They told us that the hospital provided services to help people get better. They thought that staff treated patients well and had a positive approach.

Patients were involved in their care and treatment well and the carer we spoke with felt that they were kept up to date with important information. They could speak to staff about any concerns they had.

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:

- Out of hours medical cover was not adequate. A doctor could not attend the hospital promptly if this was required. Doctors did not follow the provider's policy and procedure for remote prescribing in exceptional circumstances only. They prescribed medicines remotely routinely and where they had done so had not attended the hospital to sign the prescription afterwards.
- Staff did not always ensure the safe and proper management of medicines and equipment. A medication chart reviewed did not contain information on the dose and route and had not been signed by the prescriber. In another medication record, staff had not followed the as and when required medication protocol. At the House, the electrocardiogram pads had expired in May 2018.
- In a safeguarding incident, staff had not intervened at the earliest opportunity to protect a patient.
- Some staff felt vulnerable due to the patient acuity levels and a lack of male staff on shift and training in managing actual or potential aggression were low at 70%.
- Staff were not up to date with five out of the 19 mandatory and compliance training requirements. Less than 75% of staff were up to date in training in emergency first aid at work, introduction to monitoring physical health, probationary supervision, managing actual or potential aggression and oxygen training.

However:

- Staff assessed and managed risk to patients and themselves well. Psychology staff interpreted and reviewed information about incidents to update patient risk assessments. Staff tried to achieve a balance between maintaining safety and least restrictive practice. The hospital reviewed and had reduced blanket restrictions.
- The hospital was very clean, had good furnishings and was well-maintained.

Are services effective?

Requires improvement

We rated effective as requires improvement because:

- Three patients' care plans did not contain all of the relevant information to meet their physical health needs. We identified issues with care plans not stating when blood glucose

Summary of this inspection

monitoring should be completed, what care was required for skin integrity and what care was required where a patient had a bowel monitoring chart. Staff undertook two patients' blood glucose monitoring after breakfast. This should have been completed pre-meal.

However:

- The multi-disciplinary team consisted of a range of professionals who provided a wide range of interventions and worked well together to support the rehabilitation and recovery of patients.
- The service had a comprehensive and robust clinical audit schedule. All audits had action plans which were completed and updated promptly.
- Staff had the opportunity to undertake additional training including in phlebotomy, electrocardiogram, autism and learning disability.
- Staff understood and demonstrated their responsibilities under the Mental Health Act and the Mental Capacity Act.

Are services caring?

Good

We rated caring as good because:

- Staff treated patients well. They showed compassion, kindness and respected privacy and dignity.
- Staff understood the individual needs of patients.
- Staff involved patients and enabled patients to be partners in their care and treatment. Patients attended meetings about their care and treatment and staff listened to their views and involved them in discussions. Staff used tools and sessions to facilitate patient involvement.
- Patients had forums to share their views and provide feedback on the service. The hospital had regular community meetings and independent advocates visited frequently.
- Patient representatives attended clinical governance meetings to represent patient views and provide positive challenge to restrictive practice. This had resulted in the review and removal of some blanket restrictions.

Are services responsive?

Good

We rated responsive as good because:

- Staff planned and managed discharge well. They liaised with other external services responsible for providing aftercare and were assertive in managing the discharge pathway. The provider reported only one delayed discharge.

Summary of this inspection

- The hospital had a range of space and facilities to support care, treatment, rehabilitation and recovery. Patients could personalise their bedrooms and keep their belongings safe.
- Patients had access to a range of activities, education and work opportunities to develop and acquire new skills to support them in the future.
- Staff supported patients to develop networks in the service and in the wider community which they could continue following their discharge.
- The service treated concerns and complaints seriously. They investigated these and learned lessons.

However:

- The hospital's building design could impact on independence of patients with disabilities including reduced mobility getting around. The hospital was over two levels. Although there was a lift, patients relied on staff who held the key.

Are services well-led?

Good

We rated well-led as good because:

- Leaders had a good understanding of the service and were visible in the service and approachable for staff and patients.
- The service had a clear framework of meetings and reporting structures from ward level to the provider's board. Managers attended accountability meetings to report on the hospital's performance weekly.
- The hospital had an up to date and detailed risk register that was regularly reviewed. There was evidence of actions taken to manage and reduce risks.
- Systems to collect data were not burdensome on frontline staff. The provider had a plan to make more processes automated and the service had sufficient resources to generate and analyse information.

However:

- Some of our findings from the other key questions identified that not all governance processes operated effectively to ensure performance and management of risks.
- The hospital's clinical audit schedule had not identified all of the issues that we found during our inspection. This included concerns around access to on call doctors, medication prescribed remotely and physical health monitoring and care planning.

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.

All staff had completed training in the Mental Health Act and the Mental Health Act code of practice. Staff had working knowledge of the Mental Health Act and its code of practice. Staff had access to an onsite Mental Health Act administrator for advice and support.

The provider had up to date policies and procedures on the Mental Health Act and the Mental Health Act code of practice. All staff had access to these via the provider's intranet page.

Patients had easy access to information on independent mental health advocacy. Regular advocates frequently visited the hospital. Patients knew who they were. The hospital provided information for patients on advocacy services.

Patients had access to easy read fact sheets developed by the Department of Health and Social Care which explained about rights of the nearest relative and questions that patients could ask to know what their rights were.

Staff explained patients their rights as outlined in section 132 of the Mental Health Act. They recorded when this had been completed in patients' care and treatment records. Patients told us that they understood what their rights were. For example, to request a tribunal.

Patients had access to section 17 leave where this had been agreed by the relevant people. Section 17 leave forms outlined the terms and conditions of patients' leave. Patients could request specific leave requests by writing this down and submitting for review by the multi-disciplinary team. This was flexible and patients were not restricted by their four-weekly ward round, they could submit this for review at any time.

All but one of the ten medication records reviewed contained valid consent to treatment documentation in the form of a T2 or T3 certificate. The one medication which did not have valid consent to treatment documentation was prescribed by an on-call doctor remotely. When this was raised with the responsible clinician they addressed this immediately.

Patients' care and treatment records contained copies of detention papers. Original documents were stored by the Mental Health Act administrator. They were responsible for scrutinising the documents.

The ward environments contained signage to inform informal patients of their rights including the right to leave the ward at will. There were no informal patients staying at the hospital at the time of our inspection. However, staff informed us that they could provide informal patients with a fob so that they could leave at will. The provider had an information leaflet which provided information to informal patients on their rights.

Staff completed regular audits to assess compliance with the Mental Health Act and code of practice. Examples of these included audits of blanket restrictions, consent to treatment documentation, patients' rights. Each audit had an action plan where remedial actions were recorded and checked off when completed.

Mental Capacity Act and Deprivation of Liberty Safeguards

All staff had received training in the Mental Capacity Act. Staff had working knowledge of the Mental Capacity Act including the five statutory principles.

In the six-month period between 13 January 2018 and 12 July 2018, the provider reported that there were no applications for Deprivation of Liberty Safeguards. Up to our inspection in October 2018, there had been no applications for Deprivation of Liberty Safeguards.

Detailed findings from this inspection

The provider had up to date policies on the Mental Capacity Act and the Mental Capacity Act code of practice. Staff had access to these and all the provider's policies and procedures on the provider's intranet page.

Staff told us that they could seek advice from their colleagues on the Mental Capacity Act and the hospital's doctors usually took the lead where there were concerns about capacity.

Patients' care and treatment records contained evidence of capacity assessments. These were all related to consent to treatment decisions. The assessments contained clear documentation of the capacity assessment completed and the rationale on the outcome whether a patient was assessed as having or lacking capacity to consent to treatment.

The hospital has a service level agreement with an independent advocacy service that could provide independent mental capacity advocates.

Overview of ratings

Our ratings for this location are:

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

Long stay/rehabilitation mental health wards for working age adults

Requires improvement

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

Are long stay/rehabilitation mental health wards for working-age adults safe?

Requires improvement

Safe and clean environment

Safety of the ward layout

Although, the ward layout did not allow staff to observe all parts of the wards, we found that this risk was adequately mitigated. Staff completed regular environmental risk assessments and maintained observation of communal areas to manage and mitigate risk. Where possible, the hospital had fitted anti-ligature fixtures and fittings in the ward environments. Access to areas that contained fixed ligature anchor points was risk assessed on an individual basis. For example, the laundry room and activities of daily living kitchen which had standard taps. The most recent annual ligature risk assessments were completed in January 2018 and copies of these were available for staff to read.

Staff received training and the hospital had detailed literature on using ligature cutters. This included step by step instructions on how to use ligature cutters and a comprehensive policy and procedure. This included the action staff that should take including in the event of a potentially fatal ligature incident. Ligature cutters were available throughout the care environments.

The hospital accepted male patients only and therefore was compliant with guidance on same sex accommodation.

Patients had access to nurse call systems so that they could call for staff assistance if required. If patients used the lower ground level therapeutic areas of the house independently they could also request an alarm from staff so that they could call for assistance if needed. For example, when using the activities of daily living kitchen independently.

Staff were issued with personal mobile alarms to call for assistance when needed. Staff from the House and Lodge responded promptly when alarms were activated. However, four staff told us that the did not feel safe because the alarm system in the garden did not always activate when triggered. The hospital risk register showed that this had been identified as an issue in January 2018, in the interim additional staff and personal alarms were implemented until work and a service was undertaken by contractors.

Maintenance, cleanliness and infection control

All areas of the hospital were very clean, had good furnishings and were well-maintained. A team of domestic staff completed regular cleaning duties. The hospital employed a team of staff to ensure that maintenance was upheld. Patients told us that when something needed fixing that this was always completed promptly and the hospital was always clean. We saw maintenance staff undertaking work to maintain and improve the hospital environments. Staff adhered to infection control principles and the hospital had anti-bacterial hand gel available throughout the care environments.

Seclusion room

The hospital did not have seclusion facilities.

Clinic room and equipment

Long stay/rehabilitation mental health wards for working age adults

Requires improvement

Both wards had a fully equipped clinic and a separate examination room. Staff had access to all the equipment necessary to monitor physical health. Each ward had accessible resuscitation equipment including emergency drugs. Records showed that staff checked equipment regularly, however, at the House, the electrocardiogram pads had expired in May 2018. All other equipment was within date. Each month the hospital had an unannounced drill to ensure that staff could respond.

Safe staffing

Nursing staff

The hospital had enough medical and nursing staff. The minimum number of staff on shift across the hospital was 10 staff during the day and eight staff during the night. Two registered mental health nurses were included in these numbers as a minimum.

Between 1 April 2018 and 11 July 2018, the provider reported that the wholetime equivalent level for registered nurses was 14 and for nursing assistants was 27. The provider reported that there were whole time equivalent vacancies for one registered nurse and three nursing assistants.

In the same period, the provider reported that the number of shifts filled by bank staff to cover sickness, absence or vacancies was 388. The provider reported that in the same period 26 shifts were not filled by bank or agency staff. At the time of our visit, the hospital was using a few agency nurses to fill shifts in the period between registered nurses leaving and recruitment of substantive nursing staff.

Staff and managers reviewed staffing levels each week to ensure these were sufficient to consider the needs of the patient group. They reported that there were no issues in increasing staffing levels where this was required. Staff managed a regional bank of staff and the hospital was within 30 minutes driving distance from other hospitals within the group and staffing could be redeployed across the sites if this was required.

The provider reported that between 11 July 2017 and 11 July 2018, there was an average sickness rate of 3% and an average turnover rate of 32%. We did not identify any impact from the turnover rate.

Although information received showed that there was enough staff, four staff that we spoke with told us that they felt vulnerable on shift due to the staff team being pre-dominantly female and the presentations of some patients. Records showed that some patients could be disinhibited around female staff and the acuity of the wards could become heightened. Records showed that a female staff team had been one of the possible triggers in a series of incidents that followed. One of these involved a patient intervening to support staff. Managers and heads of care told us that they tried to ensure that there was a male presence in the hospital and male staff on shift wherever possible. Staff from the management and multi-disciplinary teams could assist on shift and the hospital was undertaking recruitment to fill vacant posts.

The hospital's managers operated a local on call rota. This duty was shared between the hospital director and the two heads of care. Incidents reports showed that managers responded to incidents and attended the hospital to support staff and patients.

Medical staff

The hospital did not have adequate medical cover out of hours. The hospital's responsible clinician provided out of hours medical cover between Mondays and Fridays each week. Between Fridays and Mondays, a doctor from within the region was on call. Apart from responding to one serious incident, staff including managers could not recall a doctor attending the hospital for any other incident. Due to the area covered by on call doctors, it would not be possible to attend the hospital quickly in an emergency if this was required. National Institute for Health and Care Excellence Violence and Aggression: short term management in mental health,

health and community settings (NG10) states that staff trained in immediate life support and a doctor trained to use resuscitation equipment should be immediately available to attend an emergency if restrictive interventions might be used. Accredited for Inpatient Mental Health

Services Standards for Inpatient Mental Health Rehabilitation Services also states that the doctor needs to be able to attend the ward/unit within 30 minutes in the event of a psychiatric emergency.

Mandatory training

Staff were not up to date with all the 19 mandatory and compliance training courses required. The overall average training compliance rate was 79%. However, there were five courses that fell below 75%. These were: introduction to

monitoring physical health (54%), probationary supervision (19%), managing actual or potential aggression (70%) oxygen training (70%) and emergency first aid at work including basic life support and automated external defibrillation (completed every three years, 67%). However, basic life support and automated external defibrillation were updated completed annually in the years between the three-yearly emergency first aid at work and 76% of staff were up to date with that course.

The training courses were:

Fire warden/ marshal 100%

Mental Health Act, Mental Capacity Act and Deprivation of Liberty Safeguards 100%

My path (electronic care records) 100%

Supervision 76%

Care certificate 75%

Dealing with concerns at work 88%

Equality and diversity 88%

Food safety 83%

Infection control 85%

Information governance awareness 86%

Protecting our health and safety 89%

Responding to emergencies 88%

Safeguarding individuals at risk 87%.

Basic life support and automated external defibrillation 76%.

Assessing and managing risk to patients and staff

Assessment of patient risk

Staff assessed and managed risks to patients and themselves well. They aimed to achieve the right balance between maintaining safety and providing the least restrictive environment possible to facilitate patients' recovery. All six patients' records reviewed contained comprehensive risk assessments and risk management plans. On admission, each patient had an admission risk assessment. Staff including the multi-disciplinary team discussed individual patient risk assessments each day and reviewed a daily risk assessment. These risk assessments were coloured red, amber and green to represent the level of risk identified. Patient records also contained individual risk assessments using the recognised Short-term Assessment of Risk and Treatability risk assessment tool.

Psychology staff reviewed and interpreted incident reports to update risk assessments. Following every incident reported, psychology staff reviewed incident reports and start forms. Start forms required staff to record information about what happened before incidents, during, afterwards, the consequence and any function of the behaviour identified. Psychology staff used the information to update risk assessments every eight weeks with up to date risk information ready for start meetings. Start meetings were meetings attended weekly by the multi-disciplinary team including managers. Every week four patients' risk assessments were reviewed in detail and updated.

Psychology staff also used the information from incidents to identify triggers, trends and themes for individual patients. This information was used by the hospital's forensic psychologist to complete formulations with patients on their caseload. The hospital's two assistant psychologists used the information and worked with staff and patients to develop and review positive behavioural support plans. We saw examples of positive behavioural support plans that were individualised and person-centred. However, out of the six records we review, we found that two records did not have a positive behavioural support plan accessible. One of these records contained a comprehensive psychological formulation, although this had detailed risk information, it was unclear what strategies and techniques were useful to maintain positive support and de-escalation for the patient. Staff advised that the other record did have a positive behavioural support plan on a shared computer drive. It was unclear whether all staff providing care to that patient would have been aware that the plan was there.

Management of patient risk

Staff completed choking risk assessments to identify any patients that may be at increased risk of choking.

Staff followed policies and procedures for observation and searching for patients. Staff undertook patient searches where there was concern that restricted items could enter the service. The searches recorded showed that these were

undertaken in response to concerns about illicit substances entering the hospital. Staff completed regular audits of searches undertaken to ensure that this complied with the hospital policy.

The hospital had a blanket restriction on plastic bags. The rationale for not permitting plastic bags was related to a directive from the coroner to the hospital group. However, this was recorded on the hospital's risk register and log of blanket restrictions. Staff and patients completed regular audits to identify restrictive practice. More recently, patient representatives had challenged blanket restrictions on ceramic cups and energy drinks. The hospital had reviewed and removed these blanket restrictions. The hospital had also installed wall lighters in the garden areas for patients to use because they did not permit patients to hold their own cigarette lighters. Individual patient records contained a log of any individual restrictions. These documented the rationale for the restriction and were regularly reviewed.

The hospital permitted smoking within the hospital gardens and grounds. Staff had facilitated group work to raise awareness on smoking. The hospital permitted the use of electronic cigarettes and could assist patients with nicotine replacement therapies.

Use of restrictive interventions

The hospital did not have seclusion facilities. Staff and the provider reported that there were no incidents of the use of seclusion or long-term segregation.

Between 12 January 2018 and 11 July 2018, the provider reported that there had been 26 incidents of restraint on seven different patients. One of these restraints was in the prone position. The prone position is a physical restraint position where a patient is chest down. This may mean that the patient's face is facing down or to the side.

Although, only 70% of staff were up to date with training in Managing Actual or Potential Aggression, incident reports showed and staff told us that they attempted de-escalation and used restraint as a last resort when de-escalation had not been effective. The training incorporated some of the principles of positive behavioural support. However, the hospital also had a plan to deliver a specific positive behavioural support training to staff.

The were no incidents of administration of rapid tranquilisation reported in the provider information return. However, when reviewing patients care and treatment records we found that after this time, there had been administration of rapid tranquilisation. Where patients had consented to physical health observations post administration, they had completed these.

Safeguarding

Eighty-seven percent of staff were up to date in safeguarding training and the staff that we spoke with demonstrated knowledge on identifying potential signs of abuse and neglect. They explained how they would act to report safeguarding concerns.

Managers maintained safeguarding records that showed details of the concern, evidence that this had been reported to the local safeguarding authority and notification to CQC. They updated a safeguarding tracker form to show what the stage in the process the safeguarding concern was at. The records had an overall tracker log that showed how many open safeguarding there were and the status of the safeguarding.

Although a safeguarding concern involving two patients had been reported to the local safeguarding team, records showed that staff had been present during an ongoing incident and had not intervened as soon as they could have to protect a patient. We raised this with a head of care during our inspection who told us they would look into this further.

Both wards had a visiting room off the ward area where patients could meet children visitors. Children would not need to enter the clinical area to access this room.

Staff access to essential information

All the information needed to deliver patient care was available to staff when they needed this. The hospital used a combination of paper based and electronic care records. Most records completed electronically, apart from progress notes, were printed and filed in patients' paper based files. All files were consistent and followed a uniform structure. Staff did not have any difficulty in navigating the files or locating information that they needed.

Medicines management

Staff did not always ensure the safe and proper management of medicines. We reviewed 10 patients' medication records. In one record we found that staff were not following the as and when required medication protocol set by the prescriber. The protocol outlined that

one medicine should be offered as and when required only when another as and when required medicine was refused. Records showed that staff had regularly administered both medicines and this had not been reviewed by the prescriber.

Another patient medication administration record contained incomplete information. The route and dose of the medicine was missing and it had not been signed by the prescriber. When we asked for further information, this medicine had been remotely prescribed by an on-call doctor. That medicine was not covered by any valid consent to treatment documentation. When we raised this, it was addressed immediately by the hospital's responsible clinician.

Problematic medical cover out of hours led to the routine practice of remote prescribing of medication. Between Mondays and Fridays, the hospital's responsible clinician was on call. At weekends, a regional doctor was on call for a group of hospitals. A doctor would not be able to attend the hospital promptly if required. The provider's policy stated that remote prescribing should only be completed in exceptional circumstances with email confirmation and that the doctor should sign the prescription chart within 24 hours or 72 hours on weekends and bank holidays. Staff including the hospital's managers could not recall a time when a doctor attended the hospital out of hours to examine a patient and prescribe medication. We found evidence where doctors on call had prescribed medicines remotely including rapid tranquilisation. There was no evidence that doctors had reviewed patients' electronic care records. Medicines records were paper based. Due to the nature of the on-call system, doctors would not necessarily know the patients and their needs unless they received contact from the hospital where they worked. There was no evidence that doctors attended the hospital after remote prescribing to sign the prescription chart. As well as this practice not conforming to the hospital's policy. We were also concerned that this practice was unsafe as doctors were not examining the patient and may not have access to all their relevant medical records.

The provider had a service level agreement with a community pharmacy for medicines supply, weekly ward based audits and support. Staff ensured that room and fridge temperatures were checked and recorded. All records showed the temperatures were consistently within the recommended ranges. Staff ensured that controlled drugs were checked and records were maintained. Staff had access to the latest British National Formulary. Staff ensured that the effects of patients' medication on their physical health was reviewed regularly.

Track record on safety

In the 12 months period, there was one serious incident. The provider undertook an independent serious incident investigation following that incident. As a result, the provider identified and implemented lessons learnt which they implemented to improve safety. This included improvement to the hospital garden stair well, improved lighting in the hospital garden and incorporating the removal of tamper seals from emergency grab bags in staff training.

Reporting incidents and learning from when things go wrong

All staff knew what types of occurrences to report as incidents. The hospital had a paper based incident reporting form. There was variable understanding of the duty of candour. Four staff that we spoke with did not know what this was. However, we found that leaders understood the duty of candour and there was evidence that the provider had carried out the duty of candour in relation to a serious incident that occurred.

Staff received feedback from the investigation of incidents internal and external to the service. The hospital held lessons learnt meetings to share learning from incidents. Managers shared information on lessons learned through editions that were sent to staff. The meeting rooms on each ward contained a file with information on lessons learned from incidents internal and external to the service. Staff also told us that they heard about lessons learnt through word of mouth.

When incidents occurred, the hospital's managers attended the hospital to support staff and patients. Following serious incidents, staff and patients received debriefs facilitated by the psychologist. Staff provided mixed feedback about receiving debriefs following less serious incidents. They stated that they did not always receive a debrief following incidents.

Long stay/rehabilitation mental health wards for working age adults

Requires improvement

Are long stay/rehabilitation mental health wards for working-age adults effective?

(for example, treatment is effective)

Requires improvement

Assessment of needs and planning of care

All six patient records we reviewed showed that staff completed a detailed mental health and physical health assessment on admission. Each patient had individualised, recovery oriented and holistic care plans. Staff updated patients' care plans regularly.

However, we found that three patients' care plans did not contain all the relevant information to meet their physical health needs. One patient's diabetes care plan did not contain information about when their blood glucose monitoring should take place. We observed that this was one of two patients with diabetes who we saw had their blood glucose monitoring completed after breakfast. This monitoring should be completed pre-meal. Another patient had a skin integrity check sheet but the patients' care plans did not contain any information about why this was required or how frequent. A further patient had a bowel monitoring sheet in place but their care plan did not contain any information on their needs around this. We saw that medical interventions had been required twice in the same month for this.

Best practice in treatment and care

Staff provided a full range of care and treatment interventions to support the rehabilitation needs of patients. Patients had access to medication, psychological therapies, education, activities, training and work opportunities. Patients and staff told us how the therapy programmes available were supporting patients to acquire living and recovery skills for the future.

Patients had access to physical healthcare. Although there were gaps in care planning and diabetes monitoring, overall patients' physical health was prioritised. Staff ensured that patients accessed community primary medical services including a local GP. Each month, dedicated staff ran a well man clinic. Patients could attend this clinic to discuss their physical health needs and observations were taken. Each patient had a health improvement plan which was used to record information about their physical health.

Staff supported patients to live healthier lives. The multi-disciplinary team worked together to run a fortnightly group called Talk About. The group had covered a range of topics aimed at improving health and well-being. This included sessions on self-esteem, healthy living, smoking and substance misuse. The hospital also provided patients with training in cycling proficiency to encourage patients to become more active and develop skills. One patient had also completed gym instructor training.

Staff used a range of ratings scales to assess and record severity and outcomes. Staff used a range of pre- and post-intervention clinical tools including the Warwick-Edinburgh Mental Well-being Scale and the Brief Symptom Inventory. The hospital also used a wide range of other clinical tools dependent on patients' individual needs. Staff also used the Model of Human Occupation Screening Tool and the provider's own outcome measure the global assessment of progress. The global assessment of progress covered different factors including clinical presentation, emotional regulation, risk, observation level, community access, medication compliance, substance use, daily living skills and absconding incidents (for detained patients).

The service had an audit schedule. The audit schedule comprised: weekly medication audits, monthly close circuit television audits, monthly engagement/observation audits, monthly health and safety audits, monthly search audits, quarterly care audits, quarterly infection control audits, quarterly physical healthcare audits, mental health act audits, quarterly S58/9 audits, six monthly blanket rules audits, annual information governance audits, annual ligature audits, annual safeguarding audits, annual suicide audits. All audits were completed at the intervals set and there was evidence that audits were critical of areas of practice that were identified as non-compliant. Each audit had an action plan which was updated to show that actions had been completed. The service submitted all audits were the quality administrator for the group after completion. In addition to internal audits, the provider's quality team completed two full audits per year and undertook regular thematic reviews across the provider's locations. However, we identified issues during our

inspection with physical health monitoring including care planning, medication prescribed remotely and gaps in documentation as a result of this that had not been identified through audits completed.

Skilled staff to deliver care

The multi-disciplinary team consisted of a wide range of professionals to meet the needs of patients in the hospital. The medical team comprised one consultant psychiatrist and one specialty doctor. The hospital had one lead occupational therapist, an occupational therapist and three therapy co-ordinators. The psychology department consisted of one forensic psychologist and two assistant psychologists. If patients required specialist input then this could be sourced from within the provider's services or externally if required. For example, speech and language therapy or clinical psychologist.

Staff were experienced and qualified and had the right skills and knowledge to meet the needs of the patient group. They demonstrated knowledge and skills throughout interviews and observations undertaken.

Seventy five percent of eligible staff had completed the care certificate. Preceptorship nurses had support on each shift from a registered nurse.

Staff received regular supervision. In the 12 months between, 1 July 2017 and 1 July 2018, the clinical supervision rate was 84%. This was one percent lower than the provider's target rate of 85%. Staff reported that they could seek support from their colleagues and managers at any time. The heads of care, occupational therapists, psychology staff and doctors had access to forums for support across the provider with their peers and counterparts from other services. These included sessions for education, reflective practice and peer support. Staff had access to regular team meetings.

As at 12 July 2018, 77% of non-medical staff had received and appraisal in the last 12 months. Both doctors had been revalidated.

Staff had opportunities to complete training to develop their skills and improve the services that they provided. Staff had recently completed training in learning disabilities and autism. They had the opportunity to complete training in phlebotomy and electrocardiograms. Managers had organised training in catheter and stoma care and moving and handling people to meet the needs of individual patients.

Managers dealt with poor staff performance promptly and effectively. Where staff performance was below the required standards, managers challenged this and used the provider's policies and procedures to support staff and raise standards.

Multi-disciplinary and inter-agency team work

Staff held regular and effective multi-disciplinary meetings. Between each shift there was a handover to staff to discuss key events and concerns. Every weekday morning, there was a morning multi-disciplinary team meeting where information from the morning handover was shared with staff from the multi-disciplinary team and each patients' individual risk assessment was reviewed and updated.

Every week the multi-disciplinary team had a start meeting where they reviewed and updated four patient risk assessments per week. Patients' ward round meetings also took place weekly with patient reviews taking place at least once within every four weeks. All staff involved in the patients' care and treatment were involved in ward round meetings.

Staff and managers tried to ensure that there were effective working relationships with commissioners, community care co-ordinators and services that would provide aftercare to patients following their discharge. The hospital accepted referrals from nationwide and it could be complex to keep the external agencies fully engaged in patients' progress throughout their care and treatment. There had been occasions where the provider had had to serve notice on commissioners to encourage prompt engagement from external services.

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

All staff had completed training in the Mental Health Act and the Mental Health Act code of practice. Staff had working knowledge of the Mental Health Act and its code of practice. Staff had access to an onsite Mental Health Act administrator for advice and support.

Long stay/rehabilitation mental health wards for working age adults

Requires improvement

The provider had up to date policies and procedures on the Mental Health Act and the Mental Health Act code of practice. All staff had access to these via the provider's intranet page.

Patients had easy access to information on independent mental health advocacy. Regular advocates frequently visited the hospital. Patients knew who they were. The hospital provided information for patients on advocacy services.

Patients had access to easy read fact sheets developed by the Department of Health and Social Care which explained about rights of the nearest relative and questions that patients could ask to know what their rights were.

Staff explained patients their rights as outlined in section 132 of the Mental Health Act. They recorded when this had been completed in patients' care and treatment records. Patients told us that they understood what their rights were. For example, to request a tribunal.

Patients had access to section 17 leave where this had been agreed by the relevant people. Section 17 leave forms outlined the terms and conditions of patients' leave. Patients could request specific leave requests by writing this down and submitting for review by the multi-disciplinary team. This was flexible and patients were not restricted by their four-weekly ward round, they could submit this for review at any time.

All but one of the ten medication records reviewed contained valid consent to treatment documentation in the form of a T2 or T3 certificate. The one medication which did not have valid consent to treatment documentation was prescribed by an on-call doctor remotely. When this was raised with the responsible clinician they addressed this immediately.

Patients' care and treatment records contained copies of detention papers. Original documents were stored by the Mental Health Act administrator. They were responsible for scrutinising the documents.

The ward environments contained signage to inform informal patients of their rights including the right to leave the ward at will. There were no informal patients staying at the hospital at the time of our inspection. However, staff informed us that they could provide informal patients with a fob so that they could leave at will. The provider had an information leaflet which provided information to informal patients on their rights.

Staff completed regular audits to assess compliance with the Mental Health Act and code of practice. Examples of these included audits of blanket restrictions, consent to treatment documentation, patients' rights. Each audit had an action plan where remedial actions were recorded and checked off when completed.

Good practice in applying the Mental Capacity Act

All staff had received training in the Mental Capacity Act. Staff had working knowledge of the Mental Capacity Act including the five statutory principles.

In the six-month period between 13 January 2018 and 12 July 2018, the provider reported that there were no applications for Deprivation of Liberty Safeguards. Following this up to our inspection, there had been no applications for Deprivation of Liberty Safeguards.

The provider had up to date policies on the Mental Capacity Act and the Mental Capacity Act code of practice. Staff had access to that and all the provider's policies and procedures on the provider's intranet page.

Staff told us that they could seek advice from their colleagues on the Mental Capacity Act and the hospital's doctors usually took the lead where there were concerns about capacity.

Patients' care and treatment records contained evidence of capacity assessments. These were all related to consent to treatment decisions. The assessments contained clear documentation of the capacity assessment completed and the rationale on the outcome whether a patient was assessed as having or lacking capacity to consent to treatment.

The hospital had a service level agreement with an independent advocacy service that could provide independent mental capacity advocates.

Are long stay/rehabilitation mental health wards for working-age adults caring?

Long stay/rehabilitation mental health wards for working age adults

Requires improvement

Good

Kindness, privacy, dignity, respect, compassion and support

Staff treated patients with compassion and kindness, respected their privacy and dignity and understood the individual needs of patients. Observations showed that staff engaged positively with patients. It was clear that staff including managers of the hospital knew patients and their individual needs very well.

Patients told us that staff worked hard to help them in their recovery, had a positive approach and treated them well.

Involvement in care

Involvement of patients

Staff involved patients in the care that they received. Prior to admission, most patients visited the service so that they could see what it was like and meet staff that would be in their care team. Staff involved patients in the development of their care and treatment records. Care plans reflected patients' views and were signed by patients. Patients had a copy of their care plan unless they had told staff that they did not want one. Patients participated in reviews of care and treatment with the multi-disciplinary team. Patients told us that they felt staff listened to them and involved them in discussions about their progress.

Staff enabled patients to be partners in their care and treatment. Staff provided patients with forms to complete and encouraged patients to bring these into meetings about their care and treatment. For example, completing leave request forms and forms with questions and requests that patients wanted to discuss in their ward round meetings. The forms had sections to complete to record what was said in the ward round meeting and patients' goals for the next four weeks. Patients had access to a weekly occupational therapy clinic and psychology clinic where they could drop in and have a short session to discuss things that could support them in their recovery and rehabilitation.

Patients could share their views and provide feedback on the service that they received. Patients had access to independent advocacy. Regular advocates visited the hospital frequently and patients knew who they were. The hospital had ways that patients could provide feedback on the service including weekly community meetings and an annual patient survey. The House and the Lodge each had a patient representative that attended clinical governance meetings. Patient representatives had successfully raised issues to reduce and review restrictive practices in the hospital. This had led to the removal of some blanket restrictions.

Involvement of families and carers

We received feedback from one carer. They told us that staff informed them and involved them appropriately by providing them with information about the treatment that the person they cared for was receiving. They could contact the staff at any time to speak to them including to raise any concerns. They felt that staff kept them informed of the important information.

The provider conducted an annual survey which carers were encouraged to participate in. The results of this survey showed that patients had provided mostly positive feedback about their experience of the service. There were no actions identified as a result of the survey results.

Are long stay/rehabilitation mental health wards for working-age adults responsive to people's needs? (for example, to feedback?)

Good

Access and discharge

Bed management

The average time between referral to the service and an initial assessment was two days. The average time from initial assessment to admission was 54 days. The provider reported that this was largely affected by external factors including authorisations and funding agreements. The average bed occupancy rates between 11 June 2018 and 11 July 2018 was 89%. Occupancy rates indicated that beds were usually available when needed for patients living within the local area.

Long stay/rehabilitation mental health wards for working age adults

Requires improvement

Where patients required more intensive care, staff worked with commissioners and community care co-ordinators to identify and gain authorisation to transfer to a more suitable care environment.

Discharge and transfer of care

Staff planned and managed discharge well. They liaised well with services that would provide aftercare and were assertive in managing the discharge care pathway. As a result, patients did not have excessive lengths of stay and discharge was rarely delayed for other than a clinical reason. The average length of stay was reported by the provider as 21 months. However, staff explained that commissioners were looking for shorter term stays between six to 18 months dependent on the individual's rehabilitation needs for new admissions. The provider reported that between 1 January 2016 and 11 July 2018 there was one delayed discharge. A lack of provision in community services was reported a key factor impacting on the timeliness of that discharge. All patients had clear discharge plans and some patients had a one-page visual discharge plan that included their hopes and goals for the future. Care plans referred to section 117 aftercare services for the relevant patients.

The facilities promote recovery, comfort, dignity and confidentiality

The hospital had a range of rooms, facilities and equipment to support treatment and care. Each ward had a kitchenette, lounge, garden, clinic room, examination room, multi-faith room and dining room. Patients also had access to activities of daily living kitchens, a relaxation room, meeting rooms, a gymnasium, computer room, recreational space with a pool table and table tennis and an art workshop. Patients could access the multi-faith room which could also be used as a quiet small lounge space on the ward. The House and Lodge each had a visitors' room accessible from the entrance receptions which was off the ward area. This was a private and quiet space and children could visit without entering the ward areas. Patients had access to a telephone room on the wards and typically patients had their own mobile phones, including those with internet, at any time. Patients had open access to outdoor space. A member of staff was allocated to garden observation when patients were in the garden.

Patients could personalise their bedrooms with their own belongings. The wards had additional cupboard storage to store any items that patients could not fit or did not want in their bedrooms. All patients had keys to their bedrooms. Staff encouraged patients to keep their possessions secure by locking their bedrooms when leaving them.

Patients provided positive feedback about the quality of food. Menus available were colour coded to assist patients with understanding the nutritional information in foods. Foods written in red contained higher calories and saturated fats, yellow medium levels and green lower levels. Patients could also purchase their own food to cook and eat, and takeaways. Patients had open access to kitchenettes on the ward to access drinks and snacks always. Patients could also use the activities of daily living kitchens to prepare their own meals and snacks. The level of access was dependent on their individual risk assessments.

The hospital provided activities throughout the week including weekends. More recently, therapy staff had started to work more flexibly to provide activities across more hours and days of the week. Activities available were displayed in an activity timetable. In addition, other activities were also offered on the wards by staff with patients to try and engage them into activities.

Patients' engagement with the wider community

Staff ensured that patients had access to education and work opportunities. An educational tutor also visited the hospital regularly and taught numeracy, literacy, drama activities and skills development from entry level to level two with the opportunity to progress onto General Certificate of Secondary Education. Patients with leave could attend educational courses outside of the hospital. Patients had allocated therapy jobs aimed at skill development and involvement in service. The therapy timetable also included community dog walking sessions.

Staff supported patients to maintain contact with their families and carers. They encouraged communication and facilitated visits at the hospital or home visits where these were agreed.

Staff encouraged patients to develop and maintain relationships with people that mattered to them, both within the service and in the wider community. Staff encouraged patients to work together as a community with frequent group meetings and involving patients as patient

Long stay/rehabilitation mental health wards for working age adults

Requires improvement

representatives. Patients attended events in the local community including at the local football club and pride. One patient told us that they had been supported to make connections in the local community which they hoped would continue following their discharge in the future.

Meeting the needs of all people who use the service

The hospital's building design impacted upon the accessibility for disabled people and those with reduced mobility. The hospital comprised of two separate buildings; the House and the Lodge. The house was a two-level building built on a gradient. This meant that the main entrance was on the ground level and there was a floor below which also at ground level at the rear entrance. On the ground level in the house, patients had access to bedrooms, a kitchenette, a lounge and a garden with step free access. The therapeutic space and dining room was on the lower ground floor accessible by steps or a lift. However, the lift was only accessible with a key which was held by staff and when the lift arrived downstairs this was into the non-patient catering area of the hospital. This meant that patients requiring use of the lift would need staff to be present and this could impact on their independence moving around the hospital. However, staff told us that pre-admission, patients would usually visit the hospital so would be aware of what it was like before they arrived.

The lodge was situated at the bottom of the gradient behind the house. All the ward facilities were on the ground level. However, the garden did not have step free access or a lift so would not have been accessible for disabled people.

The provider had made other reasonable adjustments for people. This included colour coded signage for fire evacuation and a sensory and low stimulus relaxation room. Staff obtained information and interpreters where required for people who spoke different languages.

The hospital provided food to meet the dietary requirements of religious or ethnic groups.

Patients had access to spiritual support through a visiting chaplain and could also access community based spiritual support.

Listening to and learning from concerns and complaints

The service treated concerns and complaints seriously, investigated them and learned lessons from the results. In the 12 months leading up to the submission of the provider information return, the hospital received 32 complaints. Eight of the complaints received were upheld. None were referred to the parliamentary health service ombudsman. The three themes reported were staff, peers and leave status.

Patients told us that they knew how to complain. The hospital displayed information for patients on the provider's complaints policy and procedure and how to raise a Mental Health Act complaint with the CQC. Each ward had a patient representative and they raised provider related issues on behalf of patients in the relevant forums in the hospital including clinical governance and in the reducing restrictive practice meetings.

In the same period, the hospital received six compliments.

Are long stay/rehabilitation mental health wards for working-age adults well-led?

Good

Leadership

Leaders were established in their roles and had a good understanding of the service. They had the knowledge, skills and experience to perform their roles. They were visible in the service and approachable for staff and patients.

All staff had opportunities for leadership development through lead roles and additional training should they wish to pursue this. We saw examples where this had occurred. For example, leading the well man clinics.

Vision and strategy

Staff showed awareness of the provider's vision and values. The provider's values were: helpful, responsible, respectful, honest and empathetic. The provider's vision statement was: "to enable people to progress on their personal journey to achieve more, and to be recognised as the preferred provider for outstanding quality care and

employer choice in the health care sector. We are driven by our purpose; we care, we enable, we make a positive difference and it's our mission to enable you every step of the way".

The service had undergone a transition between providers after being taken over by the Cygnet parent provider. Leaders had supported staff through this process and staff felt unaffected by this transition.

Culture

On the whole, staff felt respected, supported and valued. They demonstrated a commitment to their work and making a difference in patients' lives. They felt they could raise concerns without fear of retribution.

Staff understood the provider's whistleblowing policy and procedure. Managers were developing freedom to speak up champions in line with the nationally recognised Freedom to Speak Up Guardian role.

Managers supported staff in their development through the appraisal process and leadership opportunities. Staff that we spoke with told us how they had grown within the organisation and progressed their careers. Some of the vacancies for registered nurses in the service were as a result of nurses gaining new opportunities within the wider organisation.

The service had a low sickness rate at 3% and the provider had services to support staff well-being.

Governance

Our findings from the other key questions demonstrated that most governance processes operated effectively at ward level and that performance and risk were managed well. We identified issues with on-call medical cover, remote prescribing, some medicines, monitoring of physical health and low mandatory and compliance training rates for five courses. However, other governance systems and processes were established and embedded. These ensured the hospital was clean, that there were enough staff who received regular supervision and appraisal, staff planned and managed discharges well, incidents were investigated and learnt from and staff adhered to the Mental Health Act and Mental Capacity Act.

The service had a clear framework of meetings and reporting structures from ward level to the provider's board. This included team meetings, clinical governance meetings and reporting of key performance indicators. The hospital meetings had set agendas with representations from relevant staff and patient groups. Each week, managers reported key performance information to the regional operations director. They held accountability calls with hospital managers to discuss performance and support required. Regional operations directors reported key performance indicators and reported to the board each week.

Staff and the provider's quality team undertook regular clinical audits. Audits identified areas of practice that required improvement and there was evidence that staff had acted upon these results to address issues. However, we also identified issues that clinical audits had not identified in relation to physical health monitoring and care planning, medication prescribed remotely and the records in relation to this.

Management of risk, issues and performance

Leaders ensured that the service had risk a register that was up to date and regularly reviewed. The risk register was comprehensive and detailed the key issues within the service. Against each item was a description of the initial actions taken to reduce the initial risk ratings. Further remedial actions were scheduled to lower risks in the longer term. Where risks had been lowered consistently, leaders had closed these on the risk register. Items on the risk register matched the concerns from staff and the themes from incidents for example, substance misuse which had been a more recent challenge for the service.

We identified concerns in the key questions safe and effective. Some of these concerns had not been identified by leaders or identified through clinical audits completed. For example, the access to out of hours medical cover and remote prescribing and therefore these issues continue and had not been managed.

The provider had ensured that the service had plans for emergencies. When incidents occurred, staff had acted promptly to ensure that the service was safe and could continue to provide regulated activities.

The service did not have any cost improvement projects.

Information management

The hospital used a combination of systems and manual data collection from the services. Some of the hospital's processes were paper-based. This included incident

reporting and this meant that data collection for analysis was more burdensome. However, the managers had ensured that the hospital had enough staff support to these processes so that this was not burdensome on frontline staff and did not affect patient care. Leaders told us that the provider had plans to introduce new systems to make these processes automated.

Staff had access to the equipment required to complete their work. Although there was a combination of paper-based and electronic records, patient records were clear to navigate and staff knew where to find the information they needed.

Leaders had access to information to assess the service against the provider's key performance indicators.

Staff ensured the notifications were made to external bodies where required including the CQC and Reporting of Injuries, Diseases, Dangerous Occurrences where appropriate. The provider maintained records to ensure there was an audit trail that these had been completed for the relevant incidents.

Engagement

Staff and patients had up to date information about the provider and the services. They received information cascaded through the meetings structures. Managers also sent staff an update email each Friday to share important information to staff from throughout the week.

Patients and carers could provide feedback at any time about the service. The provider also conducted an annual stakeholder survey.

Leaders engaged well with external stakeholders. At the time of our inspection, the hospital was working with approximately eight different clinical commissioning groups. Some of these were across the country. They also worked with other stakeholders responsible providing aftercare services.

Learning, continuous improvement and innovation

The hospital did not participate in any accreditation schemes or quality improvement initiatives.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

The provider must ensure that a doctor can attend the hospital promptly when required.

The provider must ensure that staff follow the provider's policies and procedures on medicines management including remote prescribing.

The provider must ensure the safe and proper management of medicines and equipment.

The provider must ensure that all staff are up to date with mandatory and compliance training.

The provider must ensure that staff protect patients from abuse.

Action the provider SHOULD take to improve

The provider should ensure that all staff understand the duty of candour.

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 How the regulation was not met: A doctor could not attend the hospital promptly if this was required out of hours. On call doctors prescribed medicines remotely routinely. Where they had done so they had not attended the hospital to sign the prescription afterwards. This was not in line with the provider's policy. A medication chart did not contain a dose, or route for a medicine. The prescription had not been signed by a doctor. The electrocardiogram pads at the House expired in May 2018. This was a breach of regulation 12 (1) (b) (e) (g)

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 How the regulation was not met:

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
	In an incident, staff did not intervene at the earliest opportunity to protect and safeguard a patient. This was a breach of regulation 13 (1)
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 How the regulation was not met: Five out of 19 mandatory and compliance training courses fell below 75%. This included: emergency first aid including basic life support and automated external defibrillation, introduction to physical health, managing actual and potential aggression, oxygen and probationary supervision. This was a breach of regulation 18 (2) (a)