Cygnet Behavioural Health Limited

Cygnet Nield House

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

Cygnet Nield House is an independent hospital that provides care for up to 30 women with mental health conditions.

This was our first inspection of this service. We rated it as requires improvement because:

- The service did not always provide safe care. The risks presented by the ward environment were not always assessed and managed well. For example, not all parts of the ward were easily observable, and it was not always clear if information about risks was shared with temporary staff. The wards did not always have enough nurses and support workers.
- The documentation of care plans and risk assessments was not always recovery-oriented and easily accessible to patients, and all staff.
- The service did not always actively involve patients and families and carers in care decisions.
- The governance processes did not always ensure that ward procedures ran smoothly.

However

- The ward environments were clean. Staff minimised the use of restrictive practices, managed medicines safely and followed good practice with respect to safeguarding.
- Staff carried out comprehensive assessments of patients and developed care plans in response to these. They provided treatments suitable to the needs of the patients and in line with national guidance about best practice.
- The ward teams included or had access to the range of specialists required to meet the needs of patients on the wards. Managers ensured that these staff received training, supervision and appraisal. The ward staff worked well together as a multidisciplinary team and with those outside the ward who would have a role in providing aftercare.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, and understood the individual needs of patients.
- Staff understood and discharged their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Acute wards for adults of working age and psychiatric intensive care units	Requires Improvement 	We rated this core service as requires improvement. We rated this service as requires improvement because safe and well-led require improvement, but effective, caring and responsive were good. See overall summary for more information.
Personality disorder services	Requires Improvement 	We rated this core service as requires improvement. We rated this service as requires improvement because safe and well-led require improvement, but effective, caring and responsive were good. See overall summary for more information.

Summary of findings

Contents

Summary of this inspection

Background to Cygnet Nield House

Cygnet Nield House is an independent hospital registered to provide care and treatment for up to 30 women with mental health conditions. Patients may be admitted voluntarily or detained under the Mental Health Act. It has two wards:

- Compton ward – 15 bed acute inpatient ward
- Clarion ward – 15 bed inpatient ward for women with a personality disorder with disordered eating. Patients have a personality disorder and use disordered eating as a form of self-harm; they do not have a primary diagnosis of an eating disorder.

All patients are funded by the NHS. At the time of the inspection, all beds on Compton ward were block booked to specific NHS trusts. Patients were referred to Clarion ward by individual clinical commissioning groups from across the country.

Cygnet Nield House registered with the Care Quality Commission in September 2020. It is provided by Cygnet Behavioural Health Limited, which is part of Cygnet Health Care who provide mental health and learning disability services across the country. It is registered to provide the regulated activities: assessment or medical treatment for persons detained under the Mental Health Act 1983; and treatment of disease disorder or injury.

The service has a manager registered with CQC.

This was the first inspection of Cygnet Nield House and was unannounced.

What people who use the service say

Patients provided us with mixed feedback about their experience of the service.

Patients were generally positive about staff, but did not always feel they had enough input from members of the multidisciplinary team, or that they were involved in the decision making process about their care.

Some patients thought there were enough staff, and others thought there could be more. There were a lot of bank and agency staff, but this had improved and most worked in the hospital regularly.

Patients were generally positive about the environment but thought it was rather crowded on Compton ward, or would be on Clarion ward when full.

Patients knew how to make complaints, and had access to the hospital director and an independent mental health advocate.

How we carried out this inspection

Before the inspection visit we reviewed information that we held about the service.

During the inspection visit the inspection team:

Summary of this inspection

- visited both wards, looked at the ward environment and observed how staff were caring for patients
- spoke with four patients
- spoke with four relatives of patients
- spoke with the registered manager and other managers within the service
- spoke with 15 other staff
- attended two meetings
- reviewed nine care records of patients and other care related documents including prescription charts, risk assessments and observation forms
- 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 provider SHOULD take is because it was not doing something required by a regulation but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the service MUST take to improve:

We told the service that it must take action to bring services into line with legal requirements.

- The service must ensure that it has taken the necessary actions to identify and remove or mitigate against risks, and ensure that this is communicated effectively to all staff (Regulation 12(1)(2)(a)(b)(c)(d)).

Action the service SHOULD take to improve:

- The service should ensure that there are enough skilled and experienced nursing and support staff on each shift, and that this is robustly monitored, including for unfilled shifts, and takes account of the additional coordination required by high levels of one-to-one observations (Regulation 18).
- The service should ensure that all staff receive the necessary mandatory and specialist training, and supervision (Regulation 18).
- The service should ensure that there are enough allied health professionals and other suitably skilled staff to provide the stated model of care to patients (Regulation 18).
- The service should ensure that the risk register is regularly reviewed and updated to reflect the risks within the service (Regulation 17).
- The service should ensure that there are robust processes for assessing patients for admission, including at night and when there are agency staff on duty (Regulation 17).
- The service must ensure that they seek and act on feedback from patients and carers (Regulation 17).
- The service should consider how care plans and risk assessments are carried out and documented, so that they are person centred, recovery focused and the information is easily accessible to patients and staff.
- The service should consider how staff access Mental Health Act documentation.
- The service should consider reviewing how it can provide a service to people who use a wheelchair or have difficulty mobilising.

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Acute wards for adults of working age and psychiatric intensive care units	Requires Improvement	Good	Good	Good	Requires Improvement	Requires Improvement
Personality disorder services	Requires Improvement	Good	Good	Good	Requires Improvement	Requires Improvement
Overall	Requires Improvement	Good	Good	Good	Requires Improvement	Requires Improvement

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

Requires Improvement

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

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

Requires Improvement

We rated safe as requires improvement.

Safe and clean care environments

All wards were clean and well equipped, furnished, and maintained. The wards were designed and fitted to reduce the risks to patients, but the environmental risk assessments were not comprehensive.

Safety of the ward layout

Environmental risk assessments had been carried out of all ward areas, and some action had been taken to remove or mitigate risks. However, the assessments were not always comprehensive, and some risks were reliant on being managed by the vigilance and actions of staff. Where this was the case, it was not clear how this information was shared effectively with all staff, including temporary or agency workers. The service did not use observational zoning to mitigate risks.

All patients had their own single room with an ensuite toilet and shower.

Staff could not easily observe patients in all parts of the wards, but this had been partially mitigated by the use or mirrors. There was limited communal space on the ward in relation to the number of beds.

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

Maintenance, cleanliness and infection control

Ward areas were clean, well maintained and well furnished. The onsite maintenance staff ensured that all the necessary health and safety checks were completed, and that necessary maintenance and decoration was carried out. Staff made sure cleaning records were up-to-date and the premises were clean. Staff followed infection control policies, including handwashing. Staff had implemented COVID security measures during the outbreak, that reflected government guidance.

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

Requires Improvement

Clinic room and equipment

The clinic room was fully equipped. Staff checked equipment and ensured that it was maintained and cleaned regularly. There was one clinic/examination room on the acute ward (Compton ward) for both wards. Clarion ward was undergoing refurbishment to create additional rooms, including its own clinic room.

Staff had access to resuscitation equipment and emergency medicines, which was checked regularly.

Safe staffing

The service had enough medical staff, but did not always have enough nursing staff who knew the patients and received basic training to keep people safe from avoidable harm.

Nursing staff

The service did not always have enough nursing and support staff. The service had nursing and support worker vacancies and used bank and agency staff to cover these gaps, particularly at night. The service had eight vacancies out of 17 nursing posts, with three in the pipeline. There were 17 vacancies for 48 support worker posts, with four in the pipeline. Managers told us that Cygnet Nield House was on the corporate priority list for recruitment of staff. Managers requested agency staff who were familiar with the service, but this had become increasingly difficult, which the service partly attributed to external factors such as changes to tax laws.

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. Staff told us that there were usually enough staff to keep people safe, but it may be difficult to facilitate one-to-one sessions with nursing staff or leave. This had also been impacted because of COVID restrictions. There was no clear information about when shifts were without enough staff. If staffing levels on the ward were short, staff from other areas – such as occupational therapy and managers – would cover the shortfall. These staff had been trained in the use of physical interventions.

Medical staff

The service had enough daytime and night time medical cover. Each ward had a consultant psychiatrist and a speciality doctor. Three of the doctors were locums, and one was seconded to the hospital three days per week from another Cygnet service. The service was in the process of recruiting to permanent posts.

A doctor was available to go to the ward quickly in an emergency. Cygnet's on call doctor covered the service out of hours.

Mandatory training

Staff had completed and kept up-to-date with most of their mandatory training. Across the unit the lowest training levels were at 65% for immediate life support training and for online safeguarding learning. Managers told us there had been difficulties accessing training during the pandemic.

Managers monitored mandatory training and alerted staff when they needed to update their training. The online training system provided managers and staff with information about training they had completed. Managers and staff told us they had completed training on the Mental Health Act, but the list of mandatory training on the provider's training system did not include this.

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

Requires Improvement

Assessing and managing risk to patients and staff

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

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 a Short-Term Assessment of Risk and Treatability risk assessment tool for all patients, and risk was discussed in the daily risk assessment meeting. During this meeting, staff completed a daily risk assessment and gave a red/amber/green rating to a patient's risk level in areas such as self harm or risk to others.

Management of patient risk

Staff knew about any risks to each patient and acted to prevent or reduce risks. Staff identified and responded to any changes in risks to, or posed by, patients. This was discussed in the daily risk assessment meeting, and the need for reviews of risk or changes in care plans was identified. However, in two of the four care records we reviewed on Compton ward, there were some incidents that had not been reflected in the daily risk assessment. The daily handover meeting highlighted specific risks for patients, such as the need for sunscreen in warm weather (sensitivity to sun is a side effect of some medicines), or potential trigger points (such as specific dates or anniversaries). However, staff informed us, and we had been notified by the provider, of occasions when the risk assessment and care plans had not been followed and this may have or had resulted in actual self-harm. These incidents had been identified by the provider, and action taken.

Staff followed the service's policies and procedures when they needed to search patients or their bedrooms to keep them safe from harm. There were no blanket restrictions on searching patients, but where this was deemed necessary it was individually care planned.

Use of restrictive interventions

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.

The use of restraint was monitored through the service's clinical governance process. The provider carried out a quarterly review across each region which reviewed the use of restrictive interventions across its services. Managers used CCTV to review alleged incidents, and following some restraints. This enabled them to confirm that restraints were carried out correctly, and to bring in additional training or other action if required. In the previous quarter there had been eight incidents of restraint on Compton ward.

The use of enhanced observations was routinely reviewed in the multidisciplinary team meetings, and in the daily risk assessment meeting. Patients had care plans that included the restrictions that were placed on them and the rationale. There were no patients on one-to-one observations at the time of our inspection. Staff told us that patients on Compton ward were usually on general or intermittent observations.

Staff followed NICE guidance when using rapid tranquilisation. The use of rapid tranquilisation was recorded and monitored through the clinical governance meetings.

The hospital did not have a seclusion room, and did not use seclusion or long-term segregation. Some patients may be subject to quarantine in their rooms following admission due to COVID prevention measures.

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

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.

All staff were expected to complete basic training on how to recognise and report abuse, appropriate for their role. Sixty-five percent of staff were up-to-date with their safeguarding training. Staff knew how to make a safeguarding referral and who to inform if they had concerns. Managers maintained a safeguarding tracker, that included potential safeguarding concerns and the outcomes of investigations, and whether they were reported to the local authority safeguarding team. Most safeguarding concerns were related to self-harm or patient-to-patient incidents.

Staff followed clear procedures to keep children visiting the ward safe. There was a visiting room in the unit shared by both wards.

Staff access to essential information

Staff had easy access to clinical information and it was easy for them to maintain high quality clinical records. Patient notes were comprehensive and all staff could access them easily. Agency staff were provided with temporary access to the system. Although the service used a combination of electronic and paper records, staff made sure they were up-to-date and complete. Records were stored securely.

Medicines management

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

Staff followed systems and processes when safely prescribing, administering, recording and storing medicines. Staff stored and managed medicines and prescribing documents in line with the provider's policy. The ward had its own medicines room with secure storage. Each patient had a folder that included their prescription chart and related information. The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely. An external pharmacy supplied medicines to the service, provided advice, and carried out routine audits.

Staff reviewed the effects of each patient's medicines on their physical health according to NICE guidance. All patients had physical health observations take at admission, and as necessary afterwards. Staff used the National Early Warning System to record patients' observations. Staff were trained in phlebotomy and taking electrocardiograms, so regular monitoring was carried out onsite. High does antipsychotic therapy (antipsychotic medicines above recommended limits) was not prescribed regularly, but where this was the case patients were monitored in accordance with national guidance. When medicines such as clozapine and lithium was prescribed, this was increased gradually and patients monitored in accordance with national guidance.

Track record on safety

The service did not always have a good track record on safety. There had been incidents of harm to patients. The provider had responded to these and sharing information about potential risks with other services, but it was not always clear that this had been effective in preventing or reducing the risk of them reoccurring.

Reporting incidents and learning from when things go wrong

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.

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

Requires Improvement

Staff knew what incidents to report and how to report them. Staff raised concerns and reported incidents and near misses in line with the provider's policy. The provider's computer-based incident reporting system included the necessary prompts to guide staff through the reporting process. Incident reports were automatically sent to managers both within Cygnet Nield House, and to relevant staff within Cygnet Health Care.

Staff understood the duty of candour. Managers were open and transparent, and gave patients and families where relevant, an explanation if things went wrong. Patients and their families gave mixed feedback about the amount of feedback they had received. Patients told us they were not debriefed after incidents, but the incident may be discussed with them by staff or in a multidisciplinary team meeting.

Managers did not always debrief staff after any serious incident. Staff gave us mixed feedback about the use of debriefing after incidents, and said that it did not always happen, and it depended on the severity of the incident.

Managers investigated incidents, and discussed the findings with patients and, where appropriate, their families. Patients and their families gave mixed feedback about how involved in they were in investigations.

Staff met to discuss the feedback and look at improvements to patient care. Incidents and learning from incidents was discussed at the morning handover meeting.

There was evidence that some changes had been made as a result of feedback. The provider had a lessons learned document that identified changes made in response to incidents. This included changes to the environment, to how staff did things, and to how information was documented. Information about incidents was shared through the regional governance meeting.

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

Good

We rated effective as good.

Assessment of needs and planning of care

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

Staff completed a comprehensive mental health assessment of each patient either on admission or soon after. Patients had their physical health assessed soon after admission and regularly reviewed during their time on the ward. A registered general nurse provided and supported staff with patients' physical healthcare

Staff developed a comprehensive care plan for each patient that met their mental and physical health needs. Care plans were individualised, but the level of detail varied, as did the recovery focus. For example, some care plans provided clear detailed information about how to work with a patient if they were agitated; but others contained more generic

information that was not tailored to the individual. It was not always easy to find the necessary information to provide safe and effective care for patients. Staff reviewed and updated care plans when patients' needs changed. Information about patient care was included in the daily handover information and daily risk assessment that was completed for all patients.

Best practice in treatment and care

Staff provided a range of treatment and care for patients based on national guidance and best practice. They ensured that patients had good access to physical healthcare and supported them to live healthier lives. Staff used recognised rating scales to assess and record severity and outcomes.

Staff provided a range of care and treatment suitable for the patients in the service. Compton ward was an acute inpatient mental health ward, and provided short-term care and treatment whilst liaising with the commissioning NHS trust to return the patient back to their home area – either to an inpatient bed or back to the community. Patients on Compton ward did not have access to psychology services. Doctors followed prescribing guidelines, which included monitoring and review, when prescribing medicines.

Staff identified patients' physical health needs and recorded them in their care plans. Staff made sure patients had access to physical health care, including specialists as required. Patients had access to a GP, even though the surgery was 20 miles away. The GP made their first visit to the hospital during the inspection. GP consultations had taken place remotely during the COVID pandemic.

Staff used recognised rating scales to assess and record the severity of patients' conditions and care and treatment outcomes. The occupational therapists used a range of tools including interest checklists and the model of human occupation screening tool.

Skilled staff to deliver care

The ward had access to the range of specialists required to meet the needs of patients on the wards. They supported staff with supervision and opportunities to update and further develop their skills. Managers provided an induction programme for new staff.

The service had a range of specialists to meet the needs of the patients. Compton ward had an occupational therapist and assistants. Staff told us the psychology team and dietitian from Clarion ward would offer support if required, but this was not a routine part of their role. Managers told us that most patients were on the ward for a short period time, and would access specialist support in their home areas if required. There were vacancies in the occupational therapy team, which had been covered by locums/temporary staff and were in the process of being recruited to. The vacancies had impacted on the provision of occupational therapy in the service. There was a vacancy for a unit-wide social worker.

Managers gave each new member of staff a full induction to the service before they started work. Staff confirmed that they had had an induction, which was a mixture of training and observation, depending on the role of staff. Staff had found the staff team supportive, but gave mixed feedback about the induction itself. Some staff were very positive, others felt it had been overwhelming or that they were just observing.

Cygnet Health Care had an annual appraisal system. Staff had not had an appraisal yet, as the appraisal cycle only started when staff had been employed for a year, and the service had been opened for less than this.

Doctors and allied health professionals had regular supervision and clinical professional development, both through the organisation and their own individual arrangements. Nursing staff and support workers had supervision every three months.

Multi-disciplinary and interagency teamwork

Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care. The ward teams had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation.

Staff made sure they shared clear information about patients and any changes in their care, including during handover meetings. Staff from the multidisciplinary team attended the daily morning handover meeting. This included nursing staff, doctors, occupational therapy, psychology and the dietitian. The meeting had an extensive standard agenda that included a review of risks, incidents and complaints; patient observations and any nasogastric feeds; staffing; highlighting and following up on any care events such as physical health checks; consents or reviews that were due; reporting to outside organisations such as the local authority safeguarding team and the Care Quality Commission; any other issues or events such as visitors, maintenance and COVID restrictions.

Staff held regular multidisciplinary meetings to discuss patients and improve their care. These were attended by members of the multidisciplinary team.

Staff had relationships with other services outside the organisation. This included a GP, and the local NHS acute hospital. Staff shared information about the progress of patients with the commissioning services.

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.

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. Staff had access to support and advice on implementing the Mental Health Act and its Code of Practice. Staff knew who their Mental Health Act administrators were and when to ask them for support. There was a Mental Health Act administrator onsite.

Patients had easy access to information about independent mental health advocacy. Information about how to contact the mental health advocate was on display.

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. The service had policies on how frequently a patient should have their rights explained to them.

Staff made sure patients could take section 17 leave (permission to leave the hospital) when this was agreed with the responsible clinician. Patients and staff told us that leave did not always happen if there were not enough staff. Leave had been restricted due to national guidance during the COVID pandemic.

Staff requested an opinion from a Second Opinion Appointed Doctor (SOAD) when they needed to. The hospital had a process for ensuring this happened when necessary. However, staff confirmed that patients on Compton ward were not usually subject to consent to treatment under the Mental Health Act, as they were not in the hospital for long enough.

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

Requires Improvement

Staff stored copies of patients' detention papers and associated records correctly, but staff could not always access them when needed. Staff had access to Mental Health Act documents on Clarion ward, but not all staff could access Mental Health Act documents on Compton ward. This was being addressed by the provider.

Managers and staff made sure the service applied the Mental Health Act correctly by completing audits and discussing the findings. The Mental Health Act administrator carried out an audit on Compton ward every month. An audit was carried out by a regional manager every six months.

Staff received and kept up-to-date with training on the Mental Health Act and the Mental Health Act Code of Practice and could describe the Code of Practice guiding principles. Staff told us they had received training on the Mental Health Act.

Good practice in applying the Mental Capacity Act

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

The provider monitored use of the Mental Capacity Act and the Deprivation of Liberty Safeguards. There had been no Deprivation of Liberty Safeguards applications made at the hospital.

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

Staff gave patients support to make specific decisions for themselves before deciding a patient did not have the capacity to do so. Staff assessed and recorded capacity to consent clearly each time a patient needed to make an important decision. Staff used the daily morning meeting to highlight any patients that needed a capacity assessment.

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.

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

Good

We rated caring as good.

Kindness, privacy, dignity, respect, compassion and support

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

Staff gave patients help, emotional support and advice when they needed it. Patients said staff treated them well and behaved kindly. Patients were generally positive about staff, but did not always feel they had enough input from members of the multidisciplinary team, or that they were involved in the decision making process about their care.

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

Requires Improvement

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

Staff followed policy to keep patient information confidential.

Patients went to the door of the medicines room for their medicines. There was limited opportunity for private discussion as the medicines room was adjacent to the main communal area.

Involvement in care

Staff did not always involve patients in care planning and risk assessment and did not always actively seek their feedback on the quality of care provided. They ensured that patients had easy access to independent advocates.

Involvement of patients

Staff introduced patients to the ward and the service as part of their admission.

Staff did not always involve patients in their care planning and risk assessments. Patients gave us mixed feedback about how involved they were in their care.

Patients could give feedback on the service and their treatment and staff supported them to do this. Patients knew how to make complaints and had access to the hospital director. There was a weekly community meeting that patients were encouraged to attend to give feedback about the service. There was a suggestion box on each of the wards. The provider (Cygnet Health Care) carried out annual patient and carer survey, but Cygnet Nield House had not been open long enough to be part of this.

Staff made sure patients could access advocacy services. An independent advocate visited the service each week, and their contact details were on display.

Involvement of families and carers

Staff did not always support, inform and involve families or carers. We received mixed feedback from families and carers about the responsive of the service. Some relatives had found them approachable and helpful, and others found it more difficult to get information. All patients had a communication plan, so that it was clear what information they agreed should be shared with others. There were no support groups for carers or family members. Patients were on Compton ward for a relatively short periods of time, and their main support was from their local area.

Families were not always able to give feedback on the service. The provider (Cygnet Health Care) carried out an annual patient and carer survey, but Cygnet Nield House had not been open long enough to be part of this. Families were able to raise concerns and complaints, and the provider took account of this.

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

Good

We rated responsive as good.

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

Requires Improvement

Access and discharge

Staff managed beds well, and a bed was available when needed. Discharge was rarely delayed for other than clinical reasons.

Bed management

Managers regularly reviewed the length of stay for patients to ensure they did not stay longer than they needed to. All patients on Compton ward were admitted under block contracts with specific NHS trusts. Staff were in regular contact with the trusts' bed management teams about the admission and discharge of patients. The average length of stay on Compton ward was two weeks, but some patients may be on the ward for very short periods and returned to a ward in an NHS hospital. If a patient required care on a psychiatric intensive care unit, this would be discussed with the commissioning trust.

Compton ward was an acute admission ward, so patients were often admitted at short notice and with a variable amount of information. Patients may be admitted during the night, but they were not discharged at night or very early in the morning. The decision to admit was made by the nurse in charge. This included at night and by agency nurses. The manager confirmed that the nurse could contact the manager on call, but there was no requirement for them to do so, and there was no way to ensure that the nurse had the necessary skills and confidence to make that assessment and decision.

Discharge and transfers of care

The service had had no delayed transfers of care in the past year. Managers monitored the number of delayed transfers of care.

On Compton ward, staff planned patients' discharge and worked with care managers and coordinators to make sure this went well. Staff supported patients when they were referred or transferred between services.

Facilities that promote comfort, dignity and privacy

Each patient had their own bedroom with an ensuite bathroom and could keep their personal belongings safe. There were limited quiet areas for privacy, other than patients own bedrooms. The food was of good quality and patients could make hot drinks, and had access to snacks with support from staff.

Each patient had their own bedroom with an ensuite bathroom. Patients had a secure place to store personal possessions.

Staff used a full range of rooms and equipment to support treatment and care. Each ward had a lounge with a television and a streaming service. The dining area on Compton ward did not have enough seats for all 15 patients to dine at once. Staff told us that patients did not all have to have at their meals at the same time. However, we observed that patients were queueing up for breakfast. Staff and patients told us that Compton ward felt very cramped when it was full, as there was limited communal space. There was an onsite hair salon which was in regular use, and accessible by both wards.

The service had quiet areas and a room where patients could meet with visitors in private. The visitors' room was next to the reception area and was used by both wards.

Patients could make phone calls in private. Most patients had their own mobile phones, which they could use on the wards. Some patients had restricted access to their phones, following an individual risk assessment. There was a payphone on the ward.

The service had an outside space that patients could access easily. The outdoor area was open during the day and into the evening, and was always supervised by staff.

Patients could make their own hot drinks, and access snacks with support from staff.

Patients' engagement with the wider community

Staff supported patients with activities outside the service where necessary, which included family relationships.

Patients were on Compton ward for a relatively short period of time, during an acute phase of their illness, and would usually return to their home or a hospital in their local area after discharge. As such it was not usually appropriate to engage them in community activities.

Patients and staff gave mixed feedback about their interest in the activities available, and if they always happened as planned. There was an activity programme available, for each ward and with individual sessions for patients. The occupational therapy team led on activities during the week, and support workers during the weekends.

Staff helped patients to stay in contact with families and carers. Most patients had their own mobile phone, and were able to keep in touch with their friends and relatives. Patients were supported to see their relatives, either through external visits or by relatives visiting the service. This had been limited due to COVID restrictions.

Meeting the needs of all people who use the service

Staff helped patients with communication, advocacy and cultural and spiritual support.

The service could not always support and make adjustments for disabled people and those with communication needs. A patient with mobility needs would be able to access the service, but they may need support from staff. The service was accessible by someone in a wheelchair as there was level access and a lift to the first floor. However, the corridors and doorways were narrow, and although the ensuite facilities were a level access 'wet room' they did not have rails or handles. Each ward had an "assisted bathroom" with a bath, but there were no rails/handles or hoists to support patients with mobility needs.

Staff made sure patients could access information on treatment, local services, their rights and how to complain. There was information on display about how to raise concerns.

The service had access to information leaflets available in languages spoken by the patients and local community. Managers made sure staff and patients could get help from interpreters or signers when needed. Staff told us information in other languages and interpreters were available if required.

The service provided a variety of food to meet the dietary and cultural needs of individual patients. Food was prepared onsite and taken to each ward to be served. They provided for special diets such as vegetarian or diabetic as required. Staff told us they could bring in food such as Kosher or Halal if needed. The service employed a dietitian who worked primarily with patients on Clarion ward, but could often support to Compton ward if necessary.

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.

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

Requires Improvement

Patients, relatives and carers knew how to complain or raise concerns. The service clearly displayed information about how to raise a concern in patient areas.

Managers investigated complaints and identified themes. The manager maintained a complaints log. This showed that the complaints process had been followed, timescales had been monitored, and it recorded whether each complaint had been upheld. It included the action that had been taken to address immediate issues, and any lessons learned. In the year to date, there had been 11 complaints across the unit. The outcomes were a mixture of upheld, partially upheld and not upheld, and all had been dealt with by local resolution. Not all complaints were investigated within the stated timescales. Patients received feedback from managers after the investigation into their complaint. Family members gave us mixed feedback about the service's responsiveness when they made a complaint. They felt that staff could have dealt with informal complaints easily, but they had had to be progressed to the hospital director before they were resolved.

Staff understood the policy on complaints. The service used compliments to learn, celebrate success and improve the quality of care. Information about compliments and complaints was shared in the daily morning meeting.

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

Requires Improvement

We rated well-led as requires improvement.

Leadership

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

The hospital director was an experienced manager and had been in post for six months. There was a head of care for each ward. These were recent appointments, and were booked onto leadership training courses, which included duty of candour and incident investigation. They were provided with additional supervision by the regional assistant director of nursing.

Vision and strategy

Staff knew and understood the provider's vision and values and how they were applied to the work of their team. Staff told us that these were reflected in the work they did with patients, and that the organisation's values are included as part of the service's appraisal structure.

Culture

Staff felt respected, supported and valued. They said that the provider promoted equality and diversity in daily work and provided opportunities for development and career progression. They could raise any concerns without fear of retribution.

Several managers and staff told us there had been a turnover of staff since the service opened at the end of September last year, but they felt this was to be expected as it was a new and developing service. Most staff were positive about the

service, and felt supported by their colleagues; they felt that although it could be very busy and staffing levels could be challenging, everyone worked together and supported one another. Staff told us they felt able to speak out about their concerns, and most staff said they found the managers approachable, and were aware of the freedom to speak up guardian.

The Cygnet Health Care staff survey was carried out in March/April 2021. The response rate for Cygnet Nield House was 79%. Most of the questions had more positive than negative responses. Staff made more negative responses with regards to not having enough staff.

Governance

Our findings from the other key questions demonstrated that governance processes did not always operate effectively at ward level and that performance and risk were not always managed well. These are identified elsewhere in the report. For example, there was not a robust process for monitoring and reporting on the impact of staff vacancies and the high use of bank and agency staff, the lack of specialist training; or ensuring staff who made decisions about admitting patients had the necessary knowledge and support. There was not always effective identification and management of risk, including communication of risk information to all staff including those who did not work their regularly. The service did not always effectively monitor the implementation of person centred and recovery focused care plans, and there were not robust processes for patients and their families to give meaningful feedback to inform the improvement and development of the service. There had been improvements, but systems and processes were not embedded.

The provider had a framework for information sharing and monitoring across the organisation which included Cygnet Nield House. At a local level there were daily handover meetings which included information about each patient, and broader information about the service such as any incidents, events or complaints. A daily risk meeting reviewed individual risk levels for each patient. Where actions were identified – either for individual patients or for the broader service – these were followed up at the next meeting. Monthly governance meetings reviewed information about the service, and fed into monthly regional meetings which shared and compared information across Cygnet Health Care's services. Information shared through the governance process included monthly audit plans, incident data, restrictive interventions, daily risk assessment trends, staffing and training, and complaints.

The provider had a programme of local and Cygnet national audits. The local audits were carried out locally, but reviewed and monitored nationally. The service found that the issues recently identified through both processes were consistent and that the local team was being provided with support from the regional governance team.

Management of risk, issues and performance

There were two risk registers, one for each ward, which managers updated regularly. However, the risk registers reviewed during the inspection were not reflective of all the risks or the actions underway to address these risks. For example, Compton ward had limited communal space for 15 patients, and the lounge and dining room could only hold up to 10 patients at a time. Clarion ward had a slightly different layout, but action was being taken to improve the layout which included a reduction in bed numbers. Neither the risk from potential overcrowding, nor the action that had/was being taken to address this was included on the risk register.

The service had contingency plans for dealing with emergencies. This included active plans for responding to the COVID pandemic.

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

Requires Improvement

Information management

Teams had access to the information they needed to provide safe and effective care and used that information to good effect. Patients' primary care record was digital, but this was supplemented by paper records for recording information such as observations and physical health checks. All permanent and bank staff had access to the Cygnet intranet where essential information was stored including policies, guidance and training. Agency staff were given temporary access to the system.

Managers had access to information to support them with their management role. This included information on the performance of the service, staffing and patient care.

Staff made notifications to external bodies as needed. This included the commissioners of patient care, the local authority safeguarding team and the Care Quality Commission.

Engagement

Patients and carers did not always have opportunities to give feedback on the service they received in a manner that reflected their individual needs. The provider (Cygnet Health Care) carried out an annual patient and carer survey, but Cygnet Nield House had not participated in the survey as they had not been open long enough to be part of this. There was no local forum or process for carers to provide feedback about Cygnet Nield House, that ensured this fed into the service in order to make improvements. Patients or family members were not provided with a feedback form on or after discharge.

Not all the relatives we spoke with felt they had enough information about the service, or that the information they had received reflected the care that was provided. Carers did not always find it easy to get information about their relatives, and did not have a main contact to speak with.

Learning, continuous improvement and innovation

Managers told us that as the hospital had only opened in September 2020, they were still working on developing and improving the service. Work was underway to improve areas that had been identified as needing to improve through the local and regional governance process. This included developing care plans and activity plans.

The service did not have a quality improvement programme. A quality improvement approach was being developed nationally by the provider (Cygnet Health Care).

Staff were not undertaking any research at the time of our inspection.

Requires Improvement

Personality disorder services

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

Are Personality disorder services safe?

Requires Improvement

We rated safe as requires improvement.

Safe and clean care environments

All wards were clean and well equipped, furnished, and maintained. The wards were designed and fitted to reduce the risks to patients, but the environmental risk assessments were not comprehensive.

Safety of the ward layout

Environmental risk assessments had been carried out of all ward areas, and some action had been taken to remove or mitigate risks. However, the assessments were not always comprehensive, and some risks were reliant on being managed by the vigilance and actions of staff. Where this was the case, it was not clear how this information was shared effectively with all staff, including temporary or agency workers. The service did not use observational zoning to mitigate risks.

All patients had their own single room with an ensuite toilet and shower.

Staff could not easily observe patients in all parts of the wards, but this had been partially mitigated by the use or mirrors. There was limited communal space on each of the wards in relation to the number of beds.

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

Maintenance, cleanliness and infection control

Ward areas were clean, well maintained and well furnished. The onsite maintenance staff ensured that all the necessary health and safety checks were completed, and that necessary maintenance and decoration was carried out. Staff made sure cleaning records were up-to-date and the premises were clean. Staff followed infection control policies, including handwashing. Staff had implemented COVID security measures during the outbreak, that reflected government guidance.

Clinic room and equipment

The clinic room was fully equipped. Staff checked equipment and ensured that it was maintained and cleaned regularly. There was one clinic/examination room on the acute ward (Compton ward) for both wards. Staff and patients on Clarion ward told us that they preferred to use rooms on their own ward. Clarion ward was undergoing refurbishment to create additional rooms, including its own clinic room.

Staff had access to resuscitation equipment and emergency medicines, which was checked regularly.

Safe staffing

The service had enough medical staff, but did not always have enough nursing staff who knew the patients and received basic training to keep people safe from avoidable harm.

Nursing staff

The service did not always have enough nursing and support staff. The service had nursing and support worker vacancies and used bank and agency staff to cover these gaps, particularly at night. The service had eight vacancies out of 17 nursing posts, with three in the pipeline. There were 17 vacancies for 48 support worker posts, with four in the pipeline. Managers told us that Cygnet Nield House was on the corporate priority list for recruitment of staff. Managers requested agency staff who were familiar with the service, but this had become increasingly difficult, which the service partly attributed to external factors such as changes to tax laws.

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. Staff told us that there were usually enough staff to keep people safe, but it may be difficult to facilitate one-to-one sessions with nursing staff or leave. This had also been impacted because of COVID restrictions. There was no clear information about when shifts were without enough staff. If staffing levels on the ward were short, staff from other areas – such as occupational therapy and managers – would cover the shortfall. These staff had been trained in the use of physical interventions. Most of the seven patients on Clarion ward were on one-to-one observations at the time of our inspection. Staff told us there were enough staff to provide the enhanced observations, but staff were swapped from one patient to another, and may not be able to have a break between observations or carry out other parts of their role on the ward.

Medical staff

The service had enough daytime and night time medical cover. Each ward had a consultant psychiatrist and a speciality doctor. Three of the doctors were locums, and one was seconded to the hospital three days per week from another Cygnet service. The service was in the process of recruiting to permanent posts.

A doctor was available to go to the ward quickly in an emergency. Cygnet's on call doctor covered the service out of hours.

Mandatory training

Staff had completed and kept up-to-date with most of their mandatory training. Across the unit the lowest training levels were at 65% for immediate life support training and for online safeguarding learning. Staff told us they had completed training about the Mental Health Act and for competency in nasogastric feeding, but the service did not supply this information. 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. The online training system provided managers and staff with information about training they had completed.

Managers monitored mandatory training and alerted staff when they needed to update their training. The online training system provided managers and staff with information about training they had completed. Managers and staff told us they had completed training on the Mental Health Act, and competencies for nasogastric feeding. However, this was not included in the list of training on the provider's training system.

Assessing and managing risk to patients and staff

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

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 a Short-Term Assessment of Risk and Treatability risk assessment tool for all patients, and risk was discussed in the daily risk assessment meeting. During this meeting, staff completed a daily risk assessment and gave a red/amber/green rating to a patient's risk level in areas such as self harm or risk to others.

Management of patient risk

Staff knew about any risks to each patient and acted to prevent or reduce risks. Staff identified and responded to any changes in risks to, or posed by, patients. This was discussed in the daily risk assessment meeting, and the need for reviews of risk or changes in care plans was identified. The daily handover meeting highlighted specific risks for patients, such as the need for sunscreen in warm weather (sensitivity to sun is a side effect of some medicines), or potential trigger points (such as specific dates or anniversaries). However, staff informed us, and we had been notified by the provider, of occasions when the risk assessment and care plans had not been followed and this may have or had resulted in actual self-harm. These incidents had been identified by the provider, and action taken.

Staff followed the service's policies and procedures when they needed to search patients or their bedrooms to keep them safe from harm. There were no blanket restrictions on searching patients, but where this was deemed necessary it was individually care planned.

Use of restrictive interventions

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.

The use of restraint was monitored through the service's clinical governance process. The provider carried out a quarterly review across each region which reviewed the use of restrictive interventions across its services. Managers used CCTV to review alleged incidents, and following some restraints. This enabled them to confirm that restraints were carried out correctly, and to bring in additional training or other action if required. In the previous quarter there had been 83 incidents of restraint on Clarion ward, and 60 of these were to facilitate nasogastric feeding.

Clarion ward had had all of its seven patients on one-to-one observations at some point during our inspection. This was routinely reviewed in the multidisciplinary team meetings, and in the daily risk assessment meeting. Patients had care plans that included the restrictions that were placed on them and the rationale.

Staff followed NICE guidance when using rapid tranquilisation. The use of rapid tranquilisation was recorded and monitored through the clinical governance meetings.

The hospital did not have a seclusion room, and did not use seclusion or long-term segregation. Some patients may be subject to quarantine in their rooms following admission due to COVID prevention measures.

Safeguarding

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

All staff were expected to complete basic training on how to recognise and report abuse, appropriate for their role. Sixty-five percent of staff were up-to-date with their safeguarding training. Staff knew how to make a safeguarding referral and who to inform if they had concerns. Managers maintained a safeguarding tracker, that included potential safeguarding concerns and the outcomes of investigations, and whether they were reported to the local authority safeguarding team. Most safeguarding concerns were related to self-harm or patient-to-patient incidents.

Staff followed clear procedures to keep children visiting the ward safe. There was a visiting room in the unit shared by both wards.

Staff access to essential information

Staff had easy access to clinical information and it was easy for them to maintain high quality clinical records. Patient notes were comprehensive and all staff could access them easily. Agency staff were provided with temporary access to the system. Although the service used a combination of electronic and paper records, staff made sure they were up-to-date and complete. Records were stored securely.

Medicines management

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

Staff followed systems and processes when safely prescribing, administering, recording and storing medicines. Staff stored and managed medicines and prescribing documents in line with the provider's policy. The ward had its own medicines room with secure storage. Each patient had a folder that included their prescription chart and related information. The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely. An external pharmacy supplied medicines to the service, provided advice, and carried out routine audits.

Staff reviewed the effects of each patient's medicines on their physical health according to NICE guidance. All patients had physical health observations take at admission, and as necessary afterwards. Staff used the National Early Warning System to record patients' observations. Staff were trained in phlebotomy and taking electrocardiograms, so regular monitoring was carried out onsite. High does antipsychotic therapy (antipsychotic medicines above recommended limits) was not prescribed regularly, but where this was the case patients were monitored in accordance with national guidance. When medicines such as clozapine and lithium was prescribed, this was increased gradually and patients monitored in accordance with national guidance.

Track record on safety

The service did not always have a good track record on safety. There had been serious incidents of harm to patients. The provider had responded to these and sharing information about potential risks with other services, but it was not always clear that this had been effective in preventing or reducing the risk of them reoccurring.

Requires Improvement

Personality disorder services

Reporting incidents and learning from when things go wrong

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. Staff raised concerns and reported incidents and near misses in line with the provider's policy. The provider's computer-based incident reporting system included the necessary prompts to guide staff through the reporting process. Incident reports were automatically sent to managers both within Cygnet Nield House, and to relevant staff within Cygnet Health Care.

Staff understood the duty of candour. Managers were open and transparent, and gave patients and families where relevant, an explanation if things went wrong. Patients and their families gave mixed feedback about the amount of feedback they had received. Patients told us they were not debriefed after incidents, but the incident may be discussed with them by staff or in a multidisciplinary team meeting.

Managers did not always debrief staff after any serious incident. Staff gave us mixed feedback about the use of debriefing after incidents, and said that it did not always happen, and it depended on the severity of the incident.

Managers investigated incidents thoroughly, and discussed the findings with patients and, where appropriate, their families. Patients and their families gave mixed feedback about how involved in they were in investigations.

Staff met to discuss the feedback and look at improvements to patient care. Incidents and learning from incidents was discussed at the morning handover meeting.

There was evidence that changes had been made as a result of feedback. The provider had a lessons learned document that identified changes made in response to incidents. This included changes to the environment, to how staff did things, and to how information was documented. Information about incidents was shared through the regional governance meeting.

Are Personality disorder services effective?

Good

We rated effective as good.

Assessment of needs and planning of care

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

Staff completed a comprehensive mental health assessment of each patient either on admission or soon after. Patients had their physical health assessed soon after admission and regularly reviewed during their time on the ward. A registered general nurse provided and supported staff with patients' physical healthcare

Staff developed a comprehensive care plan for each patient that met their mental and physical health needs. Care plans were individualised, but the level of detail varied, as did the recovery focus. For example, some care plans provided clear

detailed information about how to work with a patient if they were agitated; but others contained more generic information that was not tailored to the individual. It was not always easy to find the necessary information to provide safe and effective care for patients. Staff reviewed and updated care plans when patients' needs changed. Information about patient care was included in the daily handover information and daily risk assessment that was completed for all patients.

Patients on Clarion ward had detailed plans about their nutritional needs. Patients who were or may have nasogastric feeds, including under restraint, had detailed plans about how this should be implemented safely and effectively, and with consideration of the patient. The plans were developed by the dietitian and the medical team.

Best practice in treatment and care

Staff provided a range of treatment and care for patients based on national guidance and best practice. They ensured that patients had good access to physical healthcare and supported them to live healthier lives. Staff used recognised rating scales to assess and record severity and outcomes.

Staff delivered care in line with best practice and national guidance. The medical and psychology staff were clear about the model of care for patients on Clarion ward. They emphasised that the focus was on each patient's personality disorder, whilst taking account of their disordered eating. The psychology team offered a range of psychological therapies, depending on the patient' phase of treatment. Nursing and support staff had not all had training in working with this patient group, but they had access to a psychology-led reflective practice group. Staff were familiar with strategies for working with patients to manage self-harm.

Staff identified patients' physical health needs and recorded them in their care plans. Staff made sure patients had access to physical health care, including specialists as required. Patients had access to a GP, even though the surgery was 20 miles away. The GP made their first visit to the hospital during the inspection. GP consultations had taken place remotely during the COVID pandemic.

Staff met patients' dietary needs, and assessed those needing specialist care for nutrition and hydration. A dietitian was employed on Clarion ward to work with patients with disordered eating. Staff confirmed that there was currently no NICE guidance for working with this condition, but they used elements of NICE guidance for working with people with a personality disorder and an eating disorder. The dietitian provided training in the guidelines for 'management of really sick patients with anorexia nervosa', which were a resource for working with patients with disordered eating.

Staff used recognised rating scales to assess and record the severity of patients' conditions and care and treatment outcomes. The occupational therapists used a range of tools including interest checklists, the model of human occupation screening tool, and the eating and meal preparation skills assessment.

Skilled staff to deliver care

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

The service had a range of specialists to meet the needs of the patients on the ward. This included a dietitian, occupational therapists and assistants, and psychologists and assistants. There were vacancies in the psychology and occupational therapy teams, which had been covered by locums/temporary staff and were in the process of being recruited to. The vacancies had impacted on the provision of occupational therapy and psychology, but the service had continued to be provided. There was a vacancy for a social worker.

Managers gave each new member of staff a full induction to the service before they started work. Staff confirmed that they had had an induction, which was a mixture of training and observation, depending on the role of staff. Staff had found the staff team supportive, but gave mixed feedback about the induction itself. Some staff were very positive, others felt it had been overwhelming or that they were just observing.

Cygnet Health Care had an annual appraisal system. Staff had not an appraisal yet, as the appraisal cycle only started when staff had been employed for a year, and the service had been opened for less than this.

Doctors and allied health professionals had regular supervision and clinical professional development, both through the organisation and their own individual arrangements. Nursing staff and support workers had supervision every three months.

Managers did not always make sure staff received any specialist training for their role. Some staff on Clarion ward told us they had received training in working with people with a personality disorder and/or eating disorder, but this was not consistent. The psychology team provided weekly reflective practice and training sessions. Staff told us they had completed training for competency in nasogastric feeding, and care plans and discussion with staff supported this. Managers did not provide information about the training and skills expected from staff, and how this was implemented.

Multi-disciplinary and interagency teamwork

Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care. The ward teams had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation.

Staff made sure they shared clear information about patients and any changes in their care, including during handover meetings. Staff from the multidisciplinary team attended the daily morning handover meeting. This included nursing staff, doctors, occupational therapy, psychology and the dietitian. The meeting had an extensive standard agenda that included a review of risks, incidents and complaints; patient observations and any nasogastric feeds; staffing; highlighting and following up on any care events such as physical health checks; consents or reviews that were due; reporting to outside organisations such as the local authority safeguarding team and the Care Quality Commission; any other issues or events such as visitors, maintenance and COVID restrictions.

Staff held regular multidisciplinary meetings to discuss patients and improve their care. These were attended by members of the multidisciplinary team.

Staff had relationships with other services outside the organisation. This included a GP, and the local NHS acute hospital. Staff shared information about the progress of patients with the commissioning services.

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.

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. Staff had access to support and advice on implementing the Mental Health Act and its Code of Practice. Staff knew who their Mental Health Act administrators were and when to ask them for support. There was a Mental Health Act administrator onsite.

Patients had easy access to information about independent mental health advocacy. Information about how to contact the mental health advocate was on display.

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. The service had policies on how frequently a patient should have their rights explained to them.

Staff made sure patients could take section 17 leave (permission to leave the hospital) when this was agreed with the responsible clinician. Patients and staff told us that leave did not always happen if there were not enough staff. Leave had been restricted due to national guidance during the COVID pandemic.

Staff requested an opinion from a Second Opinion Appointed Doctor (SOAD) when they needed to. Consent to treatment forms (for medicines under the Mental Health Act after three months) were completed appropriately, and stored with a capacity assessment with the prescription chart.

Staff stored copies of patients' detention papers and associated records correctly, but staff could not always access them when needed. Staff had access to Mental Health Act documents on Clarion ward.

Managers and staff made sure the service applied the Mental Health Act correctly by completing audits and discussing the findings. The Mental Health Act administrator carried out an audit on Clarion ward every six months. An audit was also carried out by a regional manager every six months.

Staff received and kept up-to-date with training on the Mental Health Act and the Mental Health Act Code of Practice and could describe the Code of Practice guiding principles. Staff told us they had received training on the Mental Health Act.

Good practice in applying the Mental Capacity Act

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

The provider monitored use of the Mental Capacity Act and the Deprivation of Liberty Safeguards. There had been no Deprivation of Liberty Safeguards applications made at the hospital.

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

Staff gave patients support to make specific decisions for themselves before deciding a patient did not have the capacity to do so. Staff assessed and recorded capacity to consent clearly each time a patient needed to make an important decision. Staff used the daily morning meeting to highlight any patients that needed a capacity assessment. On Clarion ward, a capacity assessment was carried out for all patients who may need nasogastric feeding.

Requires Improvement

Personality disorder services

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.

Are Personality disorder services caring?

Good

Kindness, privacy, dignity, respect, compassion and support

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

Staff gave patients help, emotional support and advice when they needed it. Patients said staff treated them well and behaved kindly. Patients were generally positive about staff, but did not always feel they had enough input from members of the multidisciplinary team, or that they were involved in the decision making process about their care.

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

Staff followed policy to keep patient information confidential.

Patients went to the door of the medicines room for their medicines. There was limited opportunity for private discussion as the medicines room was adjacent to the main communal area.

Involvement in care

Staff did not always involve patients in care planning and risk assessment and did not always actively seek their feedback on the quality of care provided. They ensured that patients had easy access to independent advocates.

Involvement of patients

Staff introduced patients to the ward and the service as part of their admission.

Staff did not always involve patients in their care planning and risk assessments. Patients gave us mixed feedback about how involved they were in their care.

Patients could give feedback on the service and their treatment and staff supported them to do this. Patients knew how to make complaints and had access to the hospital director. There was a weekly community meeting that patients were encouraged to attend to give feedback about the service. There was a suggestion box on each of the wards. The provider (Cygnet Health Care) carried out annual patient and carer survey, but Cygnet Nield House had not been open long enough to be part of this.

Staff made sure patients could access advocacy services. An independent advocate visited the service each week, and their contact details were on display.

Requires Improvement

Personality disorder services

Involvement of families and carers

Staff did not always support, inform and involve families or carers. We received mixed feedback from families and carers about the responsive of the service. Some relatives had found them approachable and helpful, and others found it more difficult to get information. All patients had a communication plan, so that it was clear what information they agreed should be shared with others. There were no support groups for carers or family members. Patients were typically on Clarion ward for over a year, but they and their relatives were from across the country.

Families were not always able to give feedback on the service. The provider (Cygnet Health Care) carried out an annual patient and carer survey, but Cygnet Nield House had not been open long enough to be part of this. Families were able to raise concerns and complaints, and the provider took account of this.

Are Personality disorder services responsive?

Good

We rated responsive as good.

Access and discharge

Staff managed beds well, and a bed was available when needed. Discharge was rarely delayed for other than clinical reasons.

Bed management

Managers regularly reviewed the length of stay for patients to ensure they did not stay longer than they needed to. However, as a new service the treatment pathway did not have an established length of stay. Clarion ward had up to eight patients at the time of our inspection. The ward had originally had 15 beds, but this was being reduced to 14 beds in order to create additional patient and office space on the ward. Admissions to the service had been staggered, and were currently on hold due to the high levels of enhanced observations and the refurbishment work being carried out.

All admissions were planned, and were scheduled so that patients were not admitted during the night or very early in the morning. A detailed assessment was carried out of patients before they were admitted to Clarion ward and discussed and agreed by the multidisciplinary team.

Discharge and transfers of care

The service had had no delayed transfers of care in the past year. Managers monitored the number of delayed transfers of care.

On Clarion ward, staff worked with commissioners to ensure patients care was reviewed regularly, and that this included discharge planning.

Facilities that promote comfort, dignity and privacy

Each patient had their own bedroom with an ensuite bathroom and could keep their personal belongings safe. There were limited quiet areas for privacy, other than patients own bedrooms. The food was of good quality and patients could make hot drinks and access to snacks with support from staff.

Each patient had their own bedroom with an ensuite bathroom. Patients could personalise their rooms, within individual risk assessments. Patients had a secure place to store personal possessions.

Staff used a full range of rooms and equipment to support treatment and care. Each ward had a lounge with a television and a streaming service. Clarion ward had limited communal space. The Ada Suite was used for nasogastric feeds, and was directly off the open dining area. Refurbishment was underway to reduce the number of beds on Clarion ward from 15 to 14, and to move the Ada Suite to a more private area of the ward. The refurbishment would also create a clinic room on Clarion Ward, which patients currently had to access on Compton ward. There was an onsite hair salon which was in regular use, and accessible by both wards.

The service had quiet areas and a room where patients could meet with visitors in private. The visitors' room was next to the reception area and was used by both wards.

Patients could make phone calls in private. Most patients had their own mobile phones, which they could use on the wards. Some patients had restricted access to their phones, following an individual risk assessment. There was a payphone on the ward.

The service had an outside space that patients could access easily. The outdoor area was open during the day and into the evening, and was always supervised by staff.

Patients had access to hot drinks and snacks with support from staff. This was restricted on Clarion ward due to individual risk assessment, and the risk of self-harm.

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 where possible. Staff told us that they were initiating a programme of activities and wanted to engage with the local colleges, but this had not been implemented yet. Some patients carried out work within the service, and had a therapeutic earning contract.

Patients and staff gave mixed feedback about their interest in the activities available, and if they always happened as planned. There was an activity programme available, for each ward and with individual sessions for patients. The occupational therapy team led on activities during the week, and support workers during the weekends. Activities on Clarion ward included yoga, pet therapy, and DBT skills led by the psychology team.

Staff helped patients to stay in contact with families and carers. Most patients had their own mobile phone, and were able to keep in touch with their friends and relatives. Patients were supported to see their relatives, either through external visits or by relatives visiting the service. This had been limited due to COVID restrictions.

Meeting the needs of all people who use the service

Staff helped patients with communication, advocacy and cultural and spiritual support.

The service could not always support and make adjustments for disabled people and those with communication needs. A patient with mobility needs would be able to access the service, but they may need support from staff. The service was accessible by someone in a wheelchair as there was level access and a lift to the first floor. However, the corridors and doorways were narrow, and although the ensuite facilities were a level access 'wet room' they did not have rails or handles. Each ward had an "assisted bathroom" with a bath, but there were no rails/handles or hoists to support patients with mobility needs.

Requires Improvement

Personality disorder services

Staff made sure patients could access information on treatment, local services, their rights and how to complain. There was information on display about how to raise concerns.

The service had access to information leaflets available in languages spoken by the patients and local community. Managers made sure staff and patients could get help from interpreters or signers when needed. Staff told us information in other languages and interpreters were available if required.

The service provided a variety of food to meet the dietary and cultural needs of individual patients. Food was prepared onsite and taken to each ward to be served. They provided for special diets such as vegetarian or diabetic as required. Staff told us they could bring in food such as Kosher or Halal if needed. The service employed a dietitian who worked with patients on Clarion ward.

Listening to and learning from concerns and complaints

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

Patients, relatives and carers knew how to complain or raise concerns. The service clearly displayed information about how to raise a concern in patient areas.

Managers investigated complaints and identified themes. The manager maintained a complaints log. This showed that the complaints process had been followed, timescales had been monitored, and it recorded whether each complaint had been upheld. It included the action that had been taken to address immediate issues, and any lessons learned. In the year to date, there had been 11 complaints across the unit. The outcomes were a mixture of upheld, partially upheld and not upheld, and all had been dealt with by local resolution. Not all complaints were investigated within the stated timescales. Patients received feedback from managers after the investigation into their complaint. Family members gave us mixed feedback about the service's responsiveness when they made a complaint. They felt that staff could have dealt with informal complaints easily, but they had had to be progressed to the hospital director before they were resolved.

Staff understood the policy on complaints. The service used compliments to learn, celebrate success and improve the quality of care. Information about compliments and complaints was shared in the daily morning meeting.

Are Personality disorder services well-led?

Requires Improvement

Leadership

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

The hospital director was an experienced manager and had been in post for six months. There was a head of care for each ward. These were recent appointments, and were booked onto leadership training courses, which included duty of candour and incident investigation. They were provided with additional supervision by the regional assistant director of nursing.

Requires Improvement

Personality disorder services

Vision and strategy

Staff knew and understood the provider's vision and values and how they were applied to the work of their team. Staff told us that these were reflected in the work they did with patients, and that the organisation's values are included as part of the service's appraisal structure.

Culture

Staff felt respected, supported and valued. They said that the provider promoted equality and diversity in daily work and provided opportunities for development and career progression. They could raise any concerns without fear of retribution.

Several managers and staff told us there had been a turnover of staff since the service opened at the end of September last year, but they felt this was to be expected as it was a new and developing service. Most staff were positive about the service, and felt supported by their colleagues; they felt that although it could be very busy and staffing levels could be challenging, everyone worked together and supported one another. Staff told us they felt able to speak out about their concerns, and most staff said they found the managers approachable, and were aware of the freedom to speak up guardian.

The Cygnet Health Care staff survey was carried out in March/April 2021. The response rate for Cygnet Nield House was 79%. Most of the questions had more positive than negative responses. Staff made more negative responses with regards to not having enough staff.

Governance

Our findings from the other key questions demonstrated that governance processes did not always operate effectively at ward level and that performance and risk were not always managed well. These are identified elsewhere in the report. For example, there was not a robust process for monitoring and reporting on the impact of staff vacancies and the high use of bank and agency staff, the lack of specialist training; or ensuring staff who made decisions about admitting patients had the necessary knowledge and support. There was not always effective identification and management of risk, including communication of risk information to all staff including those who did not work their regularly. The service did not always effectively monitor the implementation of person centred and recovery focused care plans, and there were not robust processes for patients and their families to give meaningful feedback to inform the improvement and development of the service. There had been improvements, but systems and processes were not embedded.

The provider had a framework for information sharing and monitoring across the organisation which included Cygnet Nield House. At a local level there were daily handover meetings included information about each patient, and broader information about the service such as any incidents, events or complaints. A daily risk meeting reviewed individual risk levels for each patient. Where actions were identified – either for individual patients or for the broader service – these were followed up at the next meeting. Monthly governance meetings reviewed information about the service, and fed into monthly regional meetings which shared and compared information across Cygnet Health Care's services. Information shared through the governance process included monthly audit plans, incident data, restrictive interventions, daily risk assessment trends, staffing and training, and complaints.

The provider had a programme of local and national audits. The local audits were carried out locally, but reviewed and monitored nationally. The service found that the issues recently identified through both processes were consistent and that the local team was being provided with support from the regional governance team.

Requires Improvement

Personality disorder services

Management of risk, issues and performance

There were two risk registers, one for each ward, which managers updated regularly. However, the risk registers reviewed during the inspection were not reflective of all the risks or the actions underway to address these risks. For example, Compton ward had limited communal space for 15 patients, and the lounge and dining room could only hold up to 10 patients at a time. Clarion ward had a slightly different layout, but action was being taken to improve the layout which included a reduction in bed numbers. Neither the risk from potential overcrowding, nor the action that had/was being taken to address this was included on the risk register.

The service had contingency plans for dealing with emergencies. This included active plans for responding to the COVID pandemic.

Information management

Teams had access to the information they needed to provide safe and effective care and used that information to good effect. Patients' primary care record was digital, but this was supplemented by paper records for recording information such as observations and physical health checks. All permanent and bank staff had access to the Cygnet intranet where essential information was stored including policies, guidance and training. Agency staff were given temporary access to the system.

Managers had access to information to support them with their management role. This included information on the performance of the service, staffing and patient care.

Staff made notifications to external bodies as needed. This included the commissioners of patient care, the local authority safeguarding team and the Care Quality Commission.

Engagement

Patients and carers did not always have opportunities to give feedback on the service they received in a manner that reflected their individual needs. The provider (Cygnet Health Care) carried out an annual patient and carer survey, but Cygnet Nield House had not participated in the survey as they had not been open long enough to be part of this. There was no local forum or process for carers to provide feedback about Cygnet Nield House, that ensured this fed into the service in order to make improvements. Patients or family members were not provided with a feedback form on or after discharge.

Not all the relatives we spoke with felt they had enough information about the service, or that the information they had received reflected the care that was provided. Carers did not always find it easy to get information about their relatives, and did not have a main contact to speak with.

Learning, continuous improvement and innovation

Managers told us that as the hospital had only opened in September 2020, they were still working on developing and improving the service. Work was underway to improve areas that had been identified as needing to improve through the local and regional governance process. This included developing care plans and activity plans.

The service did not have a quality improvement programme. A quality improvement approach was being developed nationally by the provider (Cygnet Health Care).

Staff were not undertaking any research at the time of our inspection.