Cygnet Hospital Stevenage

Quality Report

Graveley Road
Stevenage
Hertfordshire
SG1 4YS
Tel:01438 342942
Website: www.cygnethealth.co.uk

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

Ratings

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

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

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

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

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

Summary of findings

Overall summary

We rated Cygnet Hospital Stevenage as requires improvement because:

- Communal corridor areas throughout the hospital were not included in the ligature audit.
- We found out of date equipment and medication stored within the clinic room on Orchid ward and equipment that had not been calibrated.
- The emergency grab bag on Tiffany ward was not dated.
- The hospital had access to two seclusion rooms. One seclusion room had been damaged by a patient and was out of use at the time of inspection, leaving one seclusion room available. The available seclusion room toilet door was broken, meaning that if a patient was high risk and they needed to use the toilet, they would be required to use a disposable container.
- Staff were not consistently recording seclusion. Times and names of professionals conducting reviews were not always clear. It was unclear when multidisciplinary team reviews took place and who was involved.
- Physical health records were not consistently recorded across wards, we saw missing entries and boxes left unticked. Some entries were illegible. Patient physical health was not being monitored regularly on acute wards.
- Care plans on Orchid ward were not individualised or person centred and we saw three patients with the same care plan goal that had been copied and pasted.
- Management and clinical supervision was not being carried out regularly in line with the provider's supervision policy.
- The time allocated by the provider across the hospital for handover between staff shifts was insufficient at 15 minutes.
- Patients had delays in having their rights under the Mental Health Act 1983 explained to them.
- Patient's capacity to consent to treatment was not being routinely recorded.

However:

- Staff across the hospital were trained in safeguarding adults and knew how and when to contact the hospital safeguarding lead.
- Cygnet hospital Stevenage had a clear incident management process; incidents were investigated by managers and effectively fed back to both staff and patients.
- Patients told us ward activities were rarely cancelled and they had access to activities both on and off the ward.

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 	Requires improvement
Forensic inpatient/ secure wards	Requires improvement 	Requires improvement

Summary of findings

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Requires improvement

Cygnet Hospital Stevenage

Services we looked at

Acute wards for adults of working age; Forensic inpatient/secure wards;

Summary of this inspection

Background to Cygnet Hospital Stevenage

Cygnet Health Care was founded in 1988. Cygnet Health Care operates 21 centres across the UK. Two units are registered nursing homes providing long term and respite care and 19 provide inpatient mental health care.

Cygnet Hospital Stevenage opened in May 2006 and consists of six wards: two acute inpatient wards, two medium secure wards and two low secure wards.

Acute wards included Orchid ward, a 14 bedded female only ward and Chamberlain ward, a 14 bedded male only ward.

Acute wards at Cygnet hospital Stevenage were last inspected between 21 and 23 January 2015. We recommended that the provider:

- should ensure that all patients receive a care programme approach meeting where relevant
- should ensure that the time allocated for handover between staff shifts is reviewed
- should ensure that the reasons for non-involvement of patients in their care and treatment is clearly documented.

At the current inspection we noted that care programme approach meetings were being facilitated and patients' non-involvement in their care and treatment was being documented. However, the time allocated for handover between staff shifts had not been extended.

Forensic wards included Peplau ward, a 14 bedded male only medium secure ward, Pattison ward, a 14 bedded female only medium secure ward, Tiffany ward, a 15 bedded female only low secure ward and Saunders, a male only low secure 15 bedded ward.

Forensic wards at Cygnet hospital Stevenage were last inspected 21 - 23 January 2015. We recommended that the provider:

- must review their existing recording system for segregation, seclusion and complaints
- must ensure that every care plan is evaluated to reflect changes to assessed risk levels.

At the current inspection we noted that complaints were being dealt with robustly and care plans reflected patients risk levels. However, segregation and seclusion recording systems had not improved.

The service is registered to provide the regulated activities of treatment of disease, disorder or injury, and assessment or medical treatment for persons detained under the Mental Health Act 1983.

At the time of inspection Cygnet Hospital Stevenage did not have a registered manager; the provider was in the process of recruiting a registered manager.

Our inspection team

Team leader: Hannah Lilford

The inspection team that inspected Cygnet Hospital Stevenage included an inspection manager, four CQC inspectors, a Mental Health Act reviewer, a specialist advisor and an expert by experience.

The team would like to thank all those who met and spoke with the inspectors during the inspection for sharing their experiences and perceptions of the quality of care and treatment at the hospital.

Why we carried out this inspection

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

Summary of this inspection

How we carried out this inspection

Why we carried out this inspection

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

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

During the inspection visit, the inspection team:

- visited two acute wards and four forensic wards at the hospital, looked at the quality of the ward environment and observed how staff were caring for patients
- spoke with 26 patients
- spoke with the hospital manager and managers or acting managers for each of the wards
- spoke with 32 other staff members, including doctors, nurses, occupational therapist, psychologists and support workers
- attended and observed one hand-over meeting and a ward round
- collected feedback from 18 patients using comment cards
- spoke with three patients' carers
- looked at 55 medication charts
- looked at 35 patient care and treatment records
- carried out a specific check of the medication management on two wards and
- looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the service say

We received 18 comment cards from patients, 10 of which were positive about the care and treatment they received and eight of which were negative reviews of the service.

Negative comments included the poor cleanliness of Orchid ward, staff being too busy, side effects from medication and perceptions of excessive force being used during restraint.

We spoke with 26 patients. All patients were positive about staff. Patients told us staff were supportive, caring and respectful and that nursing staff are always visible around the ward. Patients told us they felt included in their care plan and risk assessment and said they had been offered a copy of their care plan. Nineteen patients told us they enjoyed the food options available and there were always different meal choices. All patients we spoke with said they felt their religious and spiritual needs were being met.

We spoke with three patients' carers. Carers told us that they had noticed an improvement in their family member since they had been at Cygnet Stevenage and they felt listened to and involved in the care of their family member.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Requires improvement

We rated safe as requires improvement because:

- We found out of date equipment and medication stored within the clinic room on Orchid ward. The pulse oximeter and blood glucose monitoring machines across all wards had not been calibrated.
- The hospital had access to two seclusion rooms. One seclusion room had been damaged by a patient and was out of use at the time of inspection, leaving one seclusion room available. The available seclusion room toilet door was broken. This meant if a patient was high risk and required the toilet, they would have to use disposable continence containers.
- Staff were not consistently recording seclusion. Times and names of professionals conducting reviews were not always clear. It was unclear when multi disciplinary team reviews took place and who was involved.
- Communal corridor areas throughout the hospital were not included in the ligature audit.

However:

- Patients told us they had regular one to one time with their named nurse.
- Patients told us ward activities were rarely cancelled and they had access to activities both on and off the ward.
- Staff across the hospital were trained in safeguarding adults and knew how and when to contact the hospital safeguarding lead.
- Cygnet Hospital Stevenage had a clear incident management process; incidents were investigated by managers who effectively fed back to both staff and patients.

Are services effective?

Requires improvement

We rated effective as requires improvement because:

- Management and clinical supervision was not being carried out regularly in line with the provider's supervision policy.
- Patients had delays in having their rights under the Mental Health Act 1983 explained to them.
- Patients' capacity to consent to treatment was not being routinely recorded.

Summary of this inspection

- Physical health records were not consistently recorded across wards; we saw gaps in entries and boxes left unticked. Some entries were illegible. Patient physical health was not being monitored regularly.
- Care plans on Orchid ward were not individualised or person centred and we saw three patients with the same care plan goal that had been copied and pasted. One care plan we saw had the incorrect patient's name throughout.
- The time allocated by the provider across the hospital for handover between staff shifts was insufficient at 15 minutes.

However:

- Comprehensive assessments were thorough and completed with patients within 24 hours of admission.
- Care plans on Chamberlain ward and forensic wards were holistic, thorough and person centred.
- Cygnet Hospital Stevenage offered a range of psychological interventions recommended by the National Institute for Health and Care Excellence (NICE). The psychology department provided a comprehensive treatment pathway and facilitated a weekly drop in for patients on each acute ward.

Are services caring?

Good

We rated caring as good because:

- Patients were made to feel welcome when they arrived at Cygnet Hospital Stevenage.
- Patients told us staff were polite to them, they felt cared for and well looked after. They said staff listened to them. We observed staff interacting with patients in a positive, kind, and respectful way.
- Staff knocked before entering patients' rooms, and spoke positively with patients. Staff were visible in the communal areas and attentive to the needs of the patients they cared for.
- Patients felt involved in their care and were offered a copy of their care plan.
- Carers we spoke with said they had seen improvements in their family member since they arrived at Cygnet hospital Stevenage and they felt staff were friendly and listened to them.

Are services responsive?

Good

We rated responsive as good because:

- The hospital had a full range of rooms and equipment to support treatment and care. This included quiet rooms, activity rooms, telephone rooms and clinic rooms on each ward and a large family visiting room for patient visits.

Summary of this inspection

- All wards had lounge and dining areas, activity rooms, quiet rooms, en-suite bedrooms and bathing facilities. There was a range of daily activities for patients to engage in.
- Patients told us they felt their spiritual and religious needs were being met.
- Cygnet Hospital Stevenage had a robust process for managing complaints.

However:

- Patients were unable to make their own drinks and asked staff for hot drinks and snacks.

Are services well-led?

Requires improvement

We rated well-led as requires improvement because:

- Both management and clinical supervision was not being carried out regularly in line with the provider's supervision policy.

However:

- The provider's staffing targets were being met daily.
- Staff said that morale had improved since the implementation of a new senior management team over the past 18 months. We saw team work and mutual support between staff members.
- Staff within Cygnet Hospital Stevenage had opportunities for leadership and development.
- Staff reported that senior managers attended the wards weekly to provide listening events.

Detailed findings from this inspection

Mental Health Act responsibilities

We do not rate responsibilities under the Mental Health Act 1983. We use our findings as a determiner in reaching an overall judgement about the Provider.

- Overall, 74% of staff working within Cygnet Hospital Stevenage had received Mental Health Act (MHA) training, this included a brief overview of the Mental Capacity Act (MCA).
- Mental Health Act administrators had access to legal advice in the event of a MHA query and had robust processes in place for reminding responsible clinicians of renewals and of monitoring and auditing processes.
- We reviewed four patients' Mental Health Act documents on acute wards. We saw delays in patients having their rights explained to them. One patient detained under section three did not have their rights explained until 10 days after detention and one patient detained under section two did not have their rights explained until six days after their detention. Another patient detained under section three had their rights explained five days after their detention. Staff judged the patient did not understand and planned to discuss again two days later. However, nothing further was recorded until 22 days after detention.
- Only one of the four patients whose records we reviewed on acute wards had access to section 17 leave. The expiry date on the section 17 leave authorisation was after the expiry date of the section under which the patient was detained.
- All four of the patients whose records we reviewed on acute wards were being treated under the Mental Health Act 1983 and were subject to the 3 month rule for treatment; only two of the four patients had assessments of capacity to consent to treatment.
- We reviewed 10 sets of MHA documents on forensic wards. Staff provided patients with mental health rights information on admission and information was re-presented at regular intervals in line with recommendations outlined in the Code of Practice.
- All treatment on forensic wards was given under appropriate legal authority. All prescribed medication was authorised on either a T2 (consent to treatment) form or a T3 (second opinion) form.
- Forensic ward staff showed us a form in place to record capacity and consent to treatment interviews. However, two of the forms on Peplau ward were incomplete. The responsible clinician had assessed the patients' capacity but had not made a statement about consent or action to be taken such as refer to second opinion appointed doctor (SOAD) or T2.
- Information about the independent mental health advocate (IMHA) was on display in all wards visited and patients were informed about the IMHA when their rights were explained.

Mental Capacity Act and Deprivation of Liberty Safeguards

- We were advised that formal MCA training would commence in October 2016. Staff told us that MCA training was briefly covered during Mental Health Act training.
- Staff had varying degrees of knowledge around MCA; some staff had only basic knowledge of the five statutory principles.
- Staff had recently been issued credit card sized booklets with MCA information to refer to, including the five statutory principles.
- A patient on Tiffany ward was being given medication covertly. There was no record in the patient's records of a capacity assessment or best interests meeting. The patient was being administered insulin under restraint with no separate record of a capacity assessment. Following discussion with the ward manager a safeguarding was completed to address the issues.

Detailed findings from this inspection

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	Requires improvement	Good	Good	Requires improvement	Requires improvement
Forensic inpatient/ secure wards	Requires improvement	Requires improvement	Good	Good	Requires improvement	Requires improvement
Overall	Requires improvement	Requires improvement	Good	Good	Requires improvement	Requires improvement

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

Requires improvement

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

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

Requires improvement

Safe and clean environment

- Some ward areas had poor line of sight in rooms and corridors. Staff mitigated this risk by using mirrors and increasing observation levels where necessary.
- Both Orchid ward and Chamberlain ward were visibly clean and tidy. However, the décor on Chamberlain ward was poor in places.
- Staff completed environmental risk assessments, including ligature audits. Ligature audits identify points where patients are able to tie something to if they intend to self-harm. Staff assessed patients' individual risks and had management plans in place to keep patients safe. The communal corridor areas were not included in the ligature audit.
- Both wards were same sex and therefore complied with eliminating mixed sex accommodation guidance.
- Both wards had clean and tidy clinic rooms. However, we found out of date medication and equipment stored within the clinic room on Orchid ward and the pulse oximeter and blood glucose monitoring machine had not been calibrated.
- The hospital had two seclusion rooms for patients. One seclusion room had been damaged by a patient and was out of use at the time of inspection, leaving one seclusion room available downstairs. There was no seclusion room within the ward. If a patient required seclusion they were taken down a communal corridor or the stairs to the seclusion room. The available seclusion room toilet door was broken, meaning that if a patient was high risk and required the use of the toilet, they would have to use disposable continence containers.
- Staff adhered to infection control principles. The service displayed hand washing posters at each sink within the service. Hand sanitizer was available in all areas, including the clinic room and reception area.
- Cleaning records were up to date and demonstrated that the environment was regularly cleaned.
- Staff had access to personal alarms which signalled on panels around the ward where an incident had taken place. Nurse call bells were present in all bedrooms.

Safe staffing

- Managers had estimated the numbers of staff required on each ward and ward managers told us that they were able to request additional staff if required. Cygnet hospital Stevenage had a contract in place with an external agency and had nursing staff working within the hospital on three month contracts.
- Orchid ward reported eight vacancies for qualified nurses and three vacancies for support workers. However, at the time of inspection five of the eight nursing posts and one support worker post had been filled and were awaiting start dates.
- Chamberlain ward reported five vacancies for qualified nurses and five vacancies for support workers. However, at the time of inspection three of the five nursing posts and three support worker posts had been filled and were awaiting start dates.

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

Requires improvement

- The average staff sickness between 31 December 2015 and 31 March 2016 was 15%on Chamberlain ward and seven per cent on Orchid ward. The provider had processes in place to manage staff sickness.
- Between January 2016 and June 2016, Cygnet Stevenage had an average of 3% turnover, which equated to 37 members of staff leaving the hospital within the six month period.
- Qualified nurses were present on both wards at all times.
- Patients told us they had regular one to one time with their named nurse.
- Patients told us ward activities were rarely cancelled and they had access to activities both on and off the ward. The provider did not retain figures for attendance at activities for acute wards.
- Support workers were carrying out weekly health care checks on patients.
- Medical emergency cover at the hospital was undertaken by a doctor on call rolling rota. A member of staff who was trained in immediate life support was available to call for urgent assistance and staff had a process in place to call emergency services.
- Staff were required to attend a variety of mandatory training courses. Overall, 92.5% of staff had completed equality and diversity training, 86.3% of staff had completed security awareness, 87% of staff had completed prevention and management of violence and aggression (PMVA) training and 83.1% of staff had completed cardio pulmonary resuscitation training. Overall, 85.7% of eligible staff had completed immediate life support training (ILS) which equated to 18 staff members.

Assessing and managing risk to patients and staff

- Between 1 November 2015 and 30 April 2016, Orchid ward had eight episodes of seclusion and Chamberlain ward had 17 episodes of seclusion.
- Between 1 November 2015 and 30 April 2016, Orchid ward had 46 episodes of restraint, nine of these resulted in rapid tranquilisation being used and none were recorded as prone restraint.
- Between 1 November 2015 and 30 April 2016, Chamberlain ward had 33 episodes of restraint, 22 of these were prone and 19 resulted in rapid tranquilisation being used.
- We examined 16 care records. All patients had an updated risk assessment located within their care records that had been completed within 24 hours of admission.
- Staff and patients told us that restraint was only used after de-escalation. Patients completed a debrief with staff after an episode of restraint.
- We looked at six records of rapid tranquilisation and noted that staff followed the Cygnet Health Care rapid tranquilisation policy.
- Staff were not consistently recording seclusion according to their policy. Times and names of professionals conducting reviews were not always clear. It was unclear when multidisciplinary team reviews took place and who was involved. The seclusion record for a patient on Orchid ward indicated the seclusion care plan had been reviewed but staff were unable to locate a care plan. However, the two records on Chamberlain ward included seclusion care plans which were individualised and met recommendations in the Code of Practice: Mental Health Act 1983. During one episode of seclusion on Chamberlain ward, a doctor did not attend within the first hour as required by the provider's seclusion policy and the Code of Practice: Mental Health Act 1983.
- Overall, 91% of staff across the hospital were trained in safeguarding adults. Staff knew how and when to contact the hospital safeguarding lead.
- Medicines were managed appropriately. Storage of medicines was appropriate and within temperature range and the visiting pharmacist carried out regular audits of medicines. Staff had access to records for controlled drugs and drugs liable for misuse. The hospital had an effective process to dispose of drugs.

Track record on safety

- Between February 2015 and February 2016, acute wards reported seven serious incidents. Two related to staff on patient allegations, one related to patient on patient allegations, one related to abuse and two related to

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

Requires improvement

deteriorating health of patients. Managers investigated incidents appropriately. This included sharing actions they had taken to minimise re-occurrence with staff. We saw this in incident records kept by the provider.

Reporting incidents and learning from when things go wrong

- Staff reported incidents using a paper reporting system. Managers of the service reviewed incidents and completed an investigation if required.
- Staff were able to describe incidents that would require reporting, such as violence, injury or aggression.
- Managers fed back learning from incidents and areas of good practice in team meetings, in the complaints and serious incidents requiring investigation review group and during the weekly reflective practice group. Staff reviewed closed circuit television footage of incidents and discussed areas of good practice and where practice could improve. Managers cascaded lessons learned to staff in a monthly newsletter.
- Managers offered staff a debrief after a serious incident.
- Staff debriefed with patients after an incident and placed a copy of the debrief minutes within the patients' care records.

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

(for example, treatment is effective)

Requires improvement

Assessment of needs and planning of care

- Comprehensive assessments were thorough and completed with patients within 24 hours of admission.
- We saw completed physical healthcare assessments on admission in nine of the 16 records we reviewed. Physical health records were not consistently recorded; we saw missing entries and boxes left unticked. Some entries were illegible. Five patients refused to have their physical health assessed on admission and one patient did not engage during the physical health assessment.
- We looked at six care plans on Chamberlain ward. Care plans were holistic and person centred and included staying healthy, stopping problem behaviours, mental health, drug and alcohol use and managing aggression. We looked at 10 care plans on Orchid ward. Care plans were not individualised or person centred and we saw three patients with the same care plan goal that had been copied and pasted. Overall nine care plans had been signed by patients.
- Cygnet Hospital Stevenage used a paper based recording system. Care records were stored securely in a lockable cabinet when not in use.

Best practice in treatment and care

- Medical staff were aware of, and complied with, the National Institute for Health and Care Excellence (NICE) guidelines regarding prescribing medication.
- Cygnet Hospital Stevenage offered a range of psychological interventions recommended by NICE, including cognitive analytic therapy, dialectical behaviour therapy, narrative therapy and schema therapy. The psychology department facilitated a weekly drop in for patients on each ward.
- Support workers were monitoring patients' physical healthcare weekly. However, the blood pressure machines on all wards had not been recalibrated to ensure accuracy.
- We saw evidence of clinical staff having used recognised outcome measures at the beginning and throughout patients' admissions such as Health of the Nation Outcome Scales (HoNOS). Psychology staff completed a violence risk assessment (HCR-20) with patients during their assessment.
- Clinical audits included medicines management, clinical notes audits, physical health audits, safeguarding, restrictive interventions, MHA audits and supervision audits. Staff from all disciplines participated in audits.

Skilled staff to deliver care

- There was a full range of staff to provide input to the wards including occupational therapists, psychologists, social workers, nursing staff and support workers.
- Cygnet Hospital Stevenage used agency staff, employed for three month periods to provide consistency for patients and staff.
- Staff told us they received an appropriate induction, this included agency staff. Overall, 100% of agency staff had completed the hospital induction.
- Between May 2016 and June 2016, 22% of staff on Chamberlain ward received one to one management

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

Requires improvement

and clinical supervision and 48% of staff on Orchid ward received one to one management and clinical supervision. However, all staff, including agency staff, were
offered the opportunity to attend weekly reflective practice groups on each ward to access group clinical supervision. Between April 2016 and June 2016, 15% of staff on Chamberlain ward attended reflective practice. Between February 2016 and April 2016 48% of staff on Orchid ward attended reflective practice. Staff told us that it was not always possible to attend the reflective practice due to staffing capacity. Nursing staff could attend a quarterly nursing practice development group.

- Overall, 67% of staff on Orchid ward had received an annual appraisal, which equated to eight out of 12 staff; the remaining four staff had a date booked in to have their appraisal completed.
- We saw evidence within supervision files that poor performance was being addressed effectively and saw evidence of staff being referred to occupational health.

Multi-disciplinary and inter-agency team work

- Acute wards held monthly team meetings. A daily handover was held for multi-disciplinary team staff.
- The time allocated by the provider across the hospital for handover between staff shifts was insufficient at 15 minutes. This meant that staff worked longer than their allocated shift time in order to ensure a comprehensive handover took place. During our previous inspection we recommended that handover times should be reviewed. Management advised us that handover times would be extended to 30 minutes from September 2016.
- Staff reported good working links with social services, GPs and other external organisations.

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

- Overall, 74.2% of staff working within Cygnet Stevenage had received Mental Health Act (MHA) training, which included a brief overview of the Mental Capacity Act (MCA).
- Mental Health Act administrators had access to legal advice in the event of a MHA query and had robust processes in place for reminding responsible clinicians of renewals and of monitoring and auditing processes.
- We reviewed four patients' Mental Health Act documents. We saw delays in patients having their rights explained to them. One patient detained on a section 3 did not have their rights explained until 10 days after detention and one patient on a section 2 did not have their rights explained until six days after their detention. One patient detained on section 3 had their rights explained five days after their detention. Staff judged the patient did not understand and planned to discuss again two days later. However, nothing further was recorded until 22 days after detention.
- Only one of the four patients we reviewed had access to section 17 leave. The expiry date on the section 17 leave authorisation was after the expiry date the patients section would have expired.
- All four patients we reviewed were being treated under the Mental Health Act 1983 and were subject to the three month rule for treatment; only two of the four patients had assessments of capacity to consent to treatment.
- Information about the independent mental health advocate (IMHA) was on display in all wards visited and patients were informed about the IMHA when their rights were explained.

Good practice in applying the Mental Capacity Act

- We were advised that formal MCA training would commence in October 2016.Staff told us that MCA training was briefly covered during Mental Health Act training.
- Staff had varying degrees of knowledge around MCA; some staff had only basic knowledge of the five statutory principles.
- Staff had recently been issued credit card sized booklets with MCA information to refer to, including the five statutory principles.

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

Good

Kindness, dignity, respect and support

- Patients we spoke with told us staff were polite to them, they felt cared for and well looked after. They said staff listened to them. We observed staff interacting with patients on all wards in a positive, kind, and respectful way.

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

Requires improvement

- We saw positive interactions between the staff and patients. Staff knocked before entering patients' rooms, and spoke positively with patients. Staff were visible in the communal areas and attentive to the needs of the patients they cared for.

The involvement of people in the care they receive

- Patients admitted to Orchid ward were given a welcome pack, which included ward details, a map of the ward, daily structure and information about spiritual and religious services. However, one patient told us they were taken directly to their room on arrival without being offered any food or a drink.
- Patients told us they felt involved in their care plans We looked at 16 care plans on acute wards and nine had been signed by patients. Overall, five patients we spoke with told us they had been given a copy of their care plan.
- We looked at 10 care plans on Orchid ward. Care plans were not individualised or person centred and we saw three patients with the same care plan goal that had been copied and pasted. Overall nine care plans had been signed by patients.
- We attended a ward round where we observed both patients and carers being involved in the patient's treatment.
- Notices and leaflets displayed in all ward areas gave patients information about advocacy services.
- Carers we spoke with said they had seen improvements in their family member since they arrived at Cygnet Hospital Stevenage and they felt staff were friendly and listened to them.However, carers said they were not allowed into patient's bedrooms, carers felt that it would be beneficial to help settle their family member into their bedrooms.
- We saw evidence of patients having given feedback on the service they receive. Each ward held weekly community meetings. During the meetings staff asked patients for feedback and improvement suggestions. Records of the meetings showed good attendance by patients, and that staff had followed through ideas.

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

Good

Access and discharge

- The average occupancy rate on Orchid ward between 1 November 2015 and 16 May 2016 was 87%; the average bed occupancy rate for Chamberlain ward for the same period was 87%.
- The average length of stay of patients discharged between 1 May 2015 and 30 April 2016 was 1.1 months for Chamberlain ward and 0.8 months for Orchid ward.
- Patients were admitted to the hospital within 24 hours of acceptance, dependent on travel time from their location. A visiting assessment would not be carried out for acute wards. Assessments were based on a review and admission would be arranged for as soon as the patient could be transferred.
- There were no reported delayed discharges of patients between 1 November 2015 and 16 May 2016.
- The hospital had clear assessment criteria, following on from an unsettled period on the wards when staff told us that unsuitable patients had been accepted due to discrepancies in the referral paperwork.
- The average occupancy rate on Orchid ward between 1 November 2015 and 16 May 2016 was 87%; the average bed occupancy rate for Chamberlain ward for the same period was 87%.
- The average length of stay of patients discharged between 1 May 2015 and 30 April 2016 was 1.1 months for Chamberlain ward and 0.8 months for Orchid ward.
- Patients were admitted to the hospital within 24 hours of acceptance, dependent on travel time from their location. A visiting assessment would not be carried out for acute wards. Assessments were based on a review and admission would be arranged for as soon as the patient could be transferred.
- There were no reported delayed discharges of patients between 1 November 2015 and 16 May 2016.
- The hospital had clear assessment criteria, following on from an unsettled period on the wards when staff told us that unsuitable patients had been accepted due to discrepancies in the referral paperwork.

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

Requires improvement

The facilities promote recovery, comfort, dignity and confidentiality

- The hospital had a full range of rooms and equipment to support treatment and care. This included quiet rooms, activity rooms and clinic rooms on each ward and a large family visiting room for patient visits.
- Wards had lounge and dining areas, activity rooms, quiet rooms, bedrooms and bathing facilities. En-suite single bedroom accommodation was available throughout wards.
- All wards had access to a phone in a quiet room; patients also had access to personal mobile phones.
- Wards had access to outside courtyard space; we saw patients playing badminton in the courtyard on Chamberlain ward. There was a working lift to a secure outside area for patients who used wheelchairs.
- Patient views on the quality of food differed Four patients we spoke with said they did not like the food; however 12 other patients said that it was nice, the portion size was large and there was a varied choice available.
- We looked in five patients' bedrooms, only one patient had personalised their bedroom with posters. Patients told us they were able to personalise their bedrooms if they wanted to.
- All bedrooms had a lockable safe. Patients we spoke with did not use their safe but said they felt their possessions were safe.
- Wards had a range of daily activities for patients to engage with, including art, drama, cooking sessions, relaxation and Zumba. Both wards had limited access to activities at weekends.

Meeting the needs of all people who use the service

- There was disabled access to the wards, and public areas.
- Ward areas of the hospital displayed information leaflets. Staff told us they could access these in other languages as required. The leaflets included treatments, patients' rights, and how to make a complaint.
- Staff told us that interpreters were available using an interpreting service.
- Patients had a range of meal choices, which included halal, vegetarian and healthier options. Patients told us if they did not like a meal choice staff would make them a sandwich or offer them an alternative.
- Patients told us they felt their spiritual and religious needs were being met. Patients could access spiritual support within the community when utilising section 17 leave, there was a multi faith room within the hospital and a faith box located in the quiet room on Chamberlain ward.

Listening to and learning from concerns and complaints

- Cygnet Hospital Stevenage had a robust process for managing complaints. Acute wards received 12 complaints between 18 May 2015 and 11 May 2016, four of which were upheld. All patients had received a letter acknowledging their complaint within 48 hours and all patients who complained had received a follow up letter detailing the outcome of their complaint. Upheld complaints related to lost or stolen property, complaints about other patients and a complaint about poor communication.
- We spoke with 17 patients, all patients said they knew how to make a complaint but had not made a complaint and could not comment on how they had found the process.
- Cygnet Hospital Stevenage acute wards received eight compliments since April 2016; prior to this compliments were not being logged. We saw a card from a patient thanking staff for their help and support.

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

Requires improvement

Vision and values

- Staff we spoke with were aware of the provider's visions and values. Staff had recently been issued credit card sized booklets which detailed referral criteria, visions and values and the safeguarding process.

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

Requires improvement

- Staff were aware of who the most senior managers in Cygnet Health Care were, but said that they had not visited the hospital. The senior management team from within Cygnet Hospital Stevenage visited the wards regularly.

Good governance

- Staff were required to attend a variety of mandatory training courses. Overall, 92% of staff had completed equality and diversity training, 86% of staff had completed security awareness, 87% of staff had completed prevention and management of violence and aggression (PMVA) training and 83% of staff had completed cardio-pulmonary resuscitation. Overall, 86% of eligible staff had completed immediate life support (ILS) which equated to 18 staff members.
- The provider combined management and clinical supervision. Between May 2016 and June 2016, 22% of staff on Chamberlain ward received one to one supervision and 48% of staff on Orchid ward received one to one supervision. However, all staff, including agency staff, were offered the opportunity to attend weekly reflective practice groups on each ward to access clinical supervision. Staff told us that it was not always possible to attend the reflective practice due to staffing capacity. Nursing staff could attend a quarterly nursing practice development group.
- We looked at staffing rotas and noted that the provider's staffing targets were being met daily. The hospital was using a high number of agency staff to cover shifts, to ensure that staffing did not impact on patient care the hospital arranged 25 short term contracts with agencies for three months at a time.
- Ward managers told us they had sufficient administrative support.

Leadership, morale and staff engagement

- Between January 2016 and June 2016, the hospital had an average of 3% staff leave, which equated to 37 members of staff within the six month period.
- The average staff sickness between 31 December 2015 and 31 March 2016 was 15% on Chamberlain ward and seven per cent on Orchid ward. The provider had processes in place to manage staff sickness.
- Managers told us they were not aware of any current bullying or harassment cases.
- Staff told us they were aware of the provider's whistleblowing policy and they felt comfortable raising any concerns to managers without fear of victimisation.
- Staff morale was good. Staff said that morale had improved since the implementation of a new senior management team over the past 18 months.
- We saw team work and mutual support between staff members when dealing with a patient who had become aggressive and verbally abusive on Chamberlain ward.
- Staff within Cygnet Hospital Stevenage had opportunities for leadership and development; staff we spoke with told us they had been promoted or knew colleagues who had received a temporary or permanent promotion.

Commitment to quality improvement and innovation

- Acute services were not taking part in any quality improvement or innovation.

Requires improvement

Forensic inpatient/secure wards

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

Are forensic inpatient/secure wards safe?

Requires improvement

Safe and clean environment

- Saunders ward had some areas with poor line of sight in rooms and corridors. Staff mitigated risk by using mirrors, CCTV and increasing observation levels where necessary.
- All wards were clean and tidy. However, the quiet room on Peplau ward had a number of activity related items stacked up on the table. This meant the room could not be used for its purpose. The furniture was torn in the TV lounge.
- All wards were designated same sex and therefore complied with eliminating mixed sex accommodation guidance.
- All wards had clean and tidy clinic rooms. On Tiffany ward the emergency grab bag had no expiry date and the bag valve mask was missing.
- Wards did not have access to a seclusion room within the ward. If a patient required seclusion they were taken down a communal corridor to the seclusion room. One seclusion room had been damaged by a patient and was out of use at the time of inspection, leaving one seclusion room available downstairs. There could be patients of different genders in the connecting seclusion rooms at any one time. However, the connecting door between the seclusion remained closed and a female patient told us when they were in seclusion they did not know who was in seclusion next door.
- Cleaning records were up to date and demonstrated that the environment was regularly cleaned.
- Staff had access to personal alarms which signalled on panels around the ward where an incident had taken place. Nurse call bells were present in all bedrooms.
- The service had two hours GP support per week. Staff told us that more was required to cover patient need.
- Patients told us they had regular one to one time with their named nurse.
- Patients told us ward activities were rarely cancelled and they had access to activities both on and off the ward.
- Staff across the hospital were trained in safeguarding adults and knew how and when to contact the hospital safeguarding lead.

Safe staffing

- Ward managers had estimated the number and grade of nurses required for each ward.
- Cygnet Hospital Stevenage had a contract with an outside agency and agency staff used were offered three month contracts.
- Ward managers were able to describe how they could access additional staff daily to take account of the patient case mix.
- Patients told us that there were enough staff so that individual sessions were rarely cancelled.
- Patients told us that nurses were visible on the wards.
- There was adequate medical cover day and night. The doctor was able to attend the ward within 30 minutes in an emergency.
- Overall, 92% of staff had completed equality and diversity training, 86% of staff had completed security awareness, 87% of staff had completed prevention and management of violence and aggression (PMVA) training and 83% of staff had completed CPR. Overall, 86% of eligible staff had completed immediate life support (ILS) which equated to 18 staff members.

Requires improvement

Forensic inpatient/secure wards

Assessing and managing risk to patients and staff

- Between 1 November 2015 and 30 April 2016, Peplau ward had 16 episodes of seclusion, Pattison ward had 16 episodes of seclusion, Tiffany ward had five episodes of seclusion and Saunders ward had one episode of seclusion.
- Between 1 November 2015 and 30 April 2016, Peplau ward had 13 episodes of restraint, five of these resulted in rapid tranquilisation being used and two were recorded as prone restraint.
- Between 1 November 2015 and 30 April 2016, Pattison ward had 25 episodes of restraint, three of these resulted in rapid tranquilisation being used and none were recorded as prone restraint.
- Between 1 November 2015 and 30 April 2016, Tiffany ward had 29 episodes of restraint, 12 of these resulted in rapid tranquilisation being used and 15 were recorded as prone restraint.
- Between 1 November 2015 and 30 April 2016, Saunders ward had eight episodes of restraint, four of these resulted in rapid tranquilisation being used and none were recorded as prone restraint.
- We viewed two sets of case notes which referred to a patient being given disposable urine bottles and bedpans whilst in seclusion. Staff told us this only happened if the door mechanism between the en-suite and the seclusion room was faulty but this was not the case in one of the recorded seclusion episodes.
- We examined 19 care records. All patients had an updated risk assessment located within their care records that had been completed within 24 hours of admission.
- Staff told us restraint was only used after de-escalation techniques have been utilised.
- Staff were not consistently recording seclusion according to their policy. Times and names of professionals conducting reviews were not always clear. It was unclear when multidisciplinary (MDT) reviews took place and who was involved.
- A patient from Peplau ward was secluded for 30 hours and was then relocated to their bedroom on 2:1 observations, with no record of who made this decision. A two hourly nursing review was recorded in the seclusion/long-term segregation book for the following 14 hours but this wasn't then crossed through as errors. The patient's continuation notes referred to "segregation commenced in bedroom," no record could be found of a MDT decision, a care plan or review.
- Staff did not consistently review episodes of seclusion and clearly note the times, decisions made and the names of the professionals recording such reviews.
- Overall, 91% of staff across the hospital were trained in safeguarding adults. Staff knew how and when to contact the hospital safeguarding lead.
- We reviewed 42 prescription charts for forensic wards. PRN medication (when required medication) was not consistently reviewed in 20 cases.

Track record on safety

- Between February 2015 and February 2016, forensic wards reported 18 serious incidents. Fourteen incidents related to patient on patient allegations, one related to abuse from family, three related to deteriorating health of patients. Managers investigated the incidents appropriately. This included sharing actions they had taken to minimise reoccurrence with staff. We saw this in incident records kept by the hospital.

Reporting incidents and learning from when things go wrong

- Cygnet Hospital Stevenage had a clear incident management process; Staff reported incidents using a paper reporting system. Managers of the service reviewed incidents and completed an investigation if required to do so.
- Ward managers told us about the type of incidents that would need to be reported giving examples of assaults, absconsions, serious illness, self-harm and maintenance.
- Managers fed back learning from incidents and areas of good practice in team meetings. Managers cascaded lessons learned to staff in a monthly newsletter.
- Senior staff or a clinical psychologist offered debrief sessions after a serious incident. We saw evidence of this following a recent incident.
- Staff debriefed with patients after an incident and located a copy of the debrief minutes within the patients' care records.

Are forensic inpatient/secure wards effective?

(for example, treatment is effective)

Requires improvement

Forensic inpatient/secure wards

Requires improvement

Assessment of needs and planning of care

- Patient risk assessments were thorough and completed with patients within 24 hours of admission. We saw completed physical healthcare assessments on admission for 18 of the 19 patient records we reviewed. We saw evidence of weekly vital signs monitoring for 18 patients.
- We looked at six care plans on Peplau ward and five care plans on Pattison ward. Care plans were up to date, personalised, holistic and recovery orientated. We looked at six care plans on Tiffany ward however there was evidence of a lack of involvement with one patient in developing the care plan.
- Patients told us that they were offered a copy of their care plan but most declined this.
- Cygnet Hospital Stevenage was using paper a paper based recording system. Care records were stored securely in a lockable cabinet when not in use.

Best practice in treatment and care

- Medical staff were aware of, and followed, the National Institute for Health and Care Excellence (NICE) guidelines regarding prescribing medication.
- Cygnet Hospital Stevenage offered a range of psychological interventions recommended by NICE, including cognitive analytic therapy and dialectical behaviour therapy.
- Clinical staff used recognised outcome measures at the beginning and throughout the patients' admission such as Health of the Nation Outcome Scales (HoNOS).
- Clinical audits included medicines management, clinical notes audits, physical health audits, safeguarding, restrictive interventions; Mental Health Act audits and supervision audits. Staff from all disciplines participated in audits.
- All treatment was given under appropriate legal authority, all prescribed medication was authorised on medication consent paperwork (T2 or T3).

Skilled staff to deliver care

- There was a full range of staff to provide input into the wards including occupational therapists, psychologists, social workers, nursing staff, social workers and support workers.
- Cygnet Hospital Stevenage used agency staff and employed them for three month periods to provide consistency for patients and staff.
- Staff received an appropriate induction, including all agency staff.
- Staff did not receive regular one to one supervision. However, all staff, including agency staff, were offered the opportunity to attend weekly reflective practice sessions on each ward to access clinical supervision. Attendance at the reflective practice sessions was poor with 56% attending on Pattison ward, 27% on Peplau ward and 17% on Saunders ward. No staff on Tiffany ward had attended reflective practice sessions.
- The provider combined management and clinical supervision. Between May 2016 and June 2016, 35% of staff on Peplau ward received one to one supervision. Forty-eight per cent of staff on Pattison ward, 49% of staff on Saunders ward and 32% of staff on Tiffany ward received one to one supervision during the same timescale.
- Overall, 100% of staff on Tiffany ward and Saunders ward had received a yearly appraisal.
- Cygnet Hospital Stevenage had robust checks in place for agency staff. All agency files showed that mandatory training had been completed and was in date. Risk assessments for Disclosure and Barring Service (DBS) had been completed and agency staff suitability to work within the hospital was decided by clinical managers.

Multi-disciplinary and inter-agency team work

- Regular and effective multi-disciplinary team meetings took place with representation from a range of disciplines.
- The time allocated by the provider across the hospital for handover between staff shifts was insufficient at 15 minutes. This meant that staff worked longer than their allocated shift time in order to ensure a comprehensive handover took place. At our previous inspection we recommended that handover times should be reviewed. Management advised us that handover times would be extended to 30 minutes from September 2016.
- Nursing staff reported good working links with social services, GPs and other organisations.

Requires improvement

Forensic inpatient/secure wards

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

- Overall, 74% of staff working at Cygnet Hospital Stevenage had received Mental Health Act (MHA) training, which included a brief overview of the Mental Capacity Act (MCA).
- We reviewed 10 sets of MHA documents. This included original section papers and hospital orders, transfers, renewal documents, section 132 rights, section 17 leave forms, and treatment certificates (T2 & T3 & section 62 forms). We reviewed seven seclusion records.
- Patients were provided with information on their legal rights at admission and the information was re-presented at regular intervals in line with recommendations in the MHA Code of Practice.
- All prescribed medication was authorised on either a T2 or T3, following best practice guidelines.
- We saw a form in place to record capacity and consent to treatment interviews. However, two of the forms on Peplau were incomplete. The responsible clinician had assessed the patient's capacity but had not made a statement in the patient's record about consent; nor had the responsible clinician recorded what action was to be taken as a result, such as, refer to second opinion appointed doctor (SOAD) or T2.
- Mental Health Act administrators had access to legal advice in the event of a MHA query and had effective processes in place for reminding responsible clinicians of renewals and of monitoring and auditing processes.
- Information about the independent mental health advocate (IMHA) was on display in all wards visited and patients were informed about the IMHA when their rights were explained.
- Staff and patients confirmed that the IMHA was regularly visible on the ward and staff were aware of the range of input that the IMHA could provide.

Good practice in applying the MCA

- We were advised that formal MCA training would commence in October 2016.Staff told us that MCA training was briefly covered during Mental Health Act training.
- Staff had varying degrees of knowledge around MCA, some staff had minimal knowledge however all staff had been given prompt cards on the Mental Capacity Act.
- A patient on Tiffany ward was being given medication covertly, staff were unable to find any record of a capacity assessment or best interests meeting. Insulin was being administered under restraint with no separate record of a capacity assessment. Following discussion with the ward manager a safeguarding was completed to address these issues.

Are forensic inpatient/secure wards caring?

Good

Kindness, dignity, respect and support

- Patients told us that they were made to feel welcome when they arrived at Cygnet Hospital Stevenage.
- We observed that staff were visible in communal areas and responded to patients in a respectful way.
- Staff knocked on bedroom and bathroom doors before entering and sought permission for the inspection team to view patients' bedrooms.

The involvement of people in the care they receive

- Patients admitted to Peplau ward were given a welcome pack detailing ward facilities, daily structure, staff roles and other useful information. Patients on Pattison and Saunders ward said that they had been given information when they were admitted. Tiffany ward operated a buddy system to support the orientation of newly admitted patients.
- Patients told us they felt involved in their care plans. We looked at 17 care plans; nine had been signed by patients. Five patients we spoke with told us they had been given a copy of their care plan.
- IMHA leaflets were clearly displayed on all of the wards that we visited; patients and staff knew when the IMHA visited the ward.
- Patients told us that with their permission, carers could be involved in their care at Cygnet Hospital Stevenage.
- Weekly community meetings were held on Peplau, Tiffany, Pattison and Saunders ward. However, patients on Peplau ward said that issues raised were not always dealt with by staff.
- One patient was able to explain how they had given feedback on the service using an iPad provided by the hospital.

Are forensic inpatient/secure wards responsive to people's needs?

Requires improvement

Forensic inpatient/secure wards

(for example, to feedback?)

Good

Access and discharge

- Between 1 November 2015and16 May 2016 bed occupancy was 86% on Tiffany ward, 86.7% on Saunders ward, 93% on Pattison ward and 78% on Peplau ward.
- The average length of stay of patients discharged between 1 May 2015 and 30 April 2016 was 18 months for Saunders ward, nine months for Tiffany ward, nine months for Peplau ward and 16 months for Pattison ward.
- Timescales for patients on forensic wards being admitted to the hospital were dependent on where the patient was admitted from, if a bed was available straight away and if Ministry of Justice approval was needed.
- Between 1 November 2015 and 16 May 2016 there was one delayed discharge on Peplau ward and two delayed discharges on Tiffany ward due to complex patient presentation and a waiting list for a bed to become available at an appropriate placement.
- The hospital had clear assessment criteria. This had been developed after unsettled period on Tiffany ward when staff told us that unsuitable patients had been accepted due to discrepancies in the referral paperwork.

The facilities promote recovery, comfort, dignity and confidentiality

- The hospital had a full range of rooms and equipment to support care and treatment. This included quiet rooms, activity rooms and clinic rooms on each ward and a large family visiting room for patient visits.
- Wards had lounge and dining areas, bedrooms all had en suite bathrooms and a there was a bathroom with a bath on each ward.
- All wards had access to a payphone; some patients also had access to personal mobile phones following individual risk assessment.
- Wards had access to outside courtyard space, patients accessed this for fresh air and smoke breaks. There was a working lift to a secure outside area for patients who used wheelchairs. Patients' views on the quality of food differed; four patients we spoke with said they did not like the food; however eight other patients said that food was nice and there was a varied range of choices available.
- Patients on all four wards were unable to make their own drinks and had to ask staff for hot drinks and snacks. All wards provided access to a water cooler or drinking water from a tap in the lounge area.
- Patients told us they were able to personalise their bedrooms if they wanted to, we saw evidence of this on Tiffany and Pattison ward.
- All patient bedrooms had a lockable safe. Patients told us that they did not use the safe but said they felt their possessions were safe.
- Wards had a range of daily activities for patients to engage with, including art; pamper sessions, cooking sessions, swimming, outdoor activities at a farm and Zumba. All wards had limited access to activities at weekends however patients could access the gym and church.

Meeting the needs of all people who use the service

- There was disabled access to the wards, and public areas. We saw evidence of a bedroom hoist and staff told us that the flooring had been changed in the bedroom of a patient requiring disabled access on Tiffany ward.
- Information leaflets were displayed on notice boards on all of the wards. Staff told us they could access these in other languages as required. The leaflets included treatments available, patients' rights and how to make a complaint.
- Staff on Tiffany ward told us that they accessed an interpreter for a patient to attend key meetings and discuss medication and physical health checks.
- Patients were given a choice of meal options including a halal option, vegetarian option and healthy eating option.
- Patients told us they could access church while on leave. A pastor regularly attended the wards. There was a multi faith room within the hospital.
- Staff said that they were accessing a female Imam for one of the patients on Tiffany ward.

Listening to and learning from concerns and complaints

- Cygnet Hospital Stevenage forensic wards received 45 complaints between 18 May 2015 and 11 May 2016, nine

Requires improvement

Forensic inpatient/secure wards

of which were upheld. Upheld complaints related to poor communication, lack of staff knowledge on the policy for payments relating to home visits and medication stocks not being replenished.

- We spoke with 12 patients; all patients said they knew how to make a complaint and four said that they had done so. One patient told us they had felt listened to and another said that they had been visited by hospital managers to discuss their concerns.
- Cygnet Hospital Stevenage had a robust process for managing complaints. We looked at a sample of 12 complaints from across the hospital, all patients had received a letter acknowledging their complaint within 48 hours and all patients who complained had received a follow up letter detailing the outcome of their complaint.
- Cygnet Hospital Stevenage forensic wards had not received any formal compliments since April 2016.Prior to this compliments were not being logged. However we saw several cards from patients thanking staff for their help and support.

Are forensic inpatient/secure wards well-led?

Requires improvement

Vision and values

- Staff on forensic wards knew and agreed with the provider's vision and values and were able to tell us what they were.
- We saw evidence of team working and team objectives were linked to the provider's values and objectives. This was reflected in staff appraisals.
- Staff told us the most senior managers in the hospital visited the wards weekly at night to hold listening events.

Good governance

- Training records showed that for mandatory training refreshers doctors had a compliance rate of 53%, psychology staff had a compliance rate of 88%, Occupational Therapy staff had a compliance rate of 87% and social workers had a compliance rate of 83%.
- Records showed that one to one management and clinical supervision on the forensic wards was sporadic and was provided for 56% of nursing staff on Pattison ward, 32% on Tiffany ward, 27% on Peplau ward and 18% on Saunders ward. Weekly group reflective practice sessions were provided for staff, however attendance was low. Some ward managers said that they did not have the time to provide regular one to one supervision.
- Ward managers told us that they could access additional staff depending on the patient mix. We saw evidence of this in the ward rota and noted that the provider's staffing targets were being met daily. Cygnet Hospital Stevenage was using a high number of agency staff to cover shifts. To ensure that staffing did not impact on patient care, the hospital had arranged 25 short term contracts with agencies for three months at a time.
- Ward staff said that they had a morning meeting each day to plan tasks and activities. We saw evidence of this during the inspection.
- Ward managers told us that they could submit items to the risk register where appropriate.
- One senior staff member told us that key performance indicators they used linked in with Commissioning for Quality and Innovation (CQUIN) targets payments framework.
- All forensic ward managers told us that they had sufficient authority and they could access admin support as required.

Leadership, morale and staff engagement

- The average staff sickness between 31 December 2015 and 31 March 2016 was 1% on Peplau ward, 5% on Tiffany ward, 12% on Pattison ward and 3% on Saunders ward. The hospital had processes in place to manage staff sickness.
- Managers told us they were not aware of any current bullying or harassment cases.
- Staff told us they were aware of the provider's whistleblowing policy and they felt comfortable raising any concerns to managers without fear of victimisation.
- Staff morale within forensic services was good. Staff said that morale had improved since the implementation of a new senior management team over the past 18 months.
- Staff told us about team work and mutual support between staff members when dealing with a patient who had become aggressive and assaulted a staff member on Peplau ward.

Requires improvement

Forensic inpatient/secure wards

- Staff within Cygnet Hospital Stevenage had opportunities for leadership and development, staff we spoke with told us they had been promoted on a permanent or temporary basis.

Commitment to quality improvement and innovation

- Cygnet Hospital participated in the Quality Network for Forensic Mental Health Services. The network seeks to promote quality improvements through the sharing of good practice in low and medium secure mental health services.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that staff receive monthly supervision in line with Cygnet Health Care policy.
- The provider must ensure that all medical devices are checked and serviced on a regular basis.
- The provider must ensure that all emergency grab bags on forensic wards have an expiry date and regular checks are recorded.
- The provider must ensure that care plans are holistic, individualised and person centred.
- The provider must ensure seclusion is carried out in line with the Mental Health Act Code of Practice.
- The provider must ensure that ligature risk assessments include communal areas used by patients.

Action the provider SHOULD take to improve

- The provider should consider their process for managing a medical emergency.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care Care plans on Orchid ward were not individualised or person centred and we saw three patients with the same care plan goal that looked as though it had been copied and pasted. **This was a breach of regulation 9 (3) (b)**

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The provider did not consistently review episodes of seclusion and clearly note the times, decisions made and the names of the professionals recording such reviews. The pulse oximeter and blood glucose monitoring machine had not been re-calibrated. We found out of date medication and equipment located in the clinic room on Orchid ward. The emergency grab bag on Tiffany ward had no expiry date and the bag valve mask was missing. Communal areas and corridors used by patients were not included in the ligature risk assessment. **This was a breach of regulation 12 (2) (a) (b) (f) (g)**

Regulated activity	Regulation

This section is primarily information for the provider

Requirement notices

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

Treatment of disease, disorder or injury

Regulation 18 HSCA (RA) Regulations 2014 Staffing

Not all staff received supervision on a regular basis.

This was a breach of 18 (2) (a)