Cygnet Hospital Bury

Quality Report

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

Ratings

Overall rating for this location	**Requires improvement**
Are services safe?	**Requires improvement**
Are services effective?	**Inadequate**
Are services caring?	**Good**
Are services responsive?	**Requires improvement**
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 Bury as requires improvement because:

- Staff did not always meet the requirements of the Mental Health Act and its Code of Practice. There were occasions where staff submitted requests for second opinion appointed doctors late. The seclusion policy did not comply with the Mental Health Act Code of Practice. Staff sometimes did not keep correct records of seclusion or end seclusion as soon as patients were settled. The provider had not ensured that staff had undertaken training on the revised version of the Mental Health Act Code of Practice, published 2015.
- Staff did not follow best practice with respect to Mental Capacity. The Mental Capacity Act policy did not comply with the Mental Health Act Code of Practice. The provider had not ensured that all staff had undertaken mandatory training in the Mental Capacity Act and specific capacity frameworks for children and patients including Gillick Competence. Staff had a limited understanding of the Deprivation of Liberty Safeguards; one patient was detained without following the requirements under the Court of Protection to apply for a Deprivation of Liberty. The provider did not have a policy in relation to the Deprivation of Liberty Safeguards.
- Patients care and treatment did not reflect current evidence based guidance. There was not always enough skilled staff to communicate effectively with patients who were deaf. Not all staff working within the wards for deaf patients had received the appropriate level of training in British Sign Language. Staff working with patients with a personality disorder or a learning disability had not received training in this area. Outcome measures were not being used to monitor the progress of patients within the adult services. This meant that it was difficult to capture the progress patients had made. The provider was not considering the impact of patients stopping or reducing smoking on their medication. The provider did not ensure that a patient assessed as needing aids and adaptations for a physical health condition in June 2015 had received the assessed equipment. Within the secure and rehabilitation services, the activities were not focused on rehabilitation. For patients with a learning disability, the care plans were not accessible and meaningful to patients.
- Patients did not have their privacy and dignity protected whilst using the toilet and shower facilities within the seclusion rooms where the facilities were all in one room and there were no mitigation plans in place regarding protecting patient's privacy and dignity.
- Within the secure services, there were examples of overly restrictive practices including the stages approach in the female services and searching within the rehabilitation service.
- Policies did not reflect current legislation and guidance. The safeguarding policy did not include requirements under the Care Act 2014.
- The hospital was not following their policies and procedures. This included the absent without leave policy, recruitment and selection policy and reviews of patients after they had been administered rapid tranquilisation policy. Not all staff were receiving supervision and appraisals as per hospital policy.
- Staff knowledge of duty of candour and how it applied to them was variable within the service.
- The governance structure did not ensure that where incidents had occurred, lessons learnt had been shared across adult and child and adolescent services within the hospital and actions following serious incidents had been completed. Learning from incidents was not routinely shared at a team level.

However:

- Risk assessments and risk management plans were detailed and in place in all the care records, we reviewed.
- The child and adolescent services had made significant progress in reducing their restrictive practices since our last inspection in January 2016.
- Staff had a good knowledge of safeguarding, could identify what constituted a safeguarding concern and how to respond.

Summary of findings

- There was a well-established physical health care team who provided regular and effective monitoring of patients' physical well-being throughout their inpatient admission.
- Weekly community meetings took place on the wards for patients to provide feedback. The majority of patients were involved in the creation of their care plans and received a copy of their care plan if they wished.
- We observed positive, caring interactions between staff and patients. Patients reported staff were caring and supportive.
- Staff felt supported by their managers and advised the senior managers were visible.
- Following the appointment of a complaints officer, the complaints policy was being followed and complaints were being resolved in a timely manner.

Summary of findings

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Cygnet Hospital Bury

Services we looked at

Forensic inpatient/secure wards; Long stay / rehabilitation wards for working age adults; Child and adolescent mental health wards.

Summary of this inspection

Background to Cygnet Hospital Bury

Cygnet Hospital Bury is an independent mental health hospital with 164 beds. The hospital became part of Cygnet in August 2015. Funding is primarily from NHS England specialist commissioners. There is a registered manager and a controlled drugs accountable officer in post.

The hospital is registered to provide the following regulated activities:

treatment of disease, disorder or injury;

nursing care;

diagnostic and screening procedures;

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

The registered manager had recently submitted an application to remove the regulated activity nursing care as this is included within other regulated activities.

The hospital specialises in forensic services for people with mental health needs including those who are deaf. In addition, it provides inpatient care for young people aged 11 to 18 who require urgent hospital admission due to their mental health needs. The hospital has one locked rehabilitation ward for nine women; our findings from the inspection of this ward are included in the forensic report.

The hospital has 15 wards, nine forensic wards, five child and adolescent mental health wards and one locked rehabilitation ward. We inspected all 15 wards:

- Blueberry ward, eight beds mixed, psychiatric intensive care unit for children and adolescents
- Buttercup ward, eight beds mixed, psychiatric intensive care unit for children and adolescents
- Mulberry ward, eight beds mixed, psychiatric intensive care unit for children and adolescents
- Primrose ward, eight beds for females, psychiatric intensive care unit for children and adolescents
- Wizard House, 10 beds mixed, general child and adolescent ward
- South Hampton ward, nine beds for women, locked rehabilitation
- Lower West Side, 13 beds for deaf and hearing women, low secure
- Bridge Hampton ward, 12 beds for deaf men who have a learning disability, low secure
- West Hampton ward, 10 beds for deaf men, low secure
- East Hampton ward, 13 beds for men, low secure
- Upper East ward, 13 beds for men, low secure
- Lower East ward, 13 beds for men, medium secure
- Upper West side, 13 beds for deaf and hearing women, medium secure
- Madison ward, 13 beds for men with personality disorders, medium secure
- Columbus ward, 13 beds for men with personality disorders, medium secure.

The hospital had a focused unannounced inspection in February 2015 due to concerns raised regarding the hospital. We issued four requirement notices:

- One requirement notice was in relation to staff failing to complete physical health checks on patients when rapid tranquillisation had been administered. This requirement notice was achieved when we inspected unannounced in January 2016.
- The second requirement notice was in relation to the seclusion rooms and the facilities being fit for purpose. When we inspected in May 2016, two of the eight seclusion rooms had works completed on them to have separate toilet and shower facilities to protect people's privacy and dignity. Work was being completed on the other rooms during the inspection.
- The third requirement notice was in relation to the hospital completing risk assessments for staff recruited with a conviction. The hospital had introduced a risk assessment process, however it was not being followed effectively. We have issued a warning notice in relation to good governance.
- The fourth requirement notice was in relation to governance, ensuring the structure and systems in place provided safe, effective care. We observed positive progress with the new governance structure in place, with a number of meetings taking place and feeding into the senior management level. However, the system in place to ensure actions set from serious incident investigations were achieved was in its

Summary of this inspection

infancy. A review of an action plan following an incident from October 2015 had not been fully achieved. The flow of information and understanding was evident from board to ward manager's level. Staff on the wards were not always aware of changes within the hospital and their role in relation to the duty of candour. This was a continued breach and we have issued a warning notice in relation to governance.

The hospital had a second focused, unannounced inspection in January 2016. This focused on the child and adolescent services and was in response to concerns raised and the increase in incidents including serious incidents. We only looked at the safe domain. We were assured patients were safe. However, we issued two requirement notices:

- The first requirement notice was in relation to seclusion, the hospital did not have a system in place to ensure patients could use the shower and toilet in private, no mitigation was in place. The actions were not due to be completed until 31 May 2016.
- The second requirement notice was in relation to the seclusion and observation policies not complying with the Mental Health Act 1983 Code of Practice. We reviewed the policies at inspection in May 2016, the observation policy was compliant with the Code of Practice. However, the seclusion policy was not. We also found the Mental Capacity Act policy did not comply with the Mental Health Act 1983 Code of Practice and the hospital did not have a policy in relation to Deprivation of Liberty Safeguards. We have issued a warning notice in relation to governance.

Our inspection team

Team leader: Sarah Heaton, inspector.

The team that inspected the service comprised two inspection managers, five inspectors, an assistant inspector, a Mental Health Act reviewer, four nurses, an occupational therapist, a pharmacist inspector, two consultant psychiatrists, a psychiatric trainee and a clinical psychologist. All team members had experience of child and adolescent services, forensic services or governance.

Due to the size of the hospital the team split into four teams, each with a sub team leader, one team focused on child and adolescent services, one on low secure and rehabilitation, one on medium secure and one on governance.

Why we carried out this inspection

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

How we carried out this inspection

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

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

Before the inspection visit, we reviewed information that we held about the location, asked a range of other organisations including commissioners for information and sent comment boxes and comments cards to the hospital.

During the inspection visit, the inspection team:

- received a presentation from the hospital regarding the progress made and areas for improvement;

Summary of this inspection

- visited all 15 wards at the hospital, looked at the quality of the ward environment and observed how staff were caring for patients;
- spoke with 69 patients who were using the service and collected feedback from 76 completed comment cards;
- spoke with five carers of patients using the service;
- spoke with the registered manager, general manager, clinical manager and clinical quality and compliance manager;
- spoke to ward managers or acting managers for each of the wards;
- spoke with 63 other staff members; including discipline leads, medical director, clinical services managers, doctors, nurses and support workers;
- received feedback about the service from five care co-ordinators or commissioners;
- received feedback from two independent advocates;
- attended and observed 11 meetings including a morning meeting, ward rounds, handovers and activity meetings;
- looked at 82 care and treatment records of patients;
- reviewed 112 prescription cards;
- 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 76 completed comments cards and spoke to 69 patients during the inspection. Feedback was variable.

Positives included that patients were happy in the hospital; staff had improved on responding to incidents in a timely manner; staff were caring and patients felt they had progressed since their admission to hospital; patients were positive about support provided by staff to facilitate home visits; patients felt the hospital was clean and safe.

Areas for improvement were that some staff were not approachable and supportive. Patients said they found it difficult when staff changed frequently as they had limited consistency. Some patients felt wards were overly restrictive, particularly on the low secure wards. Activities were an area of concern, including staff cancelling activities or not having staff support to attend activities and activities not focusing on rehabilitation and daily living skills.

Within the child and adolescent services, patients reported that the environment was difficult when patients are encouraged to all stay within the communal lounge.

Patients felt staff would benefit from additional training in how best to support them.

A few patients felt the hospital could improve the food, including more variety as they found it repetitive.

Being on a mixed ward for hearing and deaf patients was difficult for some in relation to communication.

Access to outside space was an area of concern for some patients as was access to psychological therapies.

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.

Since the inspection in January 2016, the provider had reviewed their seclusion policy and observation policy. The observation policy was compliant with the Mental Health Act 1983 Code of Practice. However, the seclusion policy was not and we noted a number of anomalies, omissions and contradictions within the policy.

We had some concerns about the recording of seclusion across the service. We found that staff did not record the reasons for termination of seclusion, monitoring just appeared to cease on some wards. There were examples of seclusion continuing for longer than necessary, according to the reviews of mental state of patients, which noted the patients were settled. Staff were not always conducting the reviews in a timely manner. We found two examples of medical reviews conducted for a deaf patient in seclusion without an interpreter. We were also concerned that a young person's segregation from the main ward population on Wizard House was recorded as longer-term segregation but did not adhere to the procedural safeguards of the Code of Practice or the provider's own policy. The rationale for and short-term nature of the segregation better met the definition of seclusion, but the patient was not reviewed in accordance with the seclusion policy.

The provider called seclusion care plans management plans and did not contain information about the steps that should be taken in order to end the need for seclusion as quickly as possible, any reference to patient involvement or details of the support that will be provided when the seclusion ends. Management plans did however contain a comprehensive reintegration plan to support the patient's transition back to the ward.

We found that detention papers including section 19 transfer orders and section 20 renewals were present in the patient's files. This was not the case on Wizard ward although staff rectified this during our visit. However, we also noted that detention documents did not always include a copy of the approved mental health professional report.

The provider ensured that detained patients were given information about their legal status and rights on admission in accordance with section 132. However, we found that there could be a delay in providing patients with information about their rights. We also found that where patients had not understood their rights after a few initial attempts, staff would not re-present them for another three months. We were concerned that this left patients without crucial information about their legal status and right of appeal. (Madison, Columbus, Bridgehampton). There was an independent mental health advocacy service available to all patients and this included a gender specific advocacy service for the female patients and a specialist deaf advocacy service for the deaf patients.

We saw that documentation relating to the authorisation of section 17 leave was well completed. There was evidence that staff completed risk assessments before leave was authorised. We found that leave was granted on an individual basis according to need and stage of recovery. We noted that leave was granted for a 12-month period on Bridge Hampton but were informed that this was kept under review by the multidisciplinary team. However, the outcome of leave was not always recorded and where it was recorded it did not include the patient's own view in the sample we checked.

In relation to section 58, we found that with few exceptions, prescribed medication was authorised by a form T2 or T3. However, we were concerned about the inconsistent recording of the responsible clinician's assessment of a patient's capacity to consent to treatment. For example, we found only two capacity assessments for patients on Bridgehampton whose treatment was authorised by a T3. We were also concerned about patients whose medication was authorised under section 62 emergency treatment provisions and the amount of time that elapsed between completing the certificate and requesting a second opinion appointed doctor.

We were concerned about the capacity of the Mental Health Act team to manage the workload following the appointment of the Mental Health Act manager to a

corporate position. We heard that the team was under significant strain and they expressed concerns about the auditing and reviewing of the operation of the Mental Health Act on the wards. The provider had developed new tracking tools to support the senior administrator to manage this. The Mental Health Act team was now line managed within the general management structure and not by managers who were experts in mental health law. Nor did the Mental Health Act team have direct access to legal support.

Staff attended Mental Health Act training as part of their induction when they first joined the hospital, however staff had not received training on the Mental Health Act Code of Practice, published in 2015.

Mental Capacity Act and Deprivation of Liberty Safeguards

The hospital had a Mental Capacity Act policy called accessing capacity, dated February 2014, due for review February 2016. The policy was not compliant with required elements of the Mental Health Act Code of Practice, 2015; it also referenced the Care Standards Act 2000, which has been superseded by the Health and Social Care Act 2008.

The hospital did not have a policy on Deprivation of Liberty safeguards. One young person aged 17 had been discharged from their section of the Mental Health Act. The hospital had not understood the Deprivation of Liberty safeguards process and had applied to their local authority; the provider should have submitted the application to the Court of Protection as Deprivation of Liberty safeguards only usually applies from the age of 18. There was one week where the young person was detained without appropriate safeguards in place, as they did not have the capacity to consent to their admission and the Deprivation of Liberty safeguards application was not submitted until a week after the section had ended. We raised this with the hospital. They have now submitted the application to the court of protection, have sought legal advice and provided assurances that the young person has regular contact with the Independent Mental Capacity Advocate and the service had created their care plan in conjunction with family, the advocate and multidisciplinary team.

The hospital completed a draft Mental Capacity Act policy in the week following the inspection.

Staff did not receive detailed training on the Mental Capacity Act; the provider reported it was included in the Mental Health Act training; however, the course content did not contain any information about the Mental Capacity Act.

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Forensic inpatient/ secure wards	Requires improvement	Inadequate	Good	Requires improvement	Requires improvement	Requires improvement
Child and adolescent mental health wards	Requires improvement	Requires improvement	Good	Good	Requires improvement	Requires improvement
Overall	Requires improvement	Inadequate	Good	Requires improvement	Requires improvement	Requires improvement

Requires improvement

Forensic inpatient/secure wards

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

Summary of findings

We rated safe as requires improvement because:

- Blanket restrictions in place were not always justified. This included the staged approach to observation levels where bedroom access was restricted for up to nine and a half hours per day on female wards. There was overly restrictive practice on the rehabilitation ward, in terms of searching patients. We did not find evidence that the service were assessing any of this on an individual basis.
- Staff had not correctly followed the absent without leave policy on two occasions on Columbus ward.
- On Lower West side, some staff were wearing long false nails. This meant that there was a risk of staff not being able to properly wash their hands following patient contact. This also presented a potential risk during physical intervention situations where long nails could scratch or cut patients or other staff.
- The low secure service had recently moved to a system where there was only one qualified member of staff on each ward per shift. Staff told us, at weekends, this meant that qualified staff sometimes did not get a break or that ward managers on call were covering breaks. This also meant that there was not always a qualified nurse in the communal areas of the wards for example when qualified staff were carrying out the medication round or giving handover.
- The provider had recently updated the seclusion policy; however, it was not compliant with the Mental Health Act 1983 Code of Practice.
- Although following serious incidents action plans were created, not all actions were completed. This included the adaptation of training. The provider did not disseminate the action plans to all staff and therefore learning from incidents was not consistent at ward level. This meant that there was potential for similar incidents to continue occurring.
- The provider did not ensure that a patient assessed as needing aids and adaptations for a physical health condition in June 2015 received the assessed equipment at the time of inspection.
- The hospital was not following their policy in relation to duty of candour, the written records were not in place in relation to the events where the duty of candour applied and there was no evidence of staff providing an apology. Staff on the wards were not fully aware of what the duty of candour was and how it applied to them.

However:

- There was good environmental security in place such as fences, anti-climb measures and air lock doors.
- The facilities for patient activities were appropriate to meet the needs of the patients. There were suitable rooms for patients to meet with family members including children.
- The wards were clean, tidy and well maintained.

Requires improvement

Forensic inpatient/secure wards

- Risk assessments were completed to a high standard and clearly indicated patient risk and formulation plans for these risks.

We rated effective as inadequate because:

- The staff did not have the specialist training or skills to work with the complex groups of patients. Staff did not receive training in learning disability, Bridge Hampton ward supports patients who are deaf and have a learning disability. Several patients had a diagnosis of personality disorder and two wards were specifically for people with a personality disorder, only 15% of staff had received training in personality disorder, therefore staff would not have the skills to effectively support this group of patients. On the wards for deaf patients most staff were only trained to level one or two British Sign Language. This meant that staff did not always have the specialised communication skills and had to use interpreters for discussions around mental health needs.
- Patients care and treatment did not reflect current evidence based guidance. There was variable access to psychological therapies across the wards. With some wards receiving little or none. Following stop smoking programme, patients on antipsychotics in particular olanzapine and clozapine were not having regular blood tests to monitor the effects stopping smoking may have on medication levels. Patients were not always receiving 25 hours a week of meaningful activities as recommended by NHS England. This meant that patients were not reaching their potential for recovery and rehabilitation in a timely way.
- On Bridge Hampton, a ward for patients who are deaf and have a learning disability. None of the care plans contained information on how best to communicate with patients. Care plans were not written in an accessible format for patients.
- Although the service were using outcome measures, it was not clear how they were being used to inform planning of care. This meant that it was difficult to capture the progress patients had made.
- The wards did not have access to administration support. This meant that at times qualified staff were doing administration tasks such as filing when staff could have been spending this time on direct patient care.
- Supervision was not always provided in line with the provider's policy.
- Staff failed to follow the Mental Health Act Code of Practice. There could be a delay in providing patients with information about their rights. Responsible clinicians were not recording assessment of a patient's capacity to consent to treatment consistently. Staff had not received training on the Mental Health Act Code of Practice, published in 2015.
- Arrangements in the hospital were not effective in ensuring that consent to care and treatment was obtained in line with the Mental Capacity Act. Staff did not receive training on the Mental Capacity Act. The hospital had a Mental Capacity Act policy called accessing capacity. The policy was not compliant with the Mental Health Act Code of Practice, 2015. There was no policy for Deprivation of Liberty Safeguards in place for the provider at the time of our inspection. The hospital completed a draft Mental Capacity Act policy including Deprivation of Liberty Safeguards in the week following the inspection.

However:

- The service provided physical healthcare clinics, and staff monitored patients' physical healthcare.
- Care plans were up to date, holistic and showed physical health care screening on admission. This meant that nurses had the relevant information needed to care for patients.
- Independent Mental Health Advocates also visited all the wards once a week to support patients detained under the Mental Health Act.

We rated caring as good because:

- We observed positive interactions between patients and staff that were respectful and staff respected patient's privacy.
- Positive comments from patients included that patients were happy in the hospital; staff had

Requires improvement

Forensic inpatient/secure wards

improved on responding to incidents in a timely manner. Staff were caring and patients felt they had progressed since their admission to hospital. Patients were positive about support provided by staff to facilitate home visits. Patients felt the hospital was clean and safe.

- Staff provided patients with copies of their care plans and other information. This meant that patients were involved in their care.
- There were regular community meetings where patients could give their views and feedback areas of improvement or developments in the service.
- Family and carers were kept informed of patient's care when patients had consented to this. Family and carers were invited to review meetings.
- Patients who were moving from a medium to a low secure ward were able to look around the ward before moving in order to familiarise themselves with the environment, staff and patients.

However:

- Some patient responses about staff and the service were negative. We received 65 comment cards, 44 were negative in relation to staff attitudes, not being approachable and not being supportive. Staff changes were difficult for some patients, with limited consistency, which may have an impact on progress. Some patients felt wards were overly restrictive, particularly on the low secure wards.
- Staff did not always record the outcome of leave and where it was recorded, it did not include the patient's own view.

We rated responsive as requires improvement because:

- We found that on all wards there was a lack of meaningful activity for patients that had a therapeutic value.
- The provider had a target to provide all patients in forensic services with 25 hours of meaningful activities per week. We found that although patients generally achieved this the activities listed were not meaningful or therapeutic.
- On the rehabilitation ward (South Hampton), we found that the activities provided were not recovery focused.
- Patients care plans on Bridge Hampton ward (which was a ward for deaf males who had a learning disability) were not in a format that the patients would be able to understand.
- Interpreters on deaf wards were only routinely available Monday to Friday 9am to 5pm. This meant that there were times when patients did not have access to someone who could effectively communicate important matters to them.
- On Lower West ward and South Hampton wards, the patient telephone was in a communal area with only a privacy hood surrounding it. This was not sufficient to stop others overhearing private conversations.
- Ward managers and clinical services managers we interviewed had a variable understanding of resolving complaints locally, some managing local systems without inputting the complaint or concern onto the electronic incident reporting system. Staff had not received training in managing complaints.

However:

- Patients had access to facilities to make themselves a hot drink or snack when they wanted one.
- Care plans had been created in DVD format for deaf patients.
- Patients were able to personalise their bedrooms with personal items from home and items they had made in groups within the hospital.
- There was a range of rooms available for patients to use including activity rooms, quiet rooms and communal areas.

We rated well led as requires improvement because:

- The hospital had not acted upon all previous concerns raised by CQC at earlier inspections.
- The hospital had a number of policies that were out of date, including the safeguarding policy, which did not refer to the Care Act 2014.

Requires improvement

Forensic inpatient/secure wards

- The hospital had not been routinely sharing learning from incidents at ward levels, especially between the children's and adults services. There had been a serious incident in the child and adolescent services, which required changes to the training for physical intervention, not all staff facilitating the training were aware of the changes, and the staff working in adult services were not aware of the learning from the incident. The hospital did not have a system in place to ensure staff achieved actions from serious incident investigations.
- A number of the documents we reviewed did not have dates on, including target dates within action plans. The hospital held deaf services strategy meetings, which commenced in November 2015, there was an action plan with no identified leads and timescales. Although positive improvements had been made including the increase in numbers of deaf staff and training, it was difficult to ascertain if actions had been met fully or in part and if within timescales.
- The provider had not been following their recruitment and selection policy in relation to recruiting staff with convictions. Records had been completed retrospectively for an interview.

However:

- Staff told us they felt well supported by their immediate line managers and could go to them if they had a problem.
- Ward managers felt that they had enough authority to carry out their role and had support from the senior management team.
- The senior management team were visible on all the wards regularly and staff could tell us their names.

Are forensic inpatient/secure wards safe?

Requires improvement

Safe and clean environment

At the time of our inspection both the low and medium secure units' physical security met the standards set out by the Royal College of Psychiatrists. The units had a secure perimeter with anti-climb measures in place. There was an airlock, which was used to gain entry to the unit, and there was a reception for all units where keys and alarms were given to staff entering the building.

The hospital provided all staff with personal alarms and the hospital provided the inspection team with alarms on entering the ward. We saw good management of these and the keys on all wards we visited. This included staff having keys on their person at all times and if staff needed to handover keys between staff this happened in a secure area and not out on the wards. Staff we spoke to during our inspection were able to explain the principles of physical security on the unit they worked on to us in detail. There were nurse call alarms in all patient bedrooms as well as in communal areas and bathrooms. Staff were able to respond to these alarms by looking at panels on the walls that told them where staff had activated the alarm. During our inspection we saw several occasions where alarms were activated and staff responded to these quickly not only from the ward where the alarm was activated but by all wards situated in the building.

On entering the building there was a clear list of banned items and there were lockers available for staff and visitors to secure these items in which were away from patient areas.

There was a nominated person on security duty on each shift. Their role included checking that alarms were working and that the clips for alarms and keys were in a good state of repair. They also held the security keys so they could gain access to patient belongings in the security cupboard and sign them in and out when patients needed them.

All the wards we visited were clean, tidy and in a good state of repair. All wards had single bedrooms for patients that had an en suite shower and toilet within the room. The furniture in the wards was anti ligature (a ligature point is a

place where someone intent on harming themselves could tie something around). This reduced the risk of patients harming themselves on the furniture as well as using furniture and fittings as weapons.

On all of the wards, we visited apart from East Hampton ward, the hospital reduced the risk of blind spots by the use of observations of patients, good risk assessments, good knowledge of the patient group and mirrors. On East Hampton ward there was a blind spot in the patient kitchen. There had been a recent safeguarding incident within this kitchen and there were plans in place to change the wall into a window so staff were able to see into the room from the main ward area. Each ward had an environmental risk assessment that was specific to that area. Staff were aware of the individual risks within the area they worked in and kept these in mind for carrying out observations.

All wards we visited were single sex; therefore, they complied with guidance on same sex accommodation.

Each ward had a fully equipped clinic room. All wards except East Hampton ward had resuscitation equipment and emergency medication on the ward. East Hampton shared their equipment with another ward. However, staff told us, and we observed signs that everyone was aware of where this equipment was located and how to access it in an emergency. Staff checked the emergency equipment on all wards on a regular basis and we saw evidence of the checklists being up to date and correctly completed on the day of our inspection.

Staff adhered to infection control principles. We saw examples of staff washing their hands following medication rounds. On Lower West ward, some staff were wearing long false nails. This meant that there was a risk of staff not being able to properly wash their hands following patient contact. This also presented a potential risk during physical intervention situations where long nails could scratch or cut patients or other staff. The domestic staff on duty completed cleaning records. At the time of our inspection, these were all completed and up to date.

Safe staffing

Across the forensic and rehabilitation service, there were 68 whole time equivalent qualified nursing staff and 175 whole time equivalent non-qualified staff. There were 16 vacancies for qualified nursing staff and none for non-qualified staff. The percentage of vacancies across the wards ranged from 0 to 31%. The lowest being on East Hampton and South Hampton wards and the highest on Lower East (28%) and Upper West (31%) wards. Staff sickness ranged from 0.6% to 5.5%. This was lowest on South Hampton and Lower East wards and highest at Lower West ward. During the period from December 2015 to February 2016, there were 568 shifts filled by bank/ agency staff to cover sickness absence or vacancies. This was highest on Upper West ward at 129 shifts. Shifts not filled by bank or agency staff totalled 38 across the service.

The provider had estimated the number of staff required per shift for each ward. They did this using a matrix that ward managers could use to see how many staff they needed depending on how many patients they had on the ward and what the observations levels of patients was. This set out the minimum staffing levels needed on each ward. We found that the numbers set out by the matrix matched the staffing levels on the ward rotas that we saw. However, the low secure service had recently moved to a system where there was only one qualified member of staff on each ward per shift. During the week, the ward manager supplemented this however, at weekends this meant that qualified staff sometimes did not get a break or that ward managers on call were covering breaks. This also meant that there was not always a qualified nurse in the communal areas of the wards for example when qualified staff were carrying out the medication round or giving handover.

Ward managers were clear that they were able to adjust staffing levels to take into account the mix of patients. Levels of bank and agency use were low and staff that worked on the wards and knew the patients well covered most shifts that needed cover. All bank staff received a full induction when they commenced work with the provider; they also had a local level induction if it was their first time working on the ward. If wards were busy and there was a surplus of staff on another ward then managers would occasionally move staff around to cover these wards.

Patients and staff told us that on occasion staff rearranged or cancelled leave due to shortages of staff. However, this was not a daily occurrence and staff were clear that if for any reason patients leave was cancelled, staff would rearrange this at the nearest opportunity with the patient.

There was medical cover at all times for the wards. There was a consultant and a junior doctor allocated to each ward. During the day, the junior doctor would usually base

themselves on the ward and consultants would visit for multidisciplinary meetings or if a patient had asked to see them. Out of hours, there was an on call system so staff could contact a doctor if they needed them and they would be able to attend the ward if required.

Mandatory training provided to staff was; safeguarding levels one to three, immediate life support, fire safety, risk assessment, suicide prevention, mental health and dementia awareness, management of actual or potential aggression including responding to ligatures, food hygiene, infection control, health and safety, manual handling and duty of candour. The average mandatory training rate for staff was 85%. There were two wards that fell below 75% and they were Lower West 74% and Madison 72%. However, these were above 75% for management of actual or potential aggression including responding to ligatures and immediate life support.

Assessing and managing risk to patients and staff

In the six months leading up to our inspection there were 99 episodes of seclusion across the service. This was highest on Upper West ward with 47 episodes of seclusion. There were no episodes of long-term segregation. There were 396 episodes of restraint across the service, the highest being Upper West ward with 238 episodes. Out of the 396 episodes of restraint, three were in the prone position. The provider was engaging in a government initiative called Positive and Proactive Care: reducing the need for restrictive interventions, Department of Health, April 2014, which aimed to reduce the use restrictive interventions such as seclusion and restraint and use them only as a last resort.

During our inspection, we reviewed 40 sets of care records. We found all patients had a risk assessment and they were all of a high standard. The wards all used the Salford tool for the assessment of risk. They also undertook historical clinical risk management through a recognised tool (historical clinical risk management 20) for all patients. Risk assessments clearly outlined the risks from and to patients and this fed into a formulation of risk to describe how staff should manage different types of risk for that patient. This included crisis plans where patients had identified how staff could best support them when they were in an agitated state. When we spoke to staff, they were clear on what the risks were for different patients and what techniques they would use with different patients to help calm them if they became agitated. Patients told us that they were involved in the development of their risk assessments if they wanted to be and we saw evidence of this in the files we reviewed.

We found that blanket restrictions were not always used only when justified. On the female wards, the hospital referred to the observations plan as a “staged” approach. This meant that patient’s bedroom access was restricted based on the stage they were on. Patients on stage one did not have access to their bedrooms during the hours of 9am to 19:30pm and patients on stage two only had bedroom access once for an hour during the day. We did not find evidence that this was assessed on an individual basis and that on occasion the communal areas became loud and often increased agitated behaviour in patients due to lack of personal space. If a patient was involved in an incident then they would go back to stage one until they had a period of seven days free from incidents.

We also found that on all wards except Upper East ward there was a rule in place where staff told patients they could not go out for a cigarette unless they sat in the communal area for ten minutes prior to the allocated smoking time. This again was not assessed on an individual basis and therefore was found to be a blanket restriction.

Lastly we found that patients on Lower West ward were told that they were not allowed to go on leave for the day if they did not get up to attend the morning meeting at 9am. When we spoke to staff and patients, they told us that this was in order to assess their mental state prior to going on leave. However, we found that again this was not individually risk assessed. The service expected patients who had been having leave without issue for several months to continue to adhere to this rule.

On South Hampton, which was a rehabilitation ward, we found that there were overly restrictive practices in terms of searching patients. Staff searched all patients on return from leave and some were searched prior to going on leave. We did not find evidence that this was reviewed regularly or individually and that there was evidence of searches continuing for up to three months without any evidence of patients bringing items that they should not back from leave.

However, we did find evidence of wards moving towards a less restrictive environment in other areas. For example, patients had access to their mobile phones at all times on

the low secure units and on wards where the outdoor space was directly outside the ward the doors were open during the day and patients could access this space whenever they wanted to. The provider had training available in an introduction to least restrictive practice and at the time of our inspection, there was 100% compliance with this training. The provider had also developed more detailed training in relation to reducing restrictive interventions called "hands off" which they were planning to put in place after the inspection.

The service did not have any informal patients. Patients were detained either under the Mental Health Act or subject to Ministry of Justice restrictions.

The staff were aware of the observation policy and this included an awareness of potential risks within the environment and how they would manage these. The maximum time between checks on patients was one hourly. Staff were aware of the providers search policy and there was a dedicated room on each ward for staff to carry out pat down searches.

However, we found on Columbus ward that staff had not followed the absent without leave procedure correctly on two occasions. This included there being no photograph of the patient on the form, which was a requirement in the policy. There was also incorrect information on the form, which staff gave to the police about the patient's section status and personal appearance.

We spoke to staff and patients and they told us that restraint was always used as a last resort. Patients felt that staff took time to talk to them when they felt agitated and there were clear plans in the patient files about how to manage individual patients when they became unsettled. Staff spoke about the use of de-escalation techniques with patients for example some liked to go to a quiet area alone, some patients liked to go for a walk outside and some liked to engage in activity they enjoyed. When restraint was used, staff explained that they used restrictive holds for the least time possible.

Since the inspection in January 2016, the provider had reviewed their seclusion policy and observation policy. The observation policy, reviewed March 2016 was compliant with the Mental Health Act 1983 Code of Practice. However, the seclusion policy was not and we noted a number of anomalies, omissions and contradictions within the policy. For example these included the use of seclusion as a safeguarding measure, the authorising of seclusion gowns by the nurse in charge (rather than the responsible clinician), and arrangements for informing (rather than consulting) the responsible commissioners when considering the longer term segregation of a patient. The Code of Practice gives guidance about the involvement of patients' families in response to disturbed behaviour and about the information that the provider must give to patients when secluded or segregated. We were unable to find the full requirements of the code explicitly stated within the policy. We also noted the policy calls for the signing and witnessing of advanced statements but this is not a requirement of the Code of Practice and could lead to patient views and wishes being overlooked.

During our inspection in January 2016, we had concerns about the seclusion rooms having the toilet and shower facilities within the room. This meant that the privacy and dignity of patients was not maintained when they were in seclusion. The action plan from that inspection assured us that there was a mitigation plan in place for seclusion rooms that contained a shower and toilet and that all staff were aware of this. It also stated that the provider would renovate the seclusion rooms to ensure the privacy of patients wanting to use the toilet or shower. All actions were not due to be completed until 31 May 2016. During this inspection, we found that the seclusion facilities still contained a toilet and shower with no privacy screens and that staff were not aware of how they were to protect patient's privacy when being cared for in seclusion. However, one seclusion room had been upgraded to have a separate toilet and shower. Two seclusion rooms had work in progress and three other seclusion rooms were awaiting refurbishments.

We had some concerns about the recording of seclusion across the service. We found that staff did not record the reasons for termination of seclusion, monitoring just appeared to cease on some wards. There were examples of seclusion continuing for longer than necessary, according to the reviews of mental state of patients, which noted the patients were settled. Staff were not always conducting the reviews in a timely manner. We found two examples of medical reviews conducted for a deaf patient in seclusion without an interpreter. Which meant that patients were not able to express their views and communicate how they were feeling to the reviewing team.

Requires improvement

Forensic inpatient/secure wards

The provider called seclusion care plans management plans. The plans did not contain information about the steps that staff should take to end the need for seclusion as quickly as possible, including any reference to patient involvement or details of the support that staff should provide when the seclusion ends. Management plans did however contain a comprehensive reintegration plan to support the patient's transition back to the ward.

Staff had completed mandatory safeguarding training provided by the hospital. They were aware of the safeguarding policy and could explain what constituted a safeguarding incident. They were also able to describe what actions to take if they had any concerns around safeguarding. Staff were able to tell us the name of the safeguarding leads both within the hospital and at the local authority. All the wards we visited had information displayed on safeguarding. There were good links with the local safeguarding authority. There was a safeguarding policy, dated March 2015, extended to March 2016, which did not refer to the Care Act 2014, and had the old CQC standards in.

We reviewed 76 prescription charts during inspection. The prescription charts were up-to-date and clearly presented to show the treatment people had received. Where required, the relevant legal authorities for treatment were in place.

We found one instance where a patient was prescribed antipsychotic medication with a combined dose above British National Formulary limits where this was not authorised by the T3 form (a certificate of second opinion. It is a form completed by a second opinion appointed doctor to record that a patient is not capable of understanding the treatment he or she needs or has not consented to treatment but that the treatment is necessary and can be provided without the patient's consent) in place. Two patients had been prescribed medication that was not covered by the T3 authorisation. One patient was prescribed medication, which was not authorised by the T2 form (a certificate of consent to treatment), although this had not been given. These were immediately brought to the attention of medical staff. Six patients had treatment authorised on T2 forms, which they were not prescribed, for example, additional antipsychotic or anxiolytic medications.

On East Hampton ward we found that patients who had significantly reduced or stopped smoking had not had their clozapine plasma concentrations monitored by regular blood serum level checks as recommended by National Institute for Health and Care Excellence psychosis and schizophrenia in adults: prevention and management (CG178).

Emergency equipment was stored in grab bags so that it was available immediately in an emergency. Nursing staff checked this on a daily basis on the wards that had these. Emergency medication boxes were available with resuscitation equipment if needed. Defibrillators were stored in one upstairs ward and one downstairs ward with posters displayed on each ward advising where the nearest one was. Ligature cutters had previously been stored in the clinic but due to difficulties accessing these when needed, the provider had reviewed this. Ligature cutters (and wire cutters) were stored in the ward office on all wards. This meant these were readily accessible if needed in an emergency. There was a system for these to be immediately replaced if used.

In all clinical areas, staff dispensed medication via a small hatch. The hatches were all located in communal areas, either day or dining areas. This meant patients could not discuss their treatment privately and staff could not fully assure themselves of compliance, given the small view they had of the patients.

There were no controlled drugs being stored in the wards that we checked. There was a local procedure for recordable drugs and these were stored within the controlled drugs cupboards and checked daily. The registers for these were correct.

Care plans were in place for monitoring for physical health conditions and specific medication, for example, clozapine. The GP regularly reviewed patients with physical health conditions, for example, diabetes.

On each of the wards there were arrangements in place for child visiting, which included a room off the ward for children to visit. This would be risk assessed prior to the visit and staff were clear that they would need to be aware that the child was visiting in advance in order to put the correct procedures in place.

Track record on safety

There were 36 serious incidents requiring investigation across the service between March 2015 and February 2016. We found that there were systems in place to report and

investigate serious incidents within the service. However, we did not find evidence of how learning from these incidents was implemented on the wards following action plans. This meant that there was potential for similar incidents to keep occurring.

Reporting incidents and learning from when things go wrong

Staff reported incidents within the service via the online incident reporting system. Staff we spoke with knew what kind of incidents required an incident form and how to complete these. Once the incident report was completed this went to the ward manager to review and sign off the incident. If this required further investigation for example if it were a serious incident then this would be disseminated to the relevant senior staff and an investigation and action plan would follow. Incidents were discussed within the governance meetings. All staff with the exception of agency staff had access to the system. Ward managers attended a meeting each morning where incidents were discussed and shared amongst the service. Staff received feedback on incidents via staff meetings and supervision. Staff told us that debriefs happened following serious incidents; they felt supported by the team and senior managers on these occasions.

We reviewed five incident reports and two incident investigations and found that within the incident reports, care plans were not always reviewed following incidents. We found one of the incident investigations was not dated therefore the monitoring of actions would have been difficult to follow.

Duty of Candour

We reviewed the duty of candour log, the log did not capture all duty of candour requirements and there were examples of patients not receiving a written apology. The hospital was not following their policy in relation to duty of candour, the written records were not in place in relation to the events where the duty of candour applied and there was no evidence of staff providing an apology. Staff on the wards were not fully aware of what the duty of candour was and how it applied to them. For staff that started working at the hospital following the introduction of the duty of candour in April 2015, they received an introduction to the duty of candour within the organisational induction, including the threshold for the duty of candour.

Are forensic inpatient/secure wards effective?

(for example, treatment is effective)

Inadequate

Assessment of needs and planning of care

We looked at 40 care and treatment records across 10 wards. Patients in the medium secure service were usually admitted from prison or from another hospital. Patients on the low secure wards were either stepped down from medium secure services within the hospital or another hospital or from a similar service outside of the hospital. For this reason, most admissions were planned and staff assessed the patient prior to being admitted. Staff told us that on occasion patients would be accepted as an emergency but this was rare.

All of the treatment records we saw had a comprehensive admission assessment, completed in a timely manner. This included a physical assessment on admission. We saw good evidence of staff monitoring physical health on an ongoing basis following this. For example on all wards, a GP visited once a week and patients could book in to see them for any non-urgent physical ailments.

All patients had comprehensive care plans that were personalised, holistic and up to date. On the wards that had deaf patients we saw care plans in pictorial or DVD format dependent on the preferred method of communication that the patient had. However, on Bridge Hampton, a ward supporting patients who were deaf and had a learning disability, we reviewed nine care records. We found that none of the records contained a detailed description of how best to communicate with individuals. Care plans were not written in a format that was accessible to patients, which meant that individuals were not supported to be involved in decisions about their care. Staff could not competently use the best approach to communicate with patients, as staff had not received training to care for patients with a learning disability. This was not in line with the Royal College of Speech and Language Therapists five good communication standards 2013.On South Hampton ward, which was a female rehabilitation ward we found that care plans were not recovery focused.

Requires improvement

Forensic inpatient/secure wards

The service used paper-based records at the time of our inspection. The provider stored the records in a locked cabinet usually in the ward office. This meant that records were accessible to staff when they needed them.

Best practice in treatment and care

We reviewed 76 medication charts during our inspection. Staff we spoke to told us that when prescribing medication they followed National Institute for Health and Care Excellence guidance as well as ensuring they prescribed medication within British National Formulary limits. We examined 76 medication charts and found this to be the case.

National Institute for Health and Care Excellence guidance psychosis and schizophrenia in adults: prevention and management (CG178) also recommends a range of psychological therapies in order to promote recovery and possible future care. We found that there was a lack of access to psychological therapies across some of the wards we visited. There was no lead psychologist in post for the service. This meant that there was a lack of shared vision for the psychologists in post working across the wards. For example on West Hampton ward, we were told that the psychology assistants were new to post and therefore there was currently no psychological therapies available. Records confirmed patients were not receiving individual psychological therapy. However, on Lower West side, patients had access to two assistant psychologists and they provided individual and group therapy in the form of cognitive behavioural therapy and dialectical behavioural therapy. The level of access to psychological therapies was not consistent across the service.

Physical healthcare was accessed via a GP service that visited all the wards on a weekly basis. In addition the hospital had a physical health care team consisting of three registered nurses and a phlebotomist.They used the facilities in the clinic rooms for routine physical health checks. There was access to specialist physical healthcare if this was required, for example, we spoke to patients that had been seen by the optician and the podiatrist. However, the service was planning to go smoke free in January 2017 and therefore patients were being encouraged to engage with smoking cessation programmes to reduce or stop smoking. We found that the provider was not taking into consideration the impact of patients stopping smoking on their medication, especially for patients taking clozapine. This included a lack of understanding from the staff on stopping smoking leading to high plasma concentrations and potentially more side effects. We found that patients who had significantly reduced or stopped smoking had not had their clozapine plasma concentrations monitored by regular blood serum level checks as recommended by National Institute for Health and Care Excellence psychosis and schizophrenia in adults: prevention and management (CG178).

On Madison ward there was one patient whom we had identified at a Mental Health Act reviewer visit in April 2016. Following an occupational therapy assessment in June 2015, the hospital did not get the aids and adaptations that the assessment had recommended for the patient due to a physical health problem. A Mental Health Act reviewer visit took place on 28 April 2016 where they identified that the patient had not received the assessed equipment they needed. The Mental Health Act reviewer raised this with the hospital at the time of the visit and they sent the visit report to the hospital on 11 May 2016. During this inspection, we found that the patient still did not have the aids they had been assessed as requiring. This could also be an infringement of Article 3 of the Human Rights Act, right to be free from torture, inhuman and degrading treatment.

We found little evidence of recognised rating scales to assess and record severity and outcomes. Staff told us that they used health of the nation outcome scale for secure services. However, we found little evidence of these forms in use to inform and plan the patients care. For example, we did not see evidence of these in use in one to ones with patients or in the multidisciplinary meetings to discuss how the patient was improving.

Skilled staff to deliver care

Each ward had access to staff of various different disciplines and grades. This included medical staff, occupational therapists, social workers, domestics and ward activity facilitators. Pharmacists also provided weekly input into the wards. However, the wards did not have ward administrators and nursing staff were expected to carry out this role on a day-to-day basis. This meant that time that could have been spent on direct patient care was sometimes spent doing administration jobs such as filing.

New staff completed a two-week induction. This covered mandatory training and an induction to the service. New staff were paired up with a “buddy” on commencing their role. This was a more experienced member of staff who

would work with them for the first two weeks on the ward and show them how to perform the day-to-day tasks that the role required. The induction was tailored depending on the staff member's role.

The supervision policy dated January 2015, from the previous provider referred to outcomes which were used by CQC prior to the change in regulations in 2015. The policy stated staff should receive supervision every two to three months. However, staff we spoke to understood the organisational requirement to be monthly. Supervision logs were in place in all wards except East Hampton, since March 2016 in the majority of the wards and January 2016 in Madison, Lower East and Upper East. These showed staff had received both clinical and managerial supervision. The clinical manager expected ward managers to submit monthly updates regarding supervisions completed.

Staff were not receiving supervision in line with policy and best practice. We reviewed 10 supervision files, six files showed staff were receiving supervision every one to three months, four files showed staff were receiving supervision with intervals of between five and ten months on Bridge Hampton, Lower East and Upper East. The supervision agenda included what works well, what does not work well and areas for improvement. We noted some actions had been carried over for up to a year without achievement. One staff member had requested mental health awareness training which took a year for them to receive. Supervision records were not available to review on Lower West and Columbus wards.

The total number of non-medical staff who had an appraisal in the 12 months up to 1 March 2016 was 75% for the whole hospital. Updated figures provided at the time of inspection showed the figure for the service as 72% with the lowest wards being Madison at 55% and Upper East at 53%.

Staff told us that they were able to go on specialist training aside from their mandatory training. Examples of this included staff learning to take blood samples on venepuncture courses and training in how to look after patients diagnosed with a personality disorder. We also saw examples of support staff that had been seconded to do their nurse training and returned to the service as qualified staff.

Staff were not trained to communicate effectively with deaf patients. We found that on the wards for deaf patients most staff were only trained to level one or two British Sign Language.

Staff training for British Sign Language Level one across the four wards for deaf patients were:

- Bridge Hampton ward 94%
- West Hampton ward 90%
- Lower West ward 83%
- Upper West ward 59%

Staff training for British Sign Language Level two across the four wards for deaf patients were:

- Bridge Hampton ward71%
- West Hampton ward 70%
- Lower West ward 41%
- Upper West ward 22%

This meant that staff did not always have the specialised communication skills to be able to discuss mental health problems in a detailed manner without the help of interpreters. One of the Quality Standards for Deaf Secure Services by the Royal College of Psychiatrists includes: "Any clinical intervention with a Deaf person will be delivered by suitably qualified and experienced staff with skills in BSL or with specialist Deaf equipment / aids (e.g. video relay service, BSL qualified interpreters)" British Sign Language level one content includes the alphabet, directions and numbers and level two content includes basic conversations, routine, and daily experiences. The service would not be able to communicate effectively with deaf patients after 7pm when the interpreters were not routinely available.

Staff did not receive training in learning disability. Bridge Hampton ward supports patients who are deaf and have a learning disability. Several patients had a diagnosis of personality disorder and two wards were specifically for people with a personality disorder, only 15% of staff had received training in personality disorder, therefore staff would not have the skills to effectively support this group of patients.

We were able to see through reviewing staff files that the provider followed appropriate steps to manage poor performance via the relevant policy. The ward managers

were clear that they were able to manage this via the human resource procedures provided by Cygnet and that they would have the right support to do this from their immediate managers.

Multidisciplinary and inter-agency team work

There were multidisciplinary meetings each week on all the wards we visited. Patients saw their consultant during these meetings but they also told us they could ask to see the doctor outside of these times if they needed to by asking staff to contact them.

There was a handover at the beginning of each shift between the nursing staff. This occurred twice daily as the staff worked long days. All staff on duty at the time of the handover were expected to attend.

The hospital described good working relationships with community teams and the local authority. We could see from reviewing patient care records that the provider invited care coordinators to attend multidisciplinary team meetings for their patient and that there were good links with outside agencies such as advocacy, the local GP and local authority staff.

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

Eighty- three percent of staff had training in the Mental Health Act. Staff attended Mental Health Act training as part of their induction when they first joined the hospital, however staff had not received training on the Mental Health Act Code of Practice, published in 2015.

We found that detention papers including section 19 transfer orders and section 20 renewals were present in the patient's files. However, we also noted that detention documents did not always include a copy of the approved mental health professional report.

The provider ensured that detained patients were given information about their legal status and rights on admission in accordance with section 132. We found that rights were given on admission and there was a system in place to re-present rights at three monthly intervals thereafter. However, we found that there could be a delay in providing patients with information about their rights. We also found that where patients had not understood their rights after a few initial attempts, they would not be re-presented for another three months. We were concerned that this left patients without crucial information about their legal status and right of appeal. (Madison, Columbus, Bridgehampton). A communication relay interpreter ensured that rights were signed and enacted to patients in the deaf service. There was an independent mental health advocacy service available to all patients and this included a gender specific advocacy service for the female patients and a specialist deaf advocacy service for the deaf patients.

We saw that documentation relating to the authorisation of section 17 leave was well completed. There was evidence that staff completed risk assessments before leave was authorised. We found that leave was granted on an individual basis according to need and stage of recovery. We noted that leave was granted for a 12 month period on Bridge Hampton but were informed that the multidisciplinary team kept this under review. However, the outcome of leave was not always recorded and where it was recorded it did not include the patient's own view in the sample we checked.

In relation to section 58 of the Mental Health Act, we found that with few exceptions, prescribed medication was authorised by a form T2 or T3. However, we were concerned about the inconsistent recording of the responsible clinician's assessment of a patient's capacity to consent to treatment. For example, we found only two capacity assessments for patients on Bridgehampton whose treatment was authorised by a T3. We were also concerned about patients whose medication was authorised under section 62 emergency treatment provisions and the amount of time that elapsed between completing the certificate and requesting a second opinion appointed doctor.

We were concerned about the capacity of the Mental Health Act team to manage the workload following the appointment of the Mental Health Act manager to a corporate position. We heard that the team was under significant strain and they expressed concerns about the auditing and reviewing of the operation of the Mental Health Act on the wards. New tracking tools had been developed in order to support the senior administrator to manage this. The Mental Health Act team was now line managed within the general management structure and not by managers who were experts in Mental Health Law. Nor did the Mental Health Act team have direct access to legal support.

Good practice in applying the Mental Capacity Act

Requires improvement

Forensic inpatient/secure wards

Staff did not receive training on the Mental Capacity Act.

The hospital had a Mental Capacity Act policy called accessing capacity, dated February 2014, due for review February 2016. The policy was not compliant with the Mental Health Act Code of Practice, 2015; it also referenced the Care Standards Act 2000, which has been superseded by the Health and Social Care Act 2008.

The provider reported no Deprivation of Liberty safeguards applications in the six months leading up to our inspection. There was no policy for Deprivation of Liberty safeguards in place for the provider at the time of our inspection. The hospital completed a draft Mental Capacity Act policy in the week following the inspection.

Are forensic inpatient/secure wards caring?

Good

Kindness, dignity, respect and support

We spent time in the communal areas of the wards observing staff interactions with patients. On all of the wards, we observed staff treating patients with dignity and respect. The staff knew the patients well and had a close working relationship with them. Staff were knowledgeable about the patients and were able to use this knowledge to anticipate patients' behaviours. Staff spoke about the patients in a respectful manner and we observed this in group work and interactions when we saw staff walking in the hospital grounds with patients.

We received 61 completed comments cards and spoke to 45 patients in the service during the inspection. Feedback we received was variable.

Positives included that patients were happy in the hospital; staff had improved on responding to incidents in a timely manner. Staff were caring and patients felt they had progressed since their admission to hospital. Patients were positive about support provided by staff to facilitate home visits. Patients felt the hospital was clean and safe.

Areas for improvement were that some staff were not approachable and supportive. Staff changes were difficult for some patients, with limited consistency, which may have an impact on progress. Some patients felt wards were overly restrictive, particularly on the low secure wards.

Activities were an area of concern, including staff cancelling activities or not having staff support to attend activities and activities not focusing on rehabilitation and daily living skills.

Patients felt staff would benefit from additional training in how best to support them. A few patients felt the hospital could improve the food, including more variety as they found it repetitive. Being on a mixed ward for hearing and deaf patients was difficult for some in relation to communication.

Access to outside space was an area of concern for some patients and access to psychological therapies.

The involvement of people in the care they receive

Patients were shown around the ward on admission. Some patients also told us they had the opportunity to go and have a look around the ward if they were moving from medium to low secure services. When we spoke to patients about their care plans, they told us that overall they felt involved and that they had time to discuss their care plan on a regular basis with their named nurse.

Patients told us that the advocacy service visited regularly. They were able to tell us how the advocacy service had helped them, for example supporting them in multidisciplinary meetings and tribunals. For patients that did not choose to have an advocate working with them they were able to tell us how they would access this service if they changed their minds. This included showing a member of the inspection team posters that were up around the wards.

The wards had weekly community meetings. Interpreters were present at the meetings for wards with deaf patients. Patients and staff discussed issues on the ward. This included concerns or problems, and suggestions for patient activities. The minutes from these meetings were on display on the patient notice boards on the wards we visited. We reviewed some of the previous patient meeting minutes and were able to see how changes had been made following these. For example on Upper East ward, we saw that patients had requested to be able to keep their own cutlery in their rooms between meals. We saw that staff had discussed this with all patients and implemented for those that were risk assessed as safe to do so.

We did not find evidence from reviewing patient records that advanced decisions were in place for patients. Staff

Requires improvement

Forensic inpatient/secure wards

told us they did not routinely seek to support patients to make advanced decisions for periods when they lacked capacity. We also noted that the seclusion policy calls for the signing and witnessing of advanced statements but this is not a requirement of the Code of Practice and could lead to patient views and wishes being overlooked.

We spoke to patients and they told us that their families and carers were involved in their care if they wanted them to be. For example, if patients wanted family to attend a multidisciplinary meeting or a tribunal then the provider would invite them to attend. Patients felt that their families' views were listened to when they attended such meetings.

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

(for example, to feedback?)

Requires improvement

Access and discharge

Average bed occupancy over the six months leading up to our inspection was 95%. All wards had bed occupancy of more than 85%. However as these were long stay wards with no unplanned admissions the bed occupancy tended to stay the same for long periods.

As this is a specialist service, the majority of patients came from outside of the local area to Cygnet.

Patients on leave from the ward always had the same bed to return to. Leave was usually for short periods such as a few hours rather than overnight leave. Patients were not transferred to other wards within the unit or hospital unless this was clinically necessary. Staff told us that patients would move wards if there were issues with other patients or as part of their care pathway to a less secure environment. In the six months prior to inspection there had been one delayed discharge in the secure service, this was due to awaiting a bed in a specialist older adult service. There was weekly contact between service managers and NHS England to discuss patient progress and discharge plans. Discharge was always planned and therefore happened at an appropriate time of the day.

The facilities promote recovery, comfort, dignity and confidentiality

We visited each ward and found that they had a sufficient number of clinic rooms, activity rooms and quiet areas for patients to meet their visitors. Each ward had access to outside space, which on most wards staff supervised as the outdoor area was accessed via a shared stairway.

All of the wards had access to a payphone where patients could make a phone call. However, on South Hampton and Lower West wards this was in the communal area. Although they had a privacy hood this was not sufficient to stop others being able to hear the conversation patients were having. However, patients did have access to mobile phones on all wards whether this was freely available or kept in the security cupboard and handed out by staff depended on individual patient risk assessments.

There were mixed reviews from patients regarding the food at the hospital. While some told us that there was a good choice of food, which tasted nice others told us it was small portions and there was not enough variation in the menus. The hospital was awarded a food hygiene rating of five (very good) by Bury metropolitan borough council in September 2015.

Most of the wards had access to a kitchen that patients could use to make hot drinks and snacks at all times. Open access to the kitchens was determined by a risk assessment of patients. For example, the kitchens on the medium secure wards tended to be locked, but on the low secure/ rehabilitation wards, they were open.

We saw patient bedrooms during our inspection and found that patients were able to personalise these with items from home and personal belongings. We also saw examples of patients making things in art and craft groups and in the workshop within the hospital. Patients on the low secure wards were able to keep items such as musical instruments in their bedrooms if they had been risk assessed as safe to do so by staff. Within the patient bedrooms on all wards, there was a lockable space where patients could securely store their possessions; patients had the keys to these.

On all of the wards there was a ward activity facilitator employed Monday to Friday 9am to 5pm. This person was wholly responsible for coordinating activities on the wards. We found that on all wards there was a lack of meaningful activity for patients that had a therapeutic value. Staff and patients told us that in the evenings and weekends there

was little or no activity available on the wards unless patients wanted to access board games from a cupboard. This meant that patients could not utilise their time with meaningful daytime activities that would aid recovery.

The provider had a target to provide all patients in forensic services with 25 hours of meaningful activities per week. We found from looking at care records that staff filled in a form each week to show the 25 hours of meaningful activity that patients should have on each ward. We found that although patients generally achieved this the activities listed were not meaningful or therapeutic. For example, one hour a day for medication, up to eight hours a day of self-directed time and two to three hours a day allocated for personal hygiene. On the rehabilitation ward (South Hampton), we found that the activities provided were not recovery focused. For example, patients were not actively encouraged to cook their own meals more than once a week and there were no patients engaging in self-medicating or voluntary work in the local area. Activities on this ward included pampering and film nights and these were not in keeping with a rehabilitative focus.

Meeting the needs of all people who use the service

All wards were accessible for people requiring disabled access. There was a lift to each floor and corridors were wide enough for wheelchairs if this was required. There was a fully accessible disabled bathroom on each ward. This included a wet room style shower and a bath with a chair that would lower into the bath.

Leaflets were available in other languages if required. The communication facilitator had revised the posters at the hospital to be understandable for deaf patients at the service. Care plans on the deaf wards we visited were available in a signed DVD format so patients could watch these and change them when required. The other wards displayed information for patients, and there were information leaflets available. This included information about local services, patients' rights and treatments. There were also posters about the advocacy service available on the wards and information for patients on how to complain.

For the wards with deaf patients, there were interpreters available for ward rounds and tribunals as well as one to ones with named nurses. These were booked internally by the staff that required them. The interpreters were available from Monday to Friday, 7am to 7pm. Deaf staff were also employed in the wards for deaf patients. There were two examples of interpreters not being present for medical reviews for a deaf patient in seclusion on Upper West ward, therefore staff were unable to effectively communicate with the patient and ensure they understood their plan and could contribute to the review.

Food was available to meet the needs of patients with specific dietary requirements such as diabetic, gluten free, vegetarian, vegan and halal.

There was access to spiritual support for patients on the wards. This included the local Imam visiting to speak with Muslim patients. There was also both male and female chaplains available to speak to Christian patients. The staff told us that they were able to access the local mosque with patients who had leave and there had been access to the local Buddhist Centre.

Listening to and learning from concerns and complaints

There were 105 complaints in the secure and rehabilitation services between February 2015 and January 2016. Of these complaints, the provider upheld 17 and none were referred to the ombudsman.

We spoke to patients who told us that they knew how to complain at a local level for example talking to the nurse in charge or the ward manager. Some patients told us that complaints were not formally recorded and that they did not receive feedback when they had made a complaint.

The hospital had a complaints policy, dated January 2016. The policy states that staff should record all complaints on the electronic incident reporting system. We reviewed eight complaint investigations and found prior to February 2016 the hospital were not investigating complaints fully and in a timely manner. Including the evidence of how the complaint was investigated was not stored centrally, the response to the complainant did not say if the complaint was upheld or not and did not address all aspects of the complaint. However, the complaints reviewed from February 2016, since the complaints officer was in post, showed staff were following the policy for formal complaints, offers to meet with the complainant were made and letters included an apology to the complainant with additional contacts of how to escalate the complaint if not happy with the outcome. If the complaint was not upheld the complaints officer gave reasons in writing.

Requires improvement

Forensic inpatient/secure wards

Ward managers and clinical services managers we interviewed had a variable understanding of resolving complaints locally, some managing local systems without inputting the complaint or concern onto the electronic incident reporting system.

Are forensic inpatient/secure wards well-led?

Requires improvement

Vision and values

The providers values were:

- Helpful – "go the extra mile for service user, customer and team"
- Responsible – "do what you say you will do"
- Respectful – "treat people like you like to be treated yourself"
- Honest – "be open and transparent, act fairly and consistently"
- Empathetic – "be sensitive to others' needs, caring and compassionate."

Staff we spoke with knew what the values of the service were. They told us they agreed with the values and felt they were applicable to their role and the service objectives. They had been given a pack, which included the behaviours and values that were expected from staff, and this linked in with a two-day training course about promoting values to the staff. These were used to assess values in the recruitment process when managers were interviewing for new staff.

All staff were aware of the most senior managers within the service. The senior management team were a visible presence on each ward.

Good governance

Since the inspection in February 2015, the provider had changed the hospitals governance structure, with clearer lines of accountability and reporting mechanisms in place. The structure included new roles of leads of all disciplines; there was one vacancy for the lead psychologist at the time of inspection. In addition, a clinical quality and compliance manager, clinical manager and general manager, the new structure had been in place since January 2016.

The governance action plan in place prioritised committee structures, new terms of reference for meetings and set agendas to ensure consistency of information sharing. This had clear dates for achievement of actions. We observed positive progress with the new governance structure in place, with a number of meetings taking place and feeding into the senior management level. However, the system in place to ensure actions set from serious incident investigations were achieved was in its infancy. The flow of information and understanding was evident from board to ward manager's level. Staff on the wards were not always aware of changes in the hospital and their role in relation to the duty of candour. The hospital had not ensured that concerns raised in previous inspections by CQC were fully achieved.

Recent meetings introduced included the integrated governance service meetings, chaired by the clinical services managers, ward managers and the clinical quality and compliance manager attended, the aim of the meetings were to disseminate information and ensure a flow of information from the board to ward. The meetings had been in place since January 2016. Another new meeting introduced was the restrictive intervention reduction steering group, in place from June 2015. The hospital had introduced a new role of patient engagement lead who involved patients and staff in the review of the restrictive practices taking place in the hospital. A training package had been developed to raise staff's understanding of what a restrictive practice is and ways of reducing these called 'hands off' which was due to be rolled out throughout the whole hospital.

The general manager had identified the previous poor investigation of complaints and the investigators not following the policy. A new role of complaints officer had been introduced and recruited to, with a positive impact, recent complaints we reviewed were following the policy and included a detailed investigation.

The hospital had a number of policies that were out of date, including the safeguarding policy, which did not refer to the Care Act 2014, and had the old CQC standards in and did not provide clear direction of whom was responsible for reporting incidents to external bodies including CQC. There was a review of policy log in place, with timescales for the review of policies and the introduction of the Cygnet policies.

Requires improvement

Forensic inpatient/secure wards

Incident investigations reviewed across the service were of variable quality, spelling and grammar mistakes had not been reviewed and dates were not always present.

The hospital had not been routinely sharing learning from incidents at ward levels, especially across the children's and adults services. There had been a serious incident in the child and adolescent services, which required changes to the training for physical intervention, not all staff facilitating the training were aware of the changes, and the staff working in adult services were not aware of the learning from the incident. The hospital did not have a system in place to ensure staff achieved actions from serious incident investigations.

A number of the documents we reviewed did not have dates on, including target dates within action plans. The hospital held deaf services strategy meetings, which commenced in November 2015, there was an actions plan with no identified leads and timescales, although positive improvements had been made including the increase in numbers of deaf staff and training, it was difficult to ascertain if actions had been met fully or in part and if within timescales.

We reviewed seven recruitment files, five of which adhered to the hospitals recruitment and selection policy. One recruitment file was of a staff member recruited with a conviction; the hospital had introduced a risk assessment process for staff recruited with convictions. We found the clinical manager had completed the interview notes for this person retrospectively two months later but had not indicated this. The candidate had completed the application form two months after the date of their interview. Because the application post-dated the disclosure and barring check there was no record to show that the applicant had disclosed the offence at the beginning of the recruitment process. Within the risk assessment for the offences, the provider had identified the nature of offences as not relevant to the role; however, we felt they were relevant. We raised the issue with the clinical manager who confirmed they had completed the records retrospectively as they could not find the originals; we advised it would have been preferable to put a note in the file that they had been lost. The clinical manager reported the issue as an incident following our recommendation. Another recruitment file identified the staff member had not met the bar for recruitment but had been recruited. Staff told us this was because the whole group had been told they had been successful. The provider had identified that the person required additional support in their role, however a member of the human resources team could not assure us this was happening, as they received the same support as all other staff.

Ward managers were aware of the key performance indicators for their staff team. These were used in the appraisal process where staff had set goals and a timeline to achieve them. These were managed via an online system, which alerted staff when training and appraisals were due. However, only 72% staff had received an appraisal at March 2016. Staff were not being regularly supervised in line with the hospital policy.

Ward managers were aware of the risk register and were clear that they were able to submit items to this via the hospital governance department. Managers were able to tell us which risks related to their area of work and what mitigations were in place to support this. The provider discussed the risk register at the weekly service meeting that all managers attended.

Leadership, morale and staff engagement

Daily senior management meetings took place from Monday to Friday to allow the clinical services manager to provide a summary of events in the wards from the previous 24 hours to the hospital director and clinical manager. The hospital director shared the themes from the meetings with the board.

Staff we spoke to generally felt that staff morale was good on the wards. Some staff felt recent trial changes in a reduction of qualified nurses on shift had caused a drop in morale, as there was not as much time to spend with patients with only one qualified member of staff on the ward. Other staff told us that this had been changed and that at the ward manager's discretion there was now two qualified staff on duty. Staff we spoke to felt supported by their immediate managers and felt they could approach them if they had a problem to discuss, they also felt they would be listened to. Staff also told us that they knew the senior management team and felt as though they could approach them if their immediate manager was not available or if they did not want to discuss the issue with their immediate manager. Staff were aware of the whistleblowing process and were able to tell us how they would approach this if they needed to use it.

Requires improvement

Forensic inpatient/secure wards

We reviewed minutes from team meetings on the wards we visited. We found that the length of time between meetings varied from four weekly to sometimes as long as three months. Managers told us they tried to have monthly team meetings but that this did not always happen due to the wards being unsettled or incidents occurring, staffing also had an impact on this as staff worked long days so there was no middle of the day handover to accommodate a meeting. We found that when team meetings did happen that learning from incidents was a standing agenda item on the agenda for team meetings. These were recorded and kept in the office for staff to revisit if needed. However, we found that these were almost always incidents on that particular ward and that there was a lack of sharing incidents between other similar wards and across the service as a whole. For example, incidents from the child and adolescent service were not shared with the adult services.

The hospital introduced 'senior team walkarounds' in January 2016, visits took place unannounced and included day and night visits. Senior managers completed a template and identified actions; however, there was no system in place to ensure staff acted upon actions.

Commitment to quality improvement and innovation

Medium and low secure services were part of the Royal College of Psychiatrists quality network for forensic mental health services. Staff from forensic services across the country assess and benchmark one another against a set of quality standards. The hospital sent us the reports from when they were inspected in November 2014 for both medium and low secure services.

Low secure services achieved 98% of overall standards, and met 100% of standards in ten of the standard areas, including; admission, recovery, physical health care, discharge, physical security, relational security, service environment, workforce and governance. The report highlighted equalities as an area in need of improvement for the coming cycle.

Medium secure services achieved 95% of overall standards, and met 100% of standards in six of the standard areas, including procedural security, safeguarding, family and friends and workforce. Physical security, physical healthcare, patient focus, environment, and facilities were highlighted as areas in need of improvement for the coming cycle.

When we spoke to staff on the wards, they were aware that their service had been reviewed as part of quality network for forensic mental health services. However, they were not aware of any actions following this and some told us they were still awaiting the feedback.

The service was not involved in any research.

Requires improvement

Child and adolescent mental health wards

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

Summary of findings

We rated safe as requires improvement because:

- Blueberry ward did not meet gender separation requirements as outlined within the Mental Health Act Code of Practice; there were no separate lounges for male and female patients. There was no evidence that this was regularly reviewed with the patients on the ward.
- Staff did not always follow policy and safely monitor patients who had been given rapid tranquilisation.
- In some instances, medical staff's recording of seclusion and long-term segregation was inaccurate. This was because medical staff recorded some episodes as seclusion and long-term segregation interchangeably. If patients were in long-term segregation they would not have the safeguards in place than if they were in seclusion.
- Medical seclusion reviews were variable across the service. Some records contained generic statements regarding patient's progress. They lacked detail in identifying how the young person could be supported for their seclusion episode to end.
- The provider had not updated the audit tool for managers to monitor the use of seclusion and long-term segregation to reflect Cygnet's new seclusion and long-term segregation policy.
- Staff recorded one episode of long-term segregation where, according to the Code of Practice, the episode more accurately reflected that the service had secluded the patient.
- Wizard house had no junior medical staff to support the consultant psychiatrist. This placed additional pressure on existing medical staff, which may not be sustainable.
- For three of the five wards, staff compliance in mandatory training for safeguarding vulnerable adults and children at levels one and two fell below 75%. The service's standard minimum training compliance was set at 85%.
- For all five wards, staff compliance in mandatory training for safeguarding vulnerable children at level three fell below 75%. The service's standard minimum training compliance was set at 85%.

However:

- The service had made the multidisciplinary teams ward-based in January 2016. This had the positive effect of increasing staff presence on the ward, which provided consistency and familiarity for patients.
- The service was committed to promoting least restrictive practice. This had involved reviewing the use of blanket restrictions and enhanced patient observations. Consequently, the number of recorded restraints, use of rapid tranquilisation and seclusions had reduced across all five wards between January 2016 and May 2016.

Requires improvement

Child and adolescent mental health wards

- Staff we spoke with had a good knowledge of safeguarding and displayed a clear understanding of what would constitute a safeguarding concern.

We rated effective as requires improvement because:

- There was no policy in place to support staff in the proper of use of deprivation of liberty for patients aged 18 years and below. Staff's knowledge was limited and the lack of guidance of Deprivation of Liberty Safeguards meant staff were not following the safeguards correctly.
- Staff received training in the Mental Health Act 1983 on induction to the service; however staff had not received training on the Mental Health Act Code of Practice, published in 2015. Staff demonstrated a variable knowledge of the Mental Health Act 1983 and the Code of Practice 2015.
- Staff did not receive mandatory training in the Mental Capacity Act, deemed essential for their role. This included legal safeguards and mental capacity frameworks relevant to patients aged below 16 years, such as the Gillick competence framework and the Children Act 2004. Staff demonstrated a variable knowledge of mental capacity frameworks relevant to children and patients and how this applied to their role.
- There was inconsistent filing of Mental Health Act detention paper work that did not meet the guidance as outlined in the Mental Health Act Code of Practice 2015.
- One capacity assessment identified that the patient did not have the capacity to consent to treatment was contradictory as it ran concurrently with a T2 form that identified the patient did have the capacity to consent to treatment.
- Where a patient lacked the capacity to consent to treatment, we found some delays in requesting an independent second opinion approved doctor to authorise the treatment provided by the service.
- The service had no input from a full-time, permanent female clinical psychologist. Patients on the female only ward, Primrose, identified this as an issue as they could only engage with a female psychologist due to personal, historical issues.

However:

- All patients had a range of comprehensive, individualised care plans and risk assessments.
- The hospital had a well-established physical health care team who provided regular and effective monitoring of patients' physical well-being throughout their inpatient admission.
- The service had formed effective working relationships with external agencies also involved in the care of patients, such as the local authority.

We rated caring as good because:

- Staff facilitated weekly community meetings where patients could discuss any issues and identify any changes they wanted to make to the ward.
- Staff involved patients in the compilation of their care plans and risk assessments and patients had a copy of these.
- Carers were mostly positive about the service and said that although many patients were far away from home, the service tried to involve them in decisions regarding the young person's care and treatment where appropriate. This included initiating regular telephone contact and using teleconferencing facilities to enable carers to partake in important meetings, such as care programme approach meetings.
- The interactions we observed between staff and patients were positive. Staff were kind, respectful and demonstrated a good knowledge of individual patient needs.
- Patients were mostly positive about staff attitudes towards them and said they felt supported.

However:

- We did find one example where staff had breached third party confidentiality.

Requires improvement

Child and adolescent mental health wards

- Patients were not able to help in the recruitment of new clinical staff to the service.

We rated responsive as good because:

- The service had recently employed a full-time activity co-ordinator to each ward. This had the positive effect of increasing the number and hours of formal activity provided to patients. Patients told us that activities were interesting and varied, and staff were considerate of their individual interests.
- Every ward facilitated weekly group leave where patients identified places of interest, off the hospital grounds, where they would like to go. Recently this had included the cinema, zoo and safari park.
- The service catered for patients' religious and cultural needs.
- Patients had decorated the ward to their personal preferences. Patients told us this made the ward feel more personalised and somewhere they felt relaxed in.
- We case tracked three complaints that carers and/or patients had submitted to the service between January 2016 and May 2016. We found that the service dealt with these appropriately as per the provider's complaint policy. This included offering a written apology where the hospital had acknowledged that they had made a mistake.
- Patients on Wizard house had created a buddy pack to orientate newly admitted patients to the ward. The service had plans in place to implement the buddy pack within the four psychiatric intensive care wards.

However:

- Senior managers did not demonstrate an accurate knowledge of the exclusion criteria for admission to the service. This made it potentially confusing for people referring into the service what the admission criteria was and could result in patients being inappropriately placed.

We rated well-led as requires improvement because:

- The hospital had not acted upon all previous concerns raised by CQC at earlier inspections.
- The hospital did not have key policies in place to support the service's proper implementation of Deprivation of Liberty Safeguards or the Mental Capacity Act.
- Monthly audits of Mental Health Act documentation had not identified that copies of detention paper work were not consistently filed in patients' care records.
- Qualified nursing staff and previous employees had identified that there was limited career progression for nursing staff beyond their current roles.
- The hospital introduced 'senior team walkarounds' in January 2016. Visits took place unannounced and included day and night visits. Senior managers completed a template and identified actions, however, there was no documented date to follow up and ensure actions were acted upon.
- Lessons learnt were not shared between adult and child and adolescent services within the hospital.
- Staff knowledge of duty of candour, and how it applied to them was variable within the service.

However:

- Staff throughout the service praised the support they received from their peers and senior management team.
- The service had seconded some support work staff to complete their nurse training to further their career progression.
- Staff were aware of the provider's vision and values and they mostly adhered to these within their work.

Requires improvement

Child and adolescent mental health wards

Are child and adolescent mental health wards safe?

Requires improvement

Safe and clean environment

We visited all five wards. The four psychiatric intensive care wards, based at Forestwood, all had an open lounge with bedroom corridors and other rooms leading off. This included quiet rooms, activity rooms, laundry and kitchen facilities. At the time of our inspection, all quiet rooms were open for patients to access freely. Patients we spoke with confirmed that this was usually the case. At the time of our inspection, one of the communal kitchen facilities on Wizard House had been locked. Staff told us this was because there was a kettle that some patients may use to harm themselves, for example, by scalding or using the electric cable wire to strangle themselves. This had been risk assessed for the individual patients concerned and staff had identified it as a safety risk on the ward's environmental risk assessment. However, all patients had open access to another kitchen that was located on the ward. This meant they could make cold drinks and snacks freely throughout the day or night.

Wizard House was located over two levels, split between a ground floor and first floor level. For observation purposes, staff identified the ground floor as area one and the first floor as area two. Two members of staff were allocated hourly to perform a review of the separate areas to ensure the environment was safe for patients. On all wards, staff were undertaking regular zonal and ward observation checks and CCTV monitoring was in place in all communal areas of wards.

We reviewed ligature audits for all five wards that ward managers reviewed on a monthly basis. A ligature audit identifies places to which patients intent on self-harm might tie something to strangle themselves. The audits were all in date and identified ligature points and how these would be addressed to minimise risk of harm towards patients. This included locking rooms where ligature points were present, such as serveries and laundry rooms, and allowing patients access under staff supervision. If no patients on the individual wards were identified as being at risk of ligaturing, these rooms would be left open. Patients on all the wards we visited had their own locker and stored personal items such as razors, glass toiletries and phone chargers that they could potentially use to self-harm. We found that staff risk assessed all patients individually to determine whether they were at risk of self-harm before removing these items and only allowed access under staff supervision.

With the exception of Blueberry ward, all wards had a female only lounge. All bedrooms were ensuite. On Blueberry ward, there was only one quiet lounge in addition to the communal lounge. The communal lounge could not be used to promote gender separation where needed as it was open plan and led directly onto other corridors and rooms within the ward that were accessible to all patients. At the time of our inspection, the ward was occupied by three young men and four young women. This meant that not all patients had access to a male and female only lounge. This does not comply with the Mental Health Act Code of Practice 2015.

Emergency equipment was located in ward clinics and stored in grab bags. This meant that it was available immediately in an emergency. Nursing staff conducted a daily audit to ensure all emergency equipment was in date and fit for purpose. Emergency medication boxes were available in each clinic if needed. Ligature cutters were stored in the ward office on all wards, and all wards had additional sets of these located in locked storage on the bedroom corridors. This meant these were readily accessible if needed in an emergency and additional sets meant there would be equipment available if staff had used one of the sets.

At the time of our inspection there was only one functioning seclusion room shared between four wards at Forestwood. It was located on Primrose ward. The service had recently refurbished the seclusion room following a focused inspection of the service by CQC in January 2016. Following refurbishment, it had been in use since the week commencing 9 May 2016. CQC had issued a requirement notice because the seclusion room had toilet and shower facilities that could be viewed by staff when in use. This meant that their privacy and dignity was not being maintained. Primrose ward's refurbished seclusion room had toilet and shower facilities that gave patients privacy when they used them. Staff had also placed a blue mat against part of the seclusion room's main window that looked out onto the buildings private garden area. A film had also been placed against the window to obscure the

view of the seclusion room to protect patients' privacy and dignity. However, patients within the seclusion room were able to see out of this internally and daylight was accessible via the film. Ward management told us that this was a temporary measure and that blinds had been ordered to replace the film and blue mat. A clock was installed within the seclusion room, however it was difficult for patients to identify the time of day as the reading was faint. Ward management addressed this immediately when we raised this concern. An extra care area had also been created directly outside the seclusion room. The extra care area had a settee and provided another area where patients could de-escalate. De-escalation is a preventative strategy that involves the gradual resolution of a potentially violent or aggressive situation where a young person begins to show signs of agitation. The environment in which de-escalation occurs is important because it can be used to promote de-escalation by reducing the amount of excessive stimulation that may otherwise contribute to a young person's distress. Primrose ward's seclusion room was clean and staff were completing a cleaning rota that adhered to the service's cleaning procedures.

Primrose ward was the only female only psychiatric intensive care unit within the child and adolescent inpatient service at Cygnet Bury. It was based on the first floor. However, as the only functioning seclusion room at the time of our inspection, male patients would also have to use the facility if a need had been identified. Senior management were aware that they needed to protect Primrose ward's female patient's privacy and dignity if a male patient was to enter the ward environment. Ward managers told us that if a male patient required secluding on Primrose ward, they would call the Primrose ward management team and request that all female patients be moved to an area of the ward that was not visible from the ward entrance and entry to the seclusion room. However, in accessing the seclusion room this way, a young person and the escorting staff members would have to access seven sets of doors, four of which were locked and would require staff to open them. This could be difficult to facilitate and potentially distressing to the young person due to the time it may take to initiate the safeguards before entering the ward.

Alternatively, male patients could be transported by accessing a door that entered directly into the extra care area. However, this entrance could only be accessed by a flight of stairs leading to the ground floor, Blueberry ward's secure garden and several secure gates. In order for the young person to be transported and secluded safely, this would require a level of co-operation by the young person. We had concerns that patients could not safely be transported via the stairs due to the risk of injury to themselves and staff should they become distressed and non-cooperative during the transfer to seclusion. Because patients who require seclusion are usually very distressed and therefore less likely to be co-operative, this method of transfer was not safe. This practice also diverged from Cygnet's new management of seclusion doors entry and exit procedure, January 2016 that stated that under no circumstances should stairs be used to transfer a patient during restraint.

Another seclusion room was currently being refurbished on Blueberry ward. Blueberry ward's seclusion room was the only functioning seclusion room between late January and 9 May 2016 while Primrose ward's seclusion room was being refurbished. Refurbishment was due to be completed by the end of May 2016, which meant that there would be two functioning seclusion rooms following this time.

All the wards were clean and tidy. The service employed cleaning staff who cleaned the wards daily and there were additional cleaning schedules that staff regularly completed. Furnishings and furniture had recently been updated on some of the wards, and throughout were well maintained and in good condition.

All kitchens and clinic areas had handwashing sinks installed and we saw that staff and patients were using these as appropriate. Clinic rooms also housed infection prevention equipment.

We reviewed the clinic rooms on all of the wards. Medicines were kept in locked storage as appropriate. Effective processes were in place to ensure medicines that were not needed could be appropriately removed. All clinic fridges were maintaining a safe temperature range to ensure medicines were safe to administer.

The clinic room on Wizard House was the only ward with its own examination couch. Patients based on the four psychiatric intensive care units would have to be escorted by staff to the GP clinic room to complete examinations and regular physical observations. With their consent, patients were also examined within their own bedrooms if the GP clinic room was already in use. Assessment equipment, such as electronic devices to record patients'

baseline physical observations, were available on each ward. Staff checked these daily to ensure they were fit for purpose and maintenance checks were carried out within the specified time frame.

During our focused inspection of the service in January 2016, we raised concerns that Wizard House was the only area where patients had medication dispensed privately within their clinic room. On the four other wards, staff dispensed medication via a small hatch that were located in communal areas, for example the ward dining or day room. This meant that patients could not discuss their treatment privately and staff could not fully assure themselves that patients had taken their medicines. This is because the small hatches only allowed staff a restricted view of the patients. During our inspection in May 2016, we found that staff continued to administer medicines via these small hatches. However, senior management told us that one of the de-commissioned seclusion rooms was to be converted into a modernised clinic room on Buttercup ward.

At inspection in January 2016, we also raised concerns regarding a shared clinic room between Primrose and Buttercup wards. A hatch for Primrose ward was on the wall opposite the hatch for Buttercup ward. A local procedure was in place to prevent both hatches being open at the same time due to the risk of patients over hearing conversations regarding other patients' medications. This was to promote patient confidentiality. Each ward had three separate allocated times for administering routine medication. However, we did have concerns that there could be a delay in administering as and when needed medication. For example if a young person was distressed and required medication. This was because this could coincide with a routine medication round on another ward where they shared the same clinic room. During our inspection in May 2016, staff from both wards continued to use the same clinic room, and therefore the same concerns remained.

In January 2016, we also raised concerns that on Mulberry and Primrose wards patients were using the hatches as a way to talk to staff in the clinic room. At the time, we observed this happening via patients knocking on the hatch to gain staff attention and further to discuss their progress. Staff were observed passing confidential information, such as phone numbers and written information, through the hatches. This did not promote patients' dignity. At the time of our inspection in May 2016, we observed that staff no longer communicated with the patients regarding personal information in this way. Staff and patients told us that as there were more staff available on the ward, patients were more able to access staff support in private areas of the ward at other times during the day. This included the ward's quiet rooms.

All staff used a personal alarm system to request assistance if required. A rota was in place on every ward for one designated staff member per shift to respond to emergency alarm calls. The service also had a designated security lead for each shift. They were responsible for co-ordinating and managing any concerns relating to the emergency response team.

Safe staffing

Since November 2015, the ward manager of Mulberry ward also managed Blueberry ward. In April 2016, the ward manager of Wizard House also managed Buttercup ward. This meant that they were tasked with running two wards simultaneously within a full-time contract. Senior management told us that although the transition from managing one ward to two wards had initially been difficult, they felt the current pressures were manageable and sustainable. However, this arrangement did not meet national standards as set out in the quality network for inpatient child and adolescent services by the Royal College of Psychiatrists. The set standard is one full time ward manager to every 12 patients. Only Primrose ward had a ward manager who was responsible for a ward with less than 12 patients. However, since this ward manager establishment had been in place, all five wards had seen a decrease in incidents and the quality of care for patients had not declined. This meant the change in ward management had not had a detrimental impact on patient care.

During our focused inspection of the service in January 2016, we found that staffing establishment levels were eight qualified staff for Mulberry, Blueberry, Buttercup and Primrose wards. Wizard House had 10 qualified staff in their establishment levels. However, in May 2016 we found that staffing numbers of qualified nurses had decreased across all five wards. Staffing numbers of qualified staff were five qualified staff for Blueberry and Buttercup, four for Mulberry, three for Primrose and seven for Wizard ward.

Requires improvement

Child and adolescent mental health wards

Buttercup ward had two qualified nursing vacancies, Primrose four, Mulberry three and Wizard one. Blueberry had recruited into two qualified nursing vacancies and the post-holders were currently awaiting start dates.

All the ward managers we spoke with told us that they had difficulty recruiting into qualified nursing vacancies due to the low profile of the service within the nursing community and a national shortage of qualified nurses. However, the service was establishing links with a local university to raise its profile to undergraduate nursing students.

The staffing establishment levels for unqualified staff was 17 for Blueberry, 28 for Buttercup, 23 for Mulberry, 21 for Primrose and 25 for Wizard House. Buttercup had one vacancy for unqualified staff, Blueberry seven, Primrose six, Mulberry four and Wizard House none. The service had advertised all vacancies for unqualified staff at the time of our inspection.

Due to the shortage of qualified nursing staff across the service, senior management had expanded the role of some of the more experienced unqualified nursing staff. Senior management introduced the role of senior clinical support workers who were now responsible for completing all nursing duties except for administering medicines. These duties involved acting as a named nurse for individual patients, which included reviewing risk assessments and care plans under the supervision of a qualified nurse.

Following the upskilling of some unqualified staff to senior clinical support workers, Wizard House had adjusted their staffing matrix to reflect that only one qualified nursing staff was needed per day and night duty. The staffing matrix was also adjusted on this ward to reflect an increased need for more unqualified staff to cover the deficit of qualified staff. All other wards had two qualified staff on day shifts and one qualified staff on night shifts. We checked staffing rotas for the last four months for all wards and found that they were meeting this requirement, using bank and agency nurses to meet the qualified nursing staff deficit as required.

We reviewed the staffing rotas for all five wards from February 2016 to May 2016. All reflected that senior management were working within their estimated staffing levels. Ward managers were also able to incorporate the level of acuity of the patients or any planned patient escorts into the planning for the numbers of staff required.

Between1 March 2015 and 29 February 2016, staff turnover rates across the service for qualified and unqualified nursing staff ranged between 24% and 46%. Ward managers told us that staff had left the service because they had moved away from the local area or started full-time undergraduate nurse training. We reviewed exit interviews for four previous employees who had left the service within the last six months. Staff unanimously praised the support provided at ward level by their peers and line management. Three of the four staff, who were qualified nurses, identified limited career progression opportunities as a factor in their resignation.

Where wards had difficulty covering any shifts from within their own staffing resources, senior management would offer regular staff overtime or bank shifts to ensure continuity of care and familiarity of staffing for patients. Where staff could not be sourced from within the service, senior management block-booked agency staff that were familiar with the service and the patients. Between 1 December 2015 and 29 February 2016, the five wards had covered 572 shifts with bank or agency staff. Fifty-four shifts had not been covered during this time-period.

Patients we spoke with told us that since their care team had become ward based in February 2016, following a restructure of the child and adolescent inpatient service, staff presence on the wards was higher. This meant that patients were regularly receiving one to one time with their named nurse. Patients and staff also told us that since the service had introduced a new engagement and observation policy (in March 2016) staff were more accessible. This was because the new policy guided staff to use one to one observations as a last resort when managing patient risk to self and others. Consequently, staff were more reflective and mindful to use less restrictive interventions to manage challenging behaviour before initiating 1:1 observations. This meant that there were more staff available to meaningfully interact with all the patients about the ward, not just those being monitored on enhanced observations. This also had the positive effect of improving patient and staff morale and the number of incidents requiring staff physical intervention had decreased across all five wards.

We spoke with four medical staff, including three consultant psychiatrists, who worked across the five wards. One consultant psychiatrist was the responsible clinician for all patients on Blueberry and Mulberry wards, while another consultant psychiatrist was the responsible

clinician for all patients on Buttercup and Primrose wards. Each ward could admit a maximum of eight patients, and both consultant psychiatrists could be responsible for up to 16 patients at any one time. This exceeds national service standards for the recommended patient to consultant ratio for patients in psychiatric inpatient facilities. The Royal College of Psychiatrists' national service standards, as outlined in quality network for inpatient child and adolescent mental health services, states there should be a minimum of one consultant to every 12 patients.

At Wizard House, we found that there was only one full-time locum consultant psychiatrist providing medical input into the ward during the day. The locum had only been in post three weeks prior to our inspection. No junior medical assistance was available which increased staff workload and meant the doctor had to work longer hours to ensure all patients' needs were met from a medical perspective. However, the two junior medical staff provided medical support to the two consultant psychiatrists that covered the four psychiatric intensive care wards.

We looked at 25 patient care records and spoke with patients to identify how often they had contact with their consultant psychiatrist and other medical staff across the five wards. All patients saw their consultant psychiatrist at least once every two weeks to review their individual progress. This was within patient ward round that ran fortnightly on the four psychiatric intensive care wards and once a week at Wizard house.

The medical director was responsible for creating the on-call rota for support from a psychiatrist out of hours; there was a first on call with staff grade support and then a second on call support from a consultant psychiatrist. The hospital had a service level agreement in place with a local NHS trust, which meant that the trust also provided medical staff to cover the out of hour's on-call rota. Records confirmed that on call medical staff attended routine and emergency out of hour's calls when needed.

The hospital provided all new staff with a two-week induction package that all staff within child and adolescent mental health service had completed. This included training in fire safety, safeguarding adults and children at levels one and two, Mental Health Act, risk assessment, dementia awareness, suicide prevention, information governance and confidentiality, health and safety, immediate life support, food hygiene and infection control.

Staff new to the service also completed management of actual or potential aggression and ligature training. The management of actual or potential aggression training team also advised staff working within child and adolescent services what techniques would not be suitable for use when restraining patients. This included the head bar technique that could only be used within adult services. We saw evidence of this when reviewing the training schedule for the management of actual or potential aggression course.

Following completion at induction, all staff were expected to complete a refresher course on an annual basis thereafter. Mandatory training completion rates for each ward within CAMHS were as follows:

- Blueberry – fire safety 89%, safeguarding at level one and two 89%, Mental Health Act 89%, risk assessment 89%, suicide prevention 89%, health and safety 89%, immediate life support 89%, dementia awareness 89%, food hygiene 89%, infection control 89%, management of actual or potential aggression and ligature 94%
- Mulberry - fire safety 71%, safeguarding at level one and two 71%, Mental Health Act 71%, risk assessment 71%, suicide prevention 71%, health and safety 71%, immediate life support 91%, management of actual or potential aggression and ligature 95%
- Buttercup - fire safety 73%, safeguarding at level one and two 73%, Mental Health Act 73%, risk assessment 73%, suicide prevention 73%, health and safety 73%, immediate life support 76%, management of actual or potential aggression and ligature 76%
- Primrose – fire safety 71%, safeguarding at level one and two 71%, Mental Health Act 71%, risk assessment 71%, suicide prevention 71%, health and safety 71%, immediate life support 97%, management of actual or potential aggression and ligature 97%
- Wizard - fire safety 89%, safeguarding at level one and two 89%, Mental Health Act, risk assessment 89%, suicide prevention 89%, health and safety 89%, immediate life support 92%, management of actual or potential aggression and ligature 96%

In addition to the hospital-wide induction package, new starters within child and adolescent services were expected to complete safeguarding children at level three and

complete a refresher course annually thereafter. Across all five wards, the percentage of staff that had completed this training fell below the minimum service standard of 85%. The compliance rates for each ward were as follows:

- Blueberry – 75%
- Mulberry – 53%
- Buttercup – 75%
- Primrose – 60%
- Wizard - 74%

New starters also completed a specific module entitled 'working in CAMHS'. This workbook covered material on boundary setting and childhood attachment. All staff were also expected to complete a refresher course every year to ensure they kept up to date. Across all five wards, training compliance in the workbook was above 94%.

Although staff commented that the information presented within the workbook was informative, they also said that it needed to be more interactive to enable them to learn and understand how the techniques and information presented could be used more effectively in clinical practice. Senior management told us that they were currently reviewing the delivery method of the module and had plans in place to make it more interactive to increase staff satisfaction of the course. Due to an increase in patients developing or re-emerging with an eating disorder during their inpatient stay, senior management also had plans in place to include an eating disorder awareness course with the training package, however, no dates had been set.

Assessing and managing risk to patients and staff

Before our inspection, we reviewed data provided by the service for all five wards that contained information relating to the management of violence and aggression. This covered a six month time period between September 2015 and February 2016.

The number of incidents of seclusion were Buttercup 34, Blueberry 25, Mulberry 30, Primrose 45 and Wizard House two. During our inspection, ward managers also provided us with information regarding the use of seclusion between January 2016 and April 2016. Data showed that there had been a significant decrease in the use of seclusion since only one seclusion room had been functioning due to decommissioning or refurbishment of the other facilities. For example, the number of incidents of seclusion in April 2016 were significantly lower: Buttercup one, Blueberry two, Mulberry one, Primrose two and Wizard House none.

The number of incidents of use of long-term segregation were none on Buttercup, Blueberry, Mulberry and Primrose and three incidents on Wizard House.

The number of incidents of use of restraint were Buttercup 482, Blueberry 366, Mulberry 264, Primrose 857 and Wizard House 43. Staff recorded all use of holds, including guiding people away from an area, as restraint.

During our inspection, we also reviewed restrictive practice reports that were completed by all ward managers to analyse information relating to individual wards' management of violence and aggression. This included monitoring trends, such as particular days and times, when restraint, seclusion and rapid tranquilisation were used. We saw that ward managers used monthly staff meetings to review this information and meeting minutes identified that staff were invited to reflect on specific trends and identify ways in which they could reduce the use of physical interventions where appropriate. For example, restrictive practice reports across all wards identified that the use of restraint was higher during the evening when there was less staff presence on the ward. To address this concern, ward managers had employed five activity co-ordinators that also worked some evenings during the week. This addition to the staffing establishment had the positive effect that patients were more occupied and therefore less likely to engage in challenging behaviour. The use of zonal observations also meant that the majority of staff were not engaged in 1:1 patient observations, which meant that more staff were available to support all patients where necessary.

The data provided by the hospital prior to inspection also identified that a large proportion of the incidents requiring restraint related to patients who were actively engaging in self-harm. Staff had discussed with patients how they could best support them to reduce incidents of self-harm. Patients had individually identified coping strategies, that were detailed within their care plans, so that staff would know how best to support them in a crisis without having to use physical interventions. Examples we saw included patients who had devised flash cards that detailed what staff should and should not do to support them in a crisis. Some patients also wore different coloured loom bands that signified how they were feeling so that staff would be aware if there mood was deteriorating and could support the patient before they engaged in self-harm as a coping strategy.

Requires improvement

Child and adolescent mental health wards

Of those incidents of restraint, the number of which were in the prone position were: Buttercup 42, Blueberry 22, Mulberry 26, Primrose 50 and Wizard House two. During inspection, all ward managers told us that the information relating to the services' use of prone restraint was inaccurate. This was because the electronic incident reporting system, where staff recorded restraints, did not allow for accurate recording of some of the approved physical interventions that had been taught in the management of actual or potential aggression training programme. This included the administration of rapid tranquilisation when a patient was lying on their side. Rapid tranquilisation is the administration of medication to calm/lightly sedate a patient and achieve a reduction in agitation and aggression. The electronic incident recording system did not allow staff to record such as incidents as lying side-on, and therefore staff recorded such incidents as staff administering rapid tranquilisation in the prone position. Ward managers had alerted the hospitals lead for incident reporting of this concern, which the hospital were addressing at the time of our inspection.

We reviewed 25 care records. All had a current risk assessment in place, including a risk management plan. Staff reviewed individual patients' risk assessments and management plans following any incidents. The service used the Salford tool for assessing risk, which included formulation of risk, historical facts, triggers, current risks and risk management plan. At the back of the document, there was a section for patient views. While the majority of patients had completed this, some patients had declined. Staff documented all incidents related to the patient at the back of the risk assessment as an ongoing information log.

The hospital governance team were currently reviewing the use of blanket restrictions within child and adolescent services as part of their commitment to promoting least restrictive practice within the service. At the time of our inspection, not all patients were allowed access to their mobile phones: these were placed in safekeeping at the point of admission. Staff issued patients with a personal hospital mobile phone that contained key contact details that the patient had provided, including family, friends and their inpatient and community care teams. Ward managers told us that this restriction was originally in place because there had been previous concerns where patients had accessed inappropriate material on their mobile phones internet or took pictures of other patients that breached their right to privacy and confidentiality. However, senior management had recognised that not all patients were misusing their personal mobile phones in this way and had raised this with the hospital's governance team as a restriction that required immediate review. The service had also had iPads delivered and were awaiting imminent WIFI access so that patients could access the internet when required. Patients were risk-assessed on an individual basis to determine whether it was safe for them to have unsupervised internet access.

During our focused inspection in January 2016, we found that the hospital's observation policy was due for review in August 2015; however, we found that this had not happened and that the policy did not reflect the current Mental Health Act Code of Practice. During our most recent inspection in May 2016, we found that the policy had been reviewed in March 2016. The policy described the level of observation and the use of zonal observations, which we observed staff following. The service had a policy in place for searching patients where appropriate. This was risk assessed on an individual basis and could include searching for contraband items, such as lighters and sharp objects, on return from unescorted leave from the hospital. This was captured in an individual search plan for each patient. Random, unannounced searches on patients' bedrooms could also be facilitated where risks had been identified regarding an increase in incidents that related to the improper use of contraband items.

Staff we spoke with were mindful that physical interventions should only be used as last resort to manage challenging behaviour. In the first instance where staff had identified that a patient was becoming agitated, staff would use de-escalation techniques, such as distraction or encouraging the patient to move to a quieter area of the ward. Staff also used positive behavioural support plans to identify what may help individual service users to de-escalate in emotionally charged situations. Although these were not written from the patients' point of view, staff had identified what they had observed had helped individual patients de-escalate during difficult times. Patients we spoke with told us that staff only restrained them when all other attempts to minimise their distress had failed. Patients also told us that when they were calm enough, staff would talk with them regarding the incident and explore any potential triggers that they could address to reduce the risk of similar incidents occurring again.

Requires improvement

Child and adolescent mental health wards

We reviewed the use of rapid tranquilisation. This had also decreased across all five wards since January 2016. We reviewed each ward's restrictive intervention pack during our inspection which identified that in April 2016, there had been the following use of rapid tranquilisation: Buttercup four, Blueberry one, Mulberry one, Primrose two and Wizard House none. Clinical records showed that de-escalation strategies were attempted and oral medication offered prior to use of rapid tranquilisation. Staff used a rapid tranquilisation physical health monitoring tool to record patients' baseline physical health observations (such as blood pressure, pulse, respiration rate and oxygen saturation levels) following administration of rapid tranquilisation. The monitoring form instructed nursing staff to complete physical observations where possible following rapid tranquilisation for at least 90 minutes. Ninety minutes included if a patient was asleep at the point of observation. However, we reviewed 12 rapid tranquilisation physical health monitoring forms and found that nursing staff had not continued to monitor three individual patients as per protocol when they were asleep within the 90-minute period. This put patients at risk, as the National Institute for Health and Care Excellence (ESUOM28: Rapid tranquilisation in mental health settings: promethazine hydrochloride) advises that following rapid tranquilisation, for example with the medicines promethazine and haloperidol, there is an increased risk that it will not only calm the patient and encourage them to sleep, but also to deeply sedate and lose consciousness.

We reviewed nine seclusion records; spoke with one young person who was currently in seclusion and other patients who had previously been secluded. Records reviewed confirmed that seclusion was necessary and was terminated at the earliest opportunity. Doctors who attended to authorise seclusion would consult with a nurse and a support worker and document this as an internal multidisciplinary team review. The Mental Health Act Code of Practice states that a multidisciplinary team review should consist of staff from other disciplines (in addition to medical staff and a senior nurse) who would normally be involved in patient reviews. The hospitals seclusion policy also stated that multidisciplinary seclusion reviews "should include the multidisciplinary team that are normally present for the weekly service user reviews". Although we acknowledge that staff of other professions, such as psychology, social work and occupational therapy would not be available at night to form part of the multidisciplinary team review due to their workings hours, we did not find that they were regularly involved in multidisciplinary team reviews during the day where available.

We also found that following the initial multidisciplinary team review, medical reviews were limited to twice in every 24 hours at 9am and 5pm. Although this is the minimum review requirement as specified in the Mental Health Act Code of Practice, we found that the service's own records for documenting these reviews were not clear and potentially confusing for staff to follow. For example, the seclusion log book where staff recorded nursing, medical and multidisciplinary team seclusion reviews still advised staff to document when a four-hour medical review had taken place. This had not been updated to reflect the new provider's seclusion policy (April 2016), to advise staff that "following the first internal multidisciplinary team review, medical reviews do not have to be carried out 4 hourly but they must be carried out twice daily". The quality of the medical reviews were also variable across the records we reviewed and four did not adhere to the Mental Health Act Code of Practice. For example, some records only contained very generic statements regarding the patient's progress and risk assessment while in seclusion.

Recently, a young person had been segregated from the main ward population on Wizard House within their extra care area. We were concerned because staff recorded this as longer-term segregation but did not adhere to the procedural safeguards of the Code of Practice or the provider's own policy. The rationale for and short-term nature of the segregation better met the definition of seclusion, but the patient was not reviewed in accordance with the seclusion policy. We found that following this episode of recorded long-term segregation; staff had transferred the patient to one of the psychiatric intensive care ward's seclusion rooms.

We reviewed nine patient records that detailed the use of seclusion and long-term segregation. We found that on one occasion, a responsible clinician and junior doctor had recorded an episode of seclusion as seclusion and long-term segregation interchangeably within a patients care records. This meant that it was difficult to identify what procedural safeguards of the Code of Practice medical staff were referring to keep patients safe when being secluded or restricted to long-term segregation.

Requires improvement

Child and adolescent mental health wards

Staff we spoke with had a good knowledge of safeguarding and displayed a clear understanding of what would constitute a safeguarding concern. Staff knew how to report a safeguarding concern and we saw that staff did this in a timely manner.

There were two appointed safeguarding leads across the service: a senior nurse and a consultant. Both leads had completed training in level 4 safeguarding children and adolescents. They also attended a weekly safeguarding meeting with the clinical manager for child and adolescent services where they would review the service's safeguarding dashboard and invite the local authorities safeguarding representative to address any concerns.

On all wards, there was an up to date British National Formulary and an up to date children's version. Ward managers also completed a weekly audit of prescription cards and consent documentation. We reviewed the results of these audits across all five wards as recorded between the beginning of February 2016 and April 2016. Results showed that where there had been repeated errors (for example, staff not signing when they had administered medication) senior management had addressed these concerns with staff to ensure that this did not continue to happen. The service also had a contract with an external pharmacy company. A pharmacist visited all wards once a week and completed a monthly audit across the service recording errors with consent paper work, patient details, prescribing and administration errors. The governance team reviewed the monthly audits at the medicines management meetings.

During our inspection, we did raise one concern relating to a patient who had been prescribed an anti-psychotic medication in oral form. Although staff had administered this in oral form, it had been signed to indicate that it was administered in the form of an intra-muscular injection. We also found that one patient had been administered an intramuscular injection (due to being highly agitated) but we could not find evidence that this had been authorised as appropriate under an emergency section 62 of the Mental Health Act. The incident recorded that a section 62 was being used to authorise administration, however, this was not located with the patient's care records or medicines administration charts. Although the service were later able to locate and provide us with the section 62 form, this is in breach of the Mental Health Act Code of Practice.

The Code states that all copies of original signed certificates should be kept in the patient's notes, and a copy of the certificate relating to the medication should be kept with the patient's administration chart.

Track record on safety

Between 9 March 2015 and 17 February 2016, child and adolescent services had reported 11 serious incidents to CQC. Six of these incidents related to reports of absconding and/or overdosing on prescribed medications while on authorised un-escorted leave. Senior management completed an initial 72-hour review and a root cause analysis for one of the incidents, in relation to one of the seclusion rooms. The analysis identified four actions following the root cause analysis, which the inspection team reviewed in January 2016. The inspection team were confident that the service had adequately addressed two of the four actions. The two outstanding actions were the review of the seclusion policy to include the safe exit of the seclusion room and the review of the training content in relation to management of actual or potential aggression. In May 2016, we found that the service had created a new procedure called the management of seclusion doors entry and exit. However, this did not cross-reference to the seclusion policy and the seclusion policy did not include the safe exit of seclusion. The seclusion room on Primrose ward clearly displayed the procedure for the management of seclusion doors entry and exit. We spoke to three staff, reviewed the training content, and were not assured that the staff facilitating the management of actual or potential aggression included how to safely exit seclusion in the training provided to staff.

Reporting incidents and learning from when things go wrong

Staff we spoke with could identify a variety of incidents that would require reporting and were able to access and use the service's incident reporting system to do this. This included staff of all grades and professions from within the service.

Patients told us that staff were supportive following any incidents and initiated a debrief as soon as convenient for the individual patients involved. Patients told us that this also included incidents that may not have directly involved them but also instances where they could have witnessed an incident that could have been potentially distressing to them. Incidents were also discussed within patient

Requires improvement

Child and adolescent mental health wards

handover meetings that occurred on each ward for approximately half an hour every morning. Professionals from the ward's care team also attended these meetings, which gave patients a further opportunity to discuss incidents and share any lessons learnt from a variety of perspectives.

The service had established a risk and safety group that met on a monthly basis to review the nature and number of incidents that had occurred on the wards. This included all three ward managers. Ward managers then compiled data packs that included the number of restraints, rapid tranquilisations and seclusions used and analysed this information to identify trends and further intervention strategies to reduce the use of restrictive practices within the service. Staff told us and meeting minutes confirmed that learning from incidents was a standing agenda item within staff team meetings that occurred monthly on each ward. A learning from incidents log form was also available on each ward. Ward managers completed these monthly and used these as a guide to share any lessons learnt following any incidents that had occurred from within the rest of the hospital. This form was available within a staff information folder on each of the wards, and staff we spoke with were aware of this and were able to recount incidents that had recently occurred and any learning that had been identified following a review by senior management.

Are child and adolescent mental health wards effective?

(for example, treatment is effective)

Requires improvement

Assessment of needs and planning of care

Across the five child and adolescent wards, we reviewed care records for 25 patients. Only one patient did not have a complete physical health assessment following admission. However, this was because the newly admitted patient declined to engage in the assessment, although staff continued to encourage engagement as appropriate. Assessments relating to patients' mental health were detailed and clearly identified patients' current strengths and difficulties.

Care records contained comprehensive physical health assessments that were completed by the service's physical health care team. This team comprised of senior nurses who continued to monitor patients' physical health throughout their inpatient admission. Across all five wards, we saw good examples of detailed assessments and care plans for patients with specific physical health problems such as diabetes and specific allergies. We also saw two care plans that contained comprehensive assessments and detailed monitoring of patients diagnosed with anorexia nervosa. This included monitoring for associated physical health complications such as dehydration and low blood pressure. An external general practitioner also ran a physical health clinic once a week for patients within child and adolescent services. This provided an additional opportunity for patients to have enhanced monitoring of their physical health needs.

All 25 patient care records we reviewed contained care plans that were up to date and had regularly been reviewed since admission; at a minimum of once a week or more frequently if the particular patient's care needs had changed. Patients had a variety of care plans that related to their individual needs. There were care plans for managing self-harm, safeguarding, seclusion and community leave. All care plans were goal-orientated and recovery focused, although they tended to focus more on short-term goals as opposed to what the long-term goals of patients' inpatient treatment may be.

Senior support workers completed and reviewed some care plans. We found those completed by senior support workers were completed to the same standard as those completed by qualified nursing staff.

Every patient had a positive behavioural support plan in place. The Mental Health Act Code of Practice defines a positive behavioural support plan as a care plan for patients who have been assessed as being liable to present with behavioural disturbance. The plan should include primary preventative strategies, secondary preventative strategies and tertiary strategies. However, the majority of the behavioural support plans we reviewed were reactive in nature, detailing what the patient could do in response to a difficult event to minimise their distress. Mostly, they did not detail how preventative strategies could be used to minimise the likelihood of the behavioural disturbance occurring in the first instance. However, patients told us about preventative strategies they had created, with staff support, to prevent their behaviour from escalating and said these were effective.

Requires improvement

Child and adolescent mental health wards

In addition to paper-based patient care records, the service used four different electronic systems to store information. Staff used an electronic system for daily notes including patients' daily progress, an electronic incident reporting system and an electronic system for patient observation levels, patient leave status and staff to patient ratios. Senior management used an electronic human resources system to log staff's annual leave status, appraisals and supervision notes. Staff consistently reported that they found the systems easy to navigate so that they could access information in a timely manner.

Best practice in treatment and care

Staff followed National Institute for Health and Care Excellence guidance when prescribing medication for patients. This included psychosis and schizophrenia in children and patients: recognition and management (CG155) and depression in children and patients: identification and management (CG28).

The service did offer psychological therapies, approved by the National Institute for Health and Care Excellence, for the treatment of mental health conditions in patients. This included individual cognitive behavioural therapy sessions and group dialectical behavioural therapy informed sessions. Psychology also facilitated stand-alone sessions on self-soothing, assertiveness and mindfulness. One clinical psychologist was also due to commence a course in eye movement de-sensitisation and re-processing therapy which has an evidence base for effectively treating people who have experienced trauma. The service had also identified a recent increase in the instances of patients who self-harm that were admitted to the service. In response, psychology staff were due to launch control and stop groups that were designed specifically to support patients who engage in self-harm in June 2016. This is also a psychotherapeutic approach recommended by the National Institute for Health and Care Excellence in guidance CG133; self-harm in over 8s and long-term-management.

The hospital had an established physical health care team who visited the wards regularly to assess and monitor patients' physical health needs. The team comprised of senior nursing staff. An external general practitioner also ran a clinic once a week within the hospital so that patients could attend to have any further medical issues addressed.

We saw that staff referred patients to specialist external services where appropriate. This included referrals to dietitian services for patients with an eating disorder and physiotherapy services.

Staff used rating scales to assess and record the severity of patient illness and to monitor patient outcomes through their inpatient treatment. This included the Health of the Nation Outcome scales for children and adolescents and the Children's Global Assessment Scale. Staff also used more specialist assessment tools where a clinical need indicated. This included use of the Wechsler intelligence scale for children to help identify if patients have learning difficulties or a learning disability. Ward managers completed weekly audits to ensure staff had completed all rating scales within an appropriate time frame.

Senior staff completed clinical audits on a monthly basis to ensure quality standards were maintained and to address any identified shortfalls. This included monthly audits in care planning, Salford tool for assessment of risk documentation, prescription cards and admissions packs.

Skilled staff to deliver care

The service employed a range of professionals specialising in the treatment of patients experiencing mental health difficulties, including occupational therapists, psychologists, social workers and pharmacists. However, input on Blueberry and Buttercup wards was inconsistent due to vacancies and high staff turnover rates. The service employed two full time psychologists and had two full-time vacancies that had been advertised. To help ensure the service met the national minimum standards for psychiatric intensive care units for patients (that states patients should receive a minimum of eight hours of psychological therapy per week) the service employed locum psychologists. However, some of the patients we spoke with said they valued the consistency and familiarity of treatment provided by psychologists employed in a substantive post. Some patients we spoke with on the female only ward, Primrose, also raised concerns that there were no female psychologists employed in permanent posts. Senior management were aware of this and were mindful to address this imbalance when recruiting new staff members.

The supervision policy dated January 2015 (from the previous provider) referred to historical CQC requirements of outcomes. The policy states staff should receive

supervision every two to three months. However, staff we spoke to understood the organisational requirement to be monthly. Supervision logs were in place in all wards except Buttercup. The logs had been in place since January 2016 in all wards except Wizard House, which had been in place since March 2016. The logs showed staff had received both clinical and managerial supervision. The clinical manager expected ward managers to submit monthly updates regarding supervisions completed. We reviewed 11 supervision files, which showed staff were receiving supervision every one to two months. The supervision agenda included what works well, what does not work well and areas for improvement.

Non-medical staff also received an appraisal from their line manager every twelve months. The compliance rates across the five wards were as follows;

- Blueberry – 100%
- Buttercup – 72%
- Mulberry – 79%
- Primrose – 90%
- Wizard House – 75%

Audits showed that the service had witnessed an increase in the number of patients who were identified as having an emerging personality disorder while an inpatient at Cygnet. To enable staff to care for these patients effectively, senior management recognised that staff required additional training in personality disorders. Training comprised of a two-day training course that covered topics such as what is a personality disorder (including the various classifications) possible causes, working with personality disorders and maintaining staff wellbeing when working with this client group. However, the number of staff that had completed the course across all five wards was low:

- Blueberry – 23%
- Buttercup – 14%
- Mulberry – 5%
- Primrose - 15%
- Wizard House - 14%

This was a concern as staff we spoke with across all five wards identified that working with patients who had an emerging personality disorder was challenging and that they required specialist knowledge to not only support patients effectively, but also to maintain their own mental well-being and reduce the risk of staff burnout. However, staff told us that psychology staff facilitated weekly reflective practice sessions where they were provided with an opportunity to receive specialist support and knowledge in caring for patients with a personality disorder. We reviewed previous training schedules for these practice sessions and found that psychology staff were regularly facilitating the sessions and staff told us they were a good source of support.

The service had also seen a recent increase in the number of patients admitted to the service who had an eating disorder. Although senior management told us that eating disorders were part of the exclusion criteria for admission to the service, we reviewed the referral and exclusion criteria for the service, which did not make reference to eating disorders. The service identified that some patients had either gone on to develop or had a re-emergence of a previous eating disorder while an inpatient at Cygnet. To address this concern, senior management told us that they had plans in place to facilitate a specialist eating disorders training package to eligible staff across the five wards. However, they could not provide us with dates of this training when requested.

Multidisciplinary and inter-agency team work

During inspection, we reviewed agendas and meeting minutes for staff meetings that ward managers facilitated on a monthly basis. Records demonstrated regular multidisciplinary staff attendance and that staff contributed effectively. Staff told us that these meetings provided them with an opportunity to express their concerns regarding the running of individual wards and to seek professional advice and support from other members of the multidisciplinary team. Learning from incidents was a standing agenda item where staff were made aware of any lessons learnt following incidents that occurred not only within child and adolescent mental health services but also from the wider hospital.

Psychology professionals also facilitated a reflective practice once a week (across two wards) where staff could attend to gain support, advice and knowledge if they had experienced any challenging clinical situations. Staff we spoke with commented positively on these sessions because they helped to prevent them reaching burnout when working within a challenging environment.

Every ward facilitated a staff handover, attended by the multidisciplinary team, twice a day. These occurred in the morning and evening between day and night shifts. We

attended and observed one of these handover meetings during our inspection. We observed that staff were effective in highlighting patients' current and historical risks and that staff worked collaboratively to identify solutions to identified problems. Staff from the multidisciplinary team also facilitated a second handover, once a day on each ward, where patients were also invited to discuss their plans for the day and address any matters of concern. Patients had previously raised concerns that these meetings were not very well attended by some professions within the multidisciplinary team, however they told us that attendance had significantly improved since the team had become ward-based in February 2016. It also gave patients the opportunity to direct any concerns or queries they may have to staff directly, which had the positive effect of reducing the frustration at having to wait for communication at a later point in the day.

Because Cygnet Bury was only one of few hospitals nationally to offer a psychiatric intensive care unit for patients, many of the patients admitted were not from the local area. Some of the current patients lived some 200 hundred miles from Bury. The distance made effective communication with some patients' local care teams more difficult, as due to travelling distance most communication was made either through email or telephone. We found that staff did offer a teleconferencing service so that local care teams could be involved in meetings such as care programme approach and discharge meetings where they were not able to attend in person.

The service had established an effective working relationship with their local authority safeguarding team. We saw examples of regular engagement with the local authorities designated officer to discuss thresholds to determine whether a safeguarding referral was appropriate.

Some senior management staff described a tenuous relationship with their specialist-commissioning group. They told us that this was due to external pressures to admit patients with very complex needs that, in some cases, the service did not feel that they could effectively manage. This particularly included patients who had a diagnosis of an eating disorder. However, since a new management team had been put in place at Cygnet, ward managers felt they were given more authority and confidence to say no to referrals they identified as not suitable.

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

All eligible staff had attended Mental Health Act training as part of their induction when they first joined the hospital. However, staff had not received training on the Mental Health Act Code of Practice, published in 2015.

The ward managers we spoke to were not aware if the Mental Health Act Code of Practice 2015 had been incorporated into the MHA training for new staff being inducted into the service. We spoke with staff from a variety of grades and professions who demonstrated a variable understanding of the Mental Health Act and its Code of Practice.

Certificates showing that patients had consented to their treatment (T2) or that it had been properly authorised by a second opinion approved doctor (SOAD) because they were either not capable of understanding the treatment they needed or the treatment was deemed necessary and authorised without their consent (T3) were mostly completed and attached to medicine charts where required. However, we found one example on Mulberry ward where a patient had an authorised T2 in place and an emergency section 62 treatment provision running concurrently. When the section 62 had been completed, a formal request for a review by a second opinion doctor had not been sought as appropriate. We also had concerns where another patient whose medication was authorised under section 62 emergency treatment provisions and the amount of time that elapsed between completing the certificate and requesting a SOAD.

We reviewed 25 care records for patients detained under the Mental Health Act and found that staff explained their rights and legal status under section 132 of the Mental Health Act on admission and monthly thereafter.

The hospital had an established Mental Health Act team who were responsible for the auditing and reviewing of the operation of the Mental Health Act on the wards. However, since the appointment of the Mental Health Act manager to a corporate position the team had struggled to fulfil these responsibilities due to an increased workload. For example, while on Wizard House we found that copies of detention paper work were not filed in the young person's care records as appropriate. The Mental Health Act Code of Practice states that copies of detention paperwork, consent to treatment and treatment authorisation forms should be

filed in patient care records. This is important because it allows staff to have prompt access to the patients' current legal status and identify what treatment, and under what conditions, patients can be treated.

There was an independent mental health advocacy service available to all patients and this included a gender specific advocacy service for female patients. Staff and patients spoke highly of this service and told us that an independent mental health advocate visited all the wards at least twice a week to support patients detained under the Mental Health Act. They also attended care programme approach meetings if the young person requested this and advocated on behalf of patients with NHS England regarding suitable placements for discharge if required. There was also gender specific advocacy service for male patients. However, staff and patients told us that although they attended the ward once a week, the service was not as responsive to the individual needs of the patients.

Good practice in applying the Mental Capacity Act

Senior management told us that training in the Mental Capacity Act formed a small part of the staff mandatory training course in the Mental Health Act. However, we reviewed the latest training schedule provided by the service, entitled Mental Health Act Training: Alpha Hospital Induction Programme (August 2015) and found that the Mental Capacity Act was not covered within this. This meant that staff within the service did not receive training in the Mental Capacity Act. This was a concern because the service admitted patients aged 16 and 17 years, to whom the Mental Capacity Act does apply. This could result in staff restricting patients without a lawful framework.

We reviewed 25 patient care records and found that where appropriate, most patients who had been identified as having impaired capacity had been assessed and their ability to consent had been recorded appropriately. These adhered to the Mental Capacity Act Code of Practice and were decision specific. However, on Mulberry ward we found one example where we could not find an assessment of capacity for a young person aged above 16 years who would have benefitted from this.

We also found for one patient on Mulberry ward, a capacity assessment completed on 7 March 2016 which identified the patient did not have capacity to consent to their treatment, another capacity assessment was completed on 21 March 2016 which identified the patient had fluctuating capacity to consent to treatment. Both of these capacity assessments ran concurrently with a T2 authorisation form, indicating the patient had been assessed as having the capacity to consent to their treatment. Therefore, the records were contradictory.

In the last six months, the service had made one Deprivation of Liberty safeguards application. This was for a 17-year-old patient. However, we had concerns because emergency and standard Deprivation of Liberty Safeguards authorisations can only be applied to people aged 18 years and above. The Mental Health Act Code of Practice 2015 (19.52) states that; 'In cases where a child or young person cannot be admitted and/or treated informally, and the criteria for detention under the Act are not met, legal advice should be obtained on whether to seek the assistance of the High Court.' This meant that only the Court of Protection could make a deprivation of liberty order in respect of the young person aged 17. However, at the time of our inspection in May 2016, we found that the service had not made such an application to the Court of Protection, and therefore the Deprivation of Liberty safeguards application was not valid. The patient had been unlawfully detained for two weeks. We immediately alerted senior management to this who responded to our concern promptly. They requested appropriate legal advice regarding the case, and further applied to the Court of Protection to authorise the Deprivation of Liberty safeguards. The service also ensured that, as per the Mental Capacity Act Code of Practice (2005), the young person had the appropriate legal safeguards in place while being deprived of their liberty. This included twice-weekly access to an independent mental capacity advocate weekly access to an independent mental health advocate and a multidisciplinary review of their care plan to ensure it was least restrictive.

However, despite this prompt action, we continued to have concerns that the hospital did not have a Deprivation of Liberty safeguards policy in place that staff could refer to regarding the proper use of Deprivation of Liberty safeguards for patients aged below 18 years. Senior management told us that the previous provider, who had been superseded by Cygnet in August 2015, did not have a Deprivation of Liberty Safeguards policy in place because patients admitted were ordinarily detained under the Mental Health Act. While this was likely to continue to be the case for patients admitted to the four psychiatric care wards due to the acuity of their condition, Wizard House,

Requires improvement

Child and adolescent mental health wards

opened in October 2015, was used a step down unit where patients were preparing to move on from inpatient services. This meant there was an increased likelihood that patients at Wizard House would not necessarily be detained under the Mental Health Act. Senior management assured us that Cygnet had drafted a new Deprivation of Liberty safeguards policy that had been sent for ratification to Cygnet's managing directors group.

We also had concerns that staff did not receive training in legal safeguards and mental capacity frameworks relevant to children and patients aged below 16 years. This included the Gillick competence framework and The Children Act 2004. We spoke with a range of staff of varying grades and professions and found that their knowledge of these safeguards and frameworks was limited. Although senior management acknowledged that staff knowledge in relation to legal safeguards and mental capacity frameworks relevant to patients aged below 16 years required improvement, they could not provide us with any assurance that staff would receive formal training in this in the near future. Staffs limited understanding of the safeguards available to them meant that patients could have an infringement of Article 5 of the Human Rights Act, right to liberty and security.

Senior management and staff told us that if they required information and support regarding the appropriate use of the Mental Capacity Act, they would contact the service's Mental Health Act team or safeguarding lead. They told us that the team was responsive to any concerns or queries raised. However, the Mental Health Act team had limited understanding of the Mental Capacity Act. We did not find any arrangements in place within the service to monitor adherence to the Mental Capacity Act.

Are child and adolescent mental health wards caring?

Good

Kindness, dignity, respect and support

During our inspection, we observed staff interacting with patients in the ward environment. Staff took the time to respond to individual patients' needs, we even saw this happening during busy periods of the day, such as when the general practitioner clinic was being facilitated, and there were fewer staff on the wards due to escort requirements. Staff demonstrated skill in managing challenging situations where patients had become distressed and required intensive staff support to reduce their agitation levels. Staff used de-escalation techniques, such as verbal reassurance and encouraging patients to move to quieter areas of the ward. We observed that this gave all the wards we visited a calm atmosphere, which meant that incidents were less likely to occur because patients felt comfortable in the environment.

We attended and observed seven multidisciplinary meetings that patients also participated in. This included care programme approach meetings, patient community meetings and patient handovers. We observed that staff valued patients' opinions and demonstrated a thorough understanding of their individual needs and preferences. We saw that staff involved patients in the decision making process when changes were made to the ward and patient care and treatment. This had recently included discussing and agreeing contingencies around section 17 leave of absence during a patient community meeting.

We spoke with 13 patients and reviewed eight comment cards that patients submitted to CQC during our inspection. Patients were mostly positive about how staff treated them, told us that staff were respectful, kind, and took the time to listen to them. Most patients told us that the best thing about the service was the support they received from the staff. Seven patients were positive that since the service were committed to promoting least restrictive practice and therefore more mindful to not use enhanced observations unless necessary, staff were more available to all patients on the ward which made them feel more valued, listened to and included. One young person did raise a concern that they had previously felt punished by the service when the 'alert system' was in use. The 'alert system' was used to categorise patients as red, amber or green, which the hospital linked to their behaviour and whether they had been involved in any incidents. However, the young person said that since the service had got rid of this system (in January 2016) they felt that staff were mindful to explore the reasons why incidents had occurred and were more supportive and less punitive.

The involvement of people in the care they receive

Patients told us that staff orientated them to the ward environment on admission and provided relevant and accessible information regarding the service, available

treatments and their rights if detained under the Mental Health Act. We reviewed 25 care plans for patients across the five wards and all demonstrated that patients had been involved in their formulation and that their views had been captured. Patients we spoke with identified they were involved in the formulation of the care plans and that they met with their named nurse once a week to review these collaboratively. Patients reviewed their individual star risk assessment with their named nurse once a week or more regularly if the need warranted. Risk assessments demonstrated that staff considered patients' thoughts and that staff were mindful to take positive risks where appropriate to maximise patient independence. All patients we spoke with had a copy of their care plan or staff had documented where a patient had declined.

Patients attended part of their weekly ward round to review their individual progress with the multidisciplinary team. They also attended care programme approach meetings to discuss their future care provision. We attended and observed two care programme approach meetings and one ward round with the permission of the patients involved. We observed that information was presented to patients in a sensitive and age appropriate way. Staff listened to patients' views and respected these when planning for future care.

All the female patients we spoke with commented positively on the service provided by the female gender specific independent mental health advocacy service. They told us that the advocate visited the ward regularly and that they would support them in ward rounds and care programme approach meetings if they requested. All patients across the five wards had been referred to advocacy services as appropriate. Male patients we spoke with told us that service that provided independent mental health advocacy for males were less visible on the ward than the female advocate; however, they felt that the once weekly visit generally met their needs.

Most of the carers of patients using the service spoke positively about how the service involved them in their care delivery. However, we did find examples where a carer had complained because they thought the service was withholding information regarding their son or daughter's care and treatment. However, on review of the patients' care records we found that the patients were aged 16 years or above, had been deemed to have the capacity to understand the implications of withholding information from significant others and had signed a confidentiality form barring disclosure. This meant that staff were appropriately authorised not to share the requested information.

We found one example where third party confidentiality had been breached. The service had acknowledged this failing and we checked and found that they had provided those affected with a written apology.

Two of the five carers we spoke with expressed some frustrations that maintaining meaningful contact could be difficult because they were not from the local area, which made face to face contact more difficult to facilitate. Some carers had to travel in excess of 200 miles to the hospital; this was due to the nationally limited availability of psychiatric intensive care units for children and patients. However, carers acknowledged the service were doing all they could to include carers, including regular telephone contact and teleconferencing for significant meetings if they were unable to attend. Carers also told us that the service sent them a child and adolescent services welcome pack on admission to the service to help explain what the service offered, including care pathways, different treatments and relevant contact details.

Patients were not involved in the recruitment of new staff and senior management had no plans in place to facilitate this at a future date. However, patients had recently sat on interview panels to recruit new teachers to the services education department.

At the time of our inspection, the service did not provide carers with a formal opportunity to provide feedback into the running of the service, for example via carer surveys or carer meetings. Senior management voluntarily acknowledged this was a shortfall within the service and something they planned to address.

Are child and adolescent mental health wards responsive to people's needs?
(for example, to feedback?)

Good

Access and discharge

Requires improvement

Child and adolescent mental health wards

Between 01 August 2015 and 01 January 2016 the psychiatric intensive care wards had the following average bed occupancy rates;

- Blueberry – 77%
- Buttercup – 89%
- Mulberry – 77%
- Primrose – 93%

Wizard House had opened in October 2015, and had an average bed occupancy rate of 82%.

We found that beds were available for patients living in the locality when needed. However, due to a national shortage of psychiatric intensive care units for patients, there was an increased demand to admit eligible patients that could live in excess of 200 miles away from the hospital. Where patients had been granted authorised overnight leave, the service did not admit into leave beds, which meant that there was always a bed available upon return.

Patients were sometimes moved between wards during their admission. However, this was justified on clinical grounds and was always discussed beforehand with patients and their carers where appropriate. Clinical grounds for moving patients between psychiatric intensive care wards included patient dynamics and acuity of the patient. For some patients there was a clear care pathway where Wizard House would be used a step-down placement following successful treatment on one of the psychiatric intensive care wards.

The contract and compliance team received all new referrals to the service, which they immediately sent to ward managers for review. The service had a policy in place that identified senior management must respond to all new referrals within one hour of receipt. However, this allowed additional time for senior management to request further information if the referral form was not comprehensive enough to make an informed decision. The service ran weekly referrals, admissions and discharges meetings that were attended by ward managers, medical consultants and members of the hospitals senior management team. The referrals, admissions and discharges meeting allowed staff to maintain an oversight of what happening across the service and address any concerns collaboratively regarding inappropriate referrals or delayed discharges. Local commissioners also attended on occasions to discuss and monitor any particular concerns.

The service reported an increase in the number of inappropriate referrals to the service. Senior management told us that this was particularly for patients who had a primary diagnosis of an eating disorder. Staff within the service did not have the skills or knowledge to support patients with severe eating disorders. Ward managers told us that referrers did not always capture important information on the referral forms and therefore Cygnet were not always aware of the severity of the condition until the patient was admitted.

Ward managers told us that this formed part of the exclusion criteria for admission to the service. However, we reviewed the admission and exclusion criteria for the service. The criteria did not refer to excluding patients from admission based on their diagnosis of an eating disorder. This meant that it could be potentially confusing for referrers, as the criteria for admission did not corroborate with what ward managers told us.

To reduce the number of inappropriate referrals to the service, ward managers told us that they always contacted the referrer directly via telephone to discuss further before formal acceptance or rejection. Ward managers also told us that since a new senior management team had been formed in February 2016, they felt more supported in their decision making which included the authority to reject or request further information depending on the quality of information provided on the referral form. The service also had a new commission for quality and innovation target in place following the surge in referrals that lacked comprehensive information to make an informed decision regarding admission. This was entitled ‘MH9 – Assuring the appropriateness of unplanned CAMHS admissions’. The commission for quality and innovation payment framework enables commissioners to reward excellence, by linking a proportion of English healthcare providers' income to the achievement of local quality improvement goals.

Between 1 August 2015 and 1 January 2016, the service reported two delayed discharges on Primrose and Mulberry wards. One related to a patient who was awaiting approval for funding by the local clinical commissioning group for a community placement, and another was awaiting allocation of a placement within a specialist autistic spectrum disorder service. However, the service had discharged both patients by the time of our inspection. The service recorded one delayed discharge during our

inspection. We reviewed the young person's care records and where satisfied that the service was proactive in initiating regular contact with young person's local care team to identify a future placement.

The facilities promote recovery, comfort, dignity and confidentiality

The four psychiatric intensive care wards shared one examination room that was used to complete patients' physical health examinations. The ward's clinics were either too small or shared by another ward, which meant that to maintain patients' privacy, and dignity, staff could not conduct physical health examinations there. Only Wizard House had an examination couch within the clinic room. Staff told us the medical and nursing staff would perform physical observations within individual patients' bedrooms to protect their privacy and dignity if the examination room was otherwise in use. Patients we spoke with were happy with this procedure.

The psychiatric intensive care unit had two designated meeting rooms where patients could receive visitors in private. Patients and their carers told us that this facility needed to be booked in advance due to high demand. Buttercup, Mulberry, Primrose and Wizard wards all had quiet rooms or areas where patients could meet visitors in private. However, Blueberry only had one quiet room. This could make it more difficult for patients to meet with their visitors in private, particularly if the family meeting rooms, which were based off the ward, were already in use. All five wards had phone booths that patients could use to make a phone call in private.

In September 2015, Bury Metropolitan Borough Council awarded the hospital a food hygiene rating of five (very good). Patients were mostly positive about the quality of the food provided and told us that food and drink was available throughout the day and night. The service offered three to four choices per meal in addition to specific dietary requirements. Staff provided all patients with a personal locker in which they could store their possessions. This included contraband items such as sharp objects that could be used to self-harm.

Patients told us that the quality and quantity of activities on the ward had increased in the last few months. They identified that this positive change was due to number of changes made within the service. Firstly, all wards had appointed an activity co-ordinator that worked 9am – 5pm Monday to Friday in addition to one evening a week covering the hours between 7pm and 11pm. This was in addition to occupational therapy support to facilitate activities during the week. Staff and patients also told us that group leave would be facilitated once a week and this could extend for up to a full day depending on what activity the patients wanted to do. Recently, group leave had included trips to a safari park, zoo, cinema and theatre. We reviewed planned activity timetables for all five wards, and patients confirmed that these were happening. Activities included healthy living groups, walking and art therapy. At the weekend, patients told us because there were less formal meetings occurring on the wards, more support work staff were available to lead activities or facilitate more group leave off the hospital grounds. Patients also told us that staff were available to lead activities because they were not continually engaged in high-level one to one patient observations. Staff and patients told us that this was since the service had started to promote least restrictive practice, thereby only using enhanced patient observations were necessary.

Patients' activity timetables also included formal educational sessions. Education sessions accounted for 16 hours of the timetable. Staff and patients told us that attendance at education was variable but staff encouraged patients to attend and were mindful to build structure and consistency into patients' days. Staff and patients cited the acuity of their condition as being a barrier to engage in education, and poor experience of the educational system in the past. Since the provider, Cygnet, had taken over the running of the hospital, the educational department had applied and were awaiting assessment to become registered with the Office for Standards in Education.

Meeting the needs of all people who use the service

Both Wizard House and Forestwood (which housed the four psychiatric intensive care units) had disabled access. Both units were housed over a first and ground floor and a lift was available in both. Information leaflets for patients and families where English was not their first language were available upon request. All the wards we visited had notice boards that displayed information regarding how to make a complaint, advocacy information (including contact details) and details of services and resources within the local community. Information was presented in an accessible, age appropriate way. Patients and their families were also provided with further information regarding the

service, available treatments and care pathways on admission to the service. We spoke with five carers and four of these confirmed that they had received a carer's pack on admission. Patients on Wizard House had also been involved in creating a 'buddy pack' for newly admitted patients. The pack contained information about the service that past and present patients had identified as being useful and that they hoped would familiarise new patients to the service. Due to its success amongst the patient group at Wizard house, ward managers had plans in place to implement the buddy pack on the psychiatric intensive care wards.

We found that the service mostly accessed interpreters for patients and their families who did not speak English as a first language. However, we did find one example on Wizard House where an interpreter for a young person's parents was not requested which may have been beneficial to aid the parents' understanding of the young person's care and treatment. If required, the service had access to specialists in the use of British Sign Language from the hospital's interpreting service. Patients told us that the service were able to cater for their dietary preferences, which included particular religious and ethnic requirements. One young person we spoke with was very complimentary about the service's responsiveness to her particular religious needs and that staff of the same religion would facilitate protected time for spiritual practice throughout their inpatient stay. Patients also told us that staff facilitated weekly escorts to a local church and mosque where a need or interest had been identified. A multi-faith room was available for use on-site.

Listening to and learning from concerns and complaints

Between 4 February 2015 and 30 January 2016, the service received 60 complaints. Only six of these were upheld following an initial response from the service. No complaints were referred to the independent sector complaints adjudication service (ISCAS) or to the ombudsman. Of the six upheld complaints, three of these related to complaints made by patients and/or carers on Mulberry ward regarding the lack of staff and activities available on the wards. However, since these complaints had been formally made, the service had addressed these issues via employment of activity co-ordinators and the reduced use of enhanced patient observations, which meant staff were more accessible to patients on the ward. Patients we spoke with during our inspections said that there was a sufficient level of activity on the wards and that staff had time to meet their individual needs.

Patients we spoke with knew how to make a complaint and those that had complained explained how they received feedback that was in accordance with the service's complaints policy. Staff knew how to handle complaints appropriately and explained how most concerns could be resolved at a local level before having to escalate to senior management level as a formal complaint.

During our inspection, we case-tracked three complaints that parents of patients using the service had submitted within the last four months (February 2016 – May 2016) at a ward level and two at a governance level. We found that four of the five complaints reviewed had completed investigations. Parents and or/patients had been provided with formal feedback via face to face contact and a letter within an appropriate time frame. Where appropriate, the service had offered an apology where a fault had been identified. The hospital had a complaints policy, dated January 2016. The policy states that staff should record all complaints on the electronic incident reporting system. The governance team found a complaints investigation from January 2016 did not have information of how staff investigated the complaint stored centrally; the response to the complainant did not say if the hospital upheld the complaint or not. However, the complaints reviewed from May 2016, since the complaints officer was in post, showed an empathetic and sensitive investigation and included an apology to the complainant with additional contacts of how to escalate the complaint if not happy with the outcome.

Staff received formal feedback regarding the outcome of complaints within monthly staff meetings. We reviewed meeting minutes for all five wards' monthly staff meetings and found that this was a standing agenda item. Staff were able to provide examples of where specific mistakes had been made and how learning had occurred following an investigation into the incident. Staff also told us that ward managers were both approachable and sensitive and would discuss any particular issues regarding complaints that may have related to them personally within line management supervision.

Requires improvement

Child and adolescent mental health wards

Are child and adolescent mental health wards well-led?

Requires improvement

Vision and values

The provider's values were;

- Helpful – "go the extra mile for service user, customer and team"
- Responsible – "do what you say you will do"
- Respectful – "treat people like you like to be treated yourself"
- Honest – "be open and transparent, act fairly and consistently"
- Empathetic – "be sensitive to others' needs, caring and compassionate."

Staff we spoke with demonstrated a good awareness of the organisation's values and objectives and upheld these within their work. Cygnet had recently provided all staff with prompt cards that were attached to staff lanyards. Prompt cards outlined the provider's key values and gave examples of how these could be demonstrated within clinical practice. The provider's values were also embedded within staff supervision and appraisal guidelines and staff performance was partly measured against how successfully they were incorporating these into their work.

Staff knew who the most senior managers in the hospital were and they visited the wards regularly.

Good governance

Since the inspection in February 2015, the provider had changed the hospital's governance structure, with clearer lines of accountability and reporting mechanisms in place. The structure included new roles of leads of all disciplines; there was one vacancy for the lead psychologist at the time of inspection. In addition, a clinical quality and compliance manager, clinical manager and general manager had been introduced. The new structure had been in place since January 2016.

The governance action plan in place prioritised committee structures, new terms of reference for meetings and set agendas to ensure consistency of information sharing. This had clear dates for achievement of actions. We observed positive progress with the new governance structure in place, with a number of meetings taking place and feeding into the senior management level. However, the system in place to ensure actions set from serious incident investigations were achieved was in its infancy. A review of an action plan following an incident from October 2015 had not been fully achieved. The flow of information and understanding was evident from board to ward manager's level. The hospital had not ensured that concerns raised in previous inspections by CQC were fully achieved.

Recent meetings introduced included the integrated governance service meetings, chaired by the clinical services managers. Ward managers and the clinical quality and compliance manager attended, and the aim of the meetings were to disseminate information and ensure a flow of information from the board to ward. The meetings had been in place since January 2016. Another new meeting introduced was the restrictive intervention reduction steering group, in place from June 2015. The hospital had introduced a new role of patient engagement lead who involved patients and staff in the review of the restrictive practices taking place in the hospital. A training package had been developed to raise staff's understanding of what a restrictive practice is and ways of reducing these called 'hands off' which was due to be rolled out throughout the whole hospital.

The general manager had identified the previous poor investigation of complaints and the investigators not following the policy. A new role of complaints officer had been introduced and recruited to, with a positive impact; recent complaints we reviewed were following the policy, including a detailed investigation.

The hospital had a number of policies that were out of date, including the safeguarding policy, which did not refer to the Care Act 2014, had the old CQC standards in and did not provide clear direction of who was responsible for reporting incidents to external bodies including CQC. The hospital has been part of Cygnet since August 2015, Cygnet had not fully introduced their policies within the hospital. There was a review of policy log in place, with timescales for the review of policies and the introduction of the Cygnet policies.

Incident investigations reviewed across the service were of variable quality, spelling and grammar mistakes had not been reviewed and dates were not always present.

Requires improvement

Child and adolescent mental health wards

The hospital had not been routinely sharing learning from incidents at ward levels, especially across the children's and adults' services. There had been a serious incident in the child and adolescent services, which required changes to the training for physical intervention. Not all staff facilitating the training were aware of the changes, and the staff working in adult services were not aware of the learning from the incident. However, staff we spoke with and staff meeting agendas reviewed in the child and adolescent service showed an awareness of learning from this serious incident. However, the hospital did not have a system in place to ensure staff achieved actions from serious incident investigations.

Monthly audits of Mental Health Act documentation, completed by the hospital-wide Mental Health Act team, had not identified that staff had not consistently filed copies of detention paper work in patients' care records.

Ward managers were able to add items to the hospital's risk register and identified items that were currently active, including medication errors, management of complaints and security system failure. However, ward managers told us that low nursing staffing levels were also an active item on the risk register. Although the service identified this as a concern, this was not an active item on the risk register submitted by the hospital.

We reviewed seven recruitment files, five of which adhered to the hospitals recruitment and selection policy. One recruitment file we reviewed was for a staff member the service had recruited with a conviction. We saw that the hospital had introduced a risk assessment process for staff recruited with convictions. We found the clinical manager had completed the interview notes for this person retrospectively. The candidate had completed the application form after the date of their interview. Because the application post-dated the disclosure and barring check there was no record to show that the applicant had disclosed the offence at the beginning of the recruitment process. Within the risk assessment for the offences, the hospital had identified the nature of offences as not relevant to the role; however, we felt they were relevant. We raised the issue with the clinical manager who confirmed they had completed the records retrospectively as they could not find the originals; we advised it would have been preferable to put a note in the file that they had been lost. The clinical manager reported the issue as an incident following our recommendation. Another recruitment file identified the staff member required additional support in their role, however a member of the human resources team could not assure us this was happening, as they received the same support as all other staff.

Leadership, morale and staff engagement

We reviewed four exit interviews conducted with staff members who had left the service within the last four months. Three of the four interviewees identified that there was a lack of career progression within the hospital, which had, in some instances, been part of the decision to leave their employment. This was particularly amongst qualified nursing staff. Senior support workers we spoke with commented that senior management had supported them to develop in their knowledge and skills and provided extra training in order to do this. This involved training courses in care planning and risk assessment to promote them to senior support work staff. We also found that the service were active in seconding support work staff into university nurse training programmes. The service had employed two previous support workers (who they had seconded) as full time qualified nurses. Both were awaiting start dates at the time of our inspection.

Staff told us that morale was generally good across the service but were aware that this tended to fluctuate depending on the acuity of the patients and the availability of additional staffing resources to meet this need. Staff told us that ward managers were approachable and led by example in their work. Staff knew how to use the whistleblowing process and identified a recent example within the service where this had occurred. However, staff told us that they felt confident that senior managers would address concerns raised and therefore the whistleblowing process was not something they would necessarily need to draw upon at the current time.

Daily senior management meetings took place from Monday to Friday to allow the clinical services manager to provide a summary of events in the wards from the previous 24 hours to the hospital director and clinical manager. The hospital director shared themes from the meetings with the board.

The hospital introduced 'senior team walkarounds' in January 2016, visits took place unannounced and included day and night visits. The senior team completed a template with actions identified, however, there was no documented date to follow up and ensure staff had acted upon actions.

Requires improvement

Child and adolescent mental health wards

We reviewed the duty of candour log; the log did not capture all duty of candour requirements and there were examples of patients not receiving an apology. However, we case tracked three complaints on the child and adolescent wards, submitted between January 2016 and May 2016, where carers and/or the parents had received an apology where a mistake had been identified on behalf of the service. Ward managers on the child and adolescent wards were aware of what the duty of candour was and how it applied to them. Less senior staff members displayed a variable knowledge of the duty of candour and how it applied to them. For staff that started working at the hospital following the introduction of the duty of candour in April 2015, they received an introduction to the duty of candour within the organisational induction, including the threshold for the duty of candour.

Commitment to quality improvement and innovation

At the time of our inspection, the service did not take part in any national quality improvement or innovation initiatives. The service recognised that there were key clinical areas that staff required additional training to develop their knowledge and skills to meet the complex needs of patients using the service. In response to this, the service had arranged for an external provider to deliver a two-day training course to all qualified and unqualified staff in awareness and treatment of patients diagnosed with autistic spectrum disorders. Although the service had provided staff with a course in personality disorders, compliance rates across all wards were low, averaging below 75%. Furthermore, although the service recognised the increased need for staff training in the effective management of eating disorders, the service could not provide evidence of scheduled dates for the training for staff.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that mitigation plans are in place and staff are aware of them to protect patient's privacy and dignity whilst in seclusion and using the toilet and shower facilities.
- The provider must ensure that staff follow the seclusion policy, complete medical reviews that patients can understand and end seclusion as soon as the patient is settled.
- The provider must ensure that the use of long-term segregation and seclusion comply with the Mental Health Code of Practice 2015.
- The provider must review their seclusion policy to ensure it complies with the Mental Health Act Code of Practice and includes the learning from a serious incident including exiting seclusion safely.
- The provider must review their Mental Capacity Act policy to ensure it complies with the Mental Health Act Code of Practice, and introduce a process that staff understand to implement Deprivation of Liberty safeguards.
- The provider must ensure they have a system in place to monitor compliance with the Mental Health Act including applying for a second opinion appointed doctor and ensuring copies of detention paperwork are filed in patient's care records.
- The provider must ensure they provide training to staff on the Mental Health Act 1983 Code of Practice, published 2015.
- The provider must ensure they provide training to staff on the Mental Capacity Act 2005.
- The provider must ensure they provide training to staff on mental capacity frameworks specific to children and patients, such as the Gillick Competence Framework and the Children's Act 2004.
- The provider must review the stages approach and review the response to dealing with incidents on the female wards.
- The provider must review the searching of patients policy for South Hampton ward, which is a rehabilitation ward.
- The provider must review medicines management to ensure staff review patients on high dose antipsychotics to explore the impact of patients stopping smoking on their medication.
- The provider must ensure that patients are safely monitored in accordance with their own policy following administration of rapid tranquilisation.
- The provider must ensure there is a system in place to ensure actions identified following serious incidents are completed.
- The provider must review the activities provided to patients to ensure they meet their needs and include a rehabilitative focus.
- The provider must ensure the care plans are accessible and meaningful to patients with a learning disability, primarily on Bridge Hampton ward.
- The provider must ensure that where patients are identified as needing aids and adaptations, these are provided as soon as possible to promote patient's independence and dignity.
- The provider must ensure staff facilitating the management of actual or potential aggression training includes how to safely exit seclusion as stated within the action plan from a serious incident.
- The provider must ensure they follow their recruitment and selection policy, keep accurate records of the recruitment process and provide staff with additional support if identified.
- The provider must ensure that all staff receive regular supervision as stated within the policy and have accessible records of the supervisions.
- The provider must ensure they follow their absent without leave policy and incident reporting policy.
- The provider must review the level of British Sign Language training provided to staff including managers.
- The provider must provide training in relation to personality disorder and learning disability for staff who work with this group of patients.
- The provider must follow their policy on duty of candour and ensure staff understand their role in relation to the duty of candour.

Outstanding practice and areas for improvement

- The provider must review the safeguarding policy to ensure it reflects the requirements of the Care Act 2014.

Action the provider SHOULD take to improve

- The provider should ensure they discuss with the patient population on Blueberry ward, whether they require a female only lounge.
- The provider should ensure there are dates on documents and within action plans to monitor progress made.
- The provider should ensure staff receive training in managing complaints and complaints resolved at ward level are managed consistently.
- The provider should review their outcomes monitoring for patients to capture progress made.
- The provider should review their policy in relation to staff having long fingernails, particularly when involved in physical intervention.
- The provider should ensure that regular staff meetings take place for ward staff to disseminate information and changes within the organisation.
- The provider should review the arrangements for the use of seclusion facilities in the child and adolescent services and movement of patients from the ward to seclusion that includes the use of stairs that contravenes the management of seclusion doors entry and exit policy.
- The provider should review the staffing arrangements for ward managers and consultant psychiatrists within the child and adolescent services in line with the quality network for inpatient child and adolescent services standards.
- The provider should ensure that the audit tool to monitor use of seclusion has been updated to reflect their seclusion and long-term segregation policy.
- The provider should ensure there is sufficient number of qualified nursing staff to ensure a regular presence on the ward and so that nursing staff can have an allocated break.
- The provider should ensure all patients have consistent access to psychological therapies from a professional of the same gender where a need is indicated.
- The provider should ensure they have a clear acceptance and exclusion criteria for the admission to the child and adolescent service that senior management are knowledgeable of.
- The provider should ensure that the investigations into incidents are thorough, proof read for errors, dated and have clear learning and actions identified.
- The provider should ensure that all staff receive an annual appraisal.

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 10 HSCA (RA) Regulations 2014 Dignity and respect Searches took place routinely for a patient on the rehabilitation ward, South Hampton that were not reviewed to determine whether they were necessary according to the risk the patient presented. The stages approach was in use in the two female wards, Lower West and Upper West, which was overly restrictive including needing to be incident free for seven days prior to section17 leave. This meant that patients were not treated with dignity and respect and as individuals. This was a breach of Regulation 10 (2)(a)(b)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent There was one young person, aged 17 on Wizard House that had been discharged from section 3 of the Mental Health Act, was assessed as not having the capacity to consent to their admission. The hospital took seven days to apply for a deprivation of liberty safeguard. The hospital did not understand the Mental Capacity Act and applied to the local authority rather than the court of protection. There was 14 days when the patient was detained without appropriate safeguards until an application had been submitted to the court of protection. There was no policy in place in relation to Deprivation of Liberty safeguards for staff to follow.

This section is primarily information for the provider

Requirement notices

This meant that the hospital was not acting in accordance with the Mental Capacity Act 2005.

This was a breach of Regulation 11(1)(3)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing Within the adult services, staff were not receiving supervision as stated within the policy, we reviewed 10 supervision files, four files showed staff were receiving supervision with intervals of between five and ten months on Bridge Hampton, Lower East and Upper East. We noted some actions had been carried over for up to a year without achievement. One staff member had requested mental health awareness training which took a year for them to receive it. Supervision records were not available to review on Lower West and Columbus wards. Staff had not received training in learning disability, Bridge Hampton supported patients who were deaf and had a learning disability. Only 15% of staff had received training in personality disorder. This meant staff did not have the skills and knowledge to effectively support the group of patients. Four wards cared for deaf patients; the clinical services manager was only trained to British Sign Language level one and 59% of staff working on Upper West had received British Sign Language level one, meaning staff could not effectively communicate with patients and their colleagues who were deaf. Interpreters were routinely available between 7am and 7pm Monday to Friday. This was a breach of Regulation 18 (1)(2)(a)

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 20 HSCA (RA) Regulations 2014 Duty of candour

The hospital were not following their duty of candour policy. We reviewed the duty of candour log, the log did not capture all duty of candour requirements and there were examples of patients not receiving a written apology.

This meant that patients did not know when the hospital had done something wrong that they should have apologised for.

This was a breach of Regulation 20 (4)

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

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 The provider was not providing person centred care: • A patient on Madison ward had been waiting since June 2015 for assessed aids and adaptations due to a physical health need. • On Bridge Hampton, a ward caring for patients who are deaf and have a learning disability, we reviewed nine care records, we found that none of the records contained a detailed description of how best to communicate with individuals, care plans were not written in a format that was accessible to patients which meant that individuals were not supported to be involved in decisions about their care. • A deaf patient in seclusion on Upper West ward had not had an interpreter present for two medical reviews in 24 hours. This meant staff could not effectively communicate with the patient and ascertain if they understood the seclusion plan. • Records reviewed confirmed that patients were not provided with opportunities to engage in meaningful therapeutic activities including lack of rehabilitative activities on South Hampton, a rehabilitation ward. This was a breach of Regulation 9(1)(b) (3)(b)(c)(d) We served a warning notice to be met by 10 October 2016.

Regulated activity	Regulation

This section is primarily information for the provider

Enforcement actions

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 was not ensuring patients received safe care and treatment:

- On Madison Ward, the hospital were not reviewing the consent to treatment documentation in line with changes in medication.
- On East Hampton ward, we found that patients who had significantly reduced or stopped smoking had not had their clozapine plasma concentrations monitored by regular blood serum level checks.
- There was a young person, aged 17 detained without the appropriate safeguards on Wizard House. The hospital had taken seven days to submit the Deprivation of Liberty safeguards application to the funding local authority, which does not follow the Mental Capacity Act, as it should have been submitted to the Court of Protection.
- The hospital did not have a Deprivation of Liberty Safeguards policy in place.
- The Mental Capacity Act policy called accessing capacity, dated February 2014, and was not complaint with the Mental Health Act Code of Practice.
- Staff lacked knowledge of the Mental Capacity Act and Deprivation of Liberty safeguards and had not received training on the subject.
- There had been a serious incident in the child and adolescent services, the hospital had not completed the actions from the root cause analysis within timescales set.
- A young person's segregation from the main ward population on Wizard House was recorded as longer-term segregation but did not adhere to the procedural safeguards of the Code of Practice or the provider's own policy.

This was a breach of Regulation 12(1)(2)(a)(b)

We served a warning notice to be met by 10 October 2016.

This section is primarily information for the provider

Enforcement actions

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance The hospital did not have good governance arrangements in place: • The hospital had not achieved their actions from the action plan following the focussed CQC inspection in January 2016, in relation to the review of the seclusion policy to be compliant with the Mental Health Act Code of Practice. • The risk assessment process of recruiting staff with convictions had not been followed for one personnel file we reviewed for a staff member recruited with a conviction. • There were a number of policies that were out of date, including the safeguarding policy, which did not refer to the Care Act 2014, and had the old CQC standards in and did not provide clear direction of whom was responsible for reporting incidents to external bodies including CQC. • The hospital had not been routinely sharing learning from incidents at ward levels, especially across the children's and adults services. There had been a serious incident in the child and adolescent services, which required changes to the training for physical intervention, staff facilitating the training, were not aware of the changes, and the staff working in adult services were not aware of the learning from the incident. • The hospital was not following the duty of candour policy and the log showed examples of people not receiving an apology including a written apology. • Previously, in January 2016 the hospital had met a requirement notice that was served about failing to monitor physical observations following the administration of rapid tranquilisation in patients. However, at the inspection on May 2016, there was two out of 12 instances of rapid tranquilisation being

This section is primarily information for the provider

Enforcement actions

administered where the physical observations were stopped when the patient went to sleep. Improvements that had been made in January 2016 were not sustained in May 2016.

This was a breach of Regulation 17(1)(2)(a)(b)(c)

We served a warning notice to be met by 10 October 2016.