Cygnet Hospital Bierley

Quality Report

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Date of inspection visit: 26-27 November 2019
Date of publication: 05/02/2020

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	Good
Are services safe?	Requires improvement
Are services effective?	Good
Are services caring?	Good
Are services responsive?	Good
Are services well-led?	Good

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

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

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

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

Summary of findings

Overall summary

Cygnet Hospital Bierley is an independent mental health hospital that provides care for patients on low-secure forensic, personality disorder, and psychiatric intensive care unit wards.

We rated Cygnet Hospital Bierley as good because:

- The ward environments were safe and clean. The wards had enough nurses and doctors. Staff assessed and managed risk well. They minimised the use of restrictive practices and followed good practice with respect to safeguarding.
- Staff developed holistic, recovery-oriented care plans informed by a comprehensive assessment. They provided a range of treatments suitable to the needs of the patients and in line with national guidance about best practice. For example, each ward had access to a psychology team who provided specific interventions such as offering dialectical behaviour therapy on the personality disorder ward and coping skills work on the low-secure forensic and psychiatric intensive care unit wards.
- The ward teams included or had access to the full range of specialists required to meet the needs of patients on the wards. Managers ensured that there were sufficient numbers of staff who had received training, supervision and appraisal. The ward staff worked well together as a multidisciplinary team and with those outside the ward who would have a role in providing aftercare.
- Staff ensured that patients had good access to physical healthcare throughout their admission, including access to specialists when needed. Since our last inspection the hospital had employed a registered general nurse to oversee the physical health needs of patients across all four wards.
- Staff treated patients with compassion and kindness and understood the individual needs of patients. They actively involved patients and families and carers in care decisions through involvement in care planning and review meetings.
- Staff planned and managed admissions and discharge well and liaised with services that would provide aftercare. As a result, discharge was rarely delayed for other than a clinical reason.
- The service was well-led, and the governance processes ensured that ward procedures ran smoothly. The service had made improvements in their governance systems since our last inspection. Previous breaches of regulation and areas where we had identified the provider should take action to improve the service had been addressed.
- Staff at the hospital were engaged in opportunities for quality improvement and research and had recently won an award at the 'Association of Psychological Therapies Awards' for the hospital's Relaxation Workshop. The provider recognised staff success through an 'employee of the month' award and 'random acts of kindness' award.
- Patients and carers were involved in decision-making about changes to the service and a 'you said, we did' board in reception which reflected suggestions made by patients and changes made as a result, such as staff purchasing a number of cameras to allow patients to take and print their own photos.

However:

- The service did not consistently provide safe care with regards to the management of medicines including in relation to prescribing, administering, recording and storing medicines. On the psychiatric intensive care unit and low-secure forensic wards staff did not always keep accurate records of the treatment patients received and did not consistently administer medication in the manner prescribed. For example, a patient continued to be administered medication after their prescription had finished and medication cards were not always signed so it was unclear if medication was given. Consent to treatment documents were not always signed by patients or the responsible clinician and were not all reviewed in a timely manner. On the psychiatric intensive care unit and specialist personality disorder ward we found staff were storing patient specific medication that was either no longer prescribed or was for patients no longer on the wards and on the specialist personality disorder ward staff were storing general skin creams in the clinic room that were not prescribed to individual patients but used for any patient on the ward and as such could be

an infection control risk. On the psychiatric intensive care unit staff did not follow systems and processes to accurately record, store and dispose of illicit substances brought onto the ward.

- Staff did not consistently follow guidance from the National Institute of Health and Care Excellence and Mental Health Act Code of Practice in relation to physical health monitoring following rapid tranquilisation on the female low-secure forensic ward and personality disorder service ward, and with regards to completion of independent multi-disciplinary reviews during episodes of seclusion on the psychiatric intensive care unit.
- The ground-floor seclusion room, which could be used by patients from any ward, did not fully comply with guidance in the Mental Health Act code of practice as there was no facility to dim any of the lights.
- A blanket restriction was identified with regards to the type of e-cigarettes patients could use across the hospital. This had not been individually risk assessed and was not noted on any of the ward blanket restriction logs at the time of inspection.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Acute wards for adults of working age and psychiatric intensive care units	Good	
Forensic inpatient or secure wards	Good	
Personality disorder services	Good	

Summary of findings

Contents

Good

Cygnet Hospital Bierley

Services we looked at;
Acute wards for adults of working age and psychiatric intensive care units; Forensic inpatient or secure wards; Personality disorder services

Summary of this inspection

Background to Cygnet Hospital Bierley

Cygnet Hospital Bierley is an independent mental health hospital provided by Cygnet Health Care Ltd. The hospital provides care for 63 male and female patients across four different wards:

• Bronte ward is a 16-bed forensic low secure service for women (only admitting to 12 beds at the time of inspection)

• Shelley ward is a 16-bed forensic low secure service for men

• Denholme ward is a 15-bed psychiatric intensive care unit for women (only admitting to 12 beds at the time of inspection)

• Bowling ward is a 16-bed specialist personality disorder service for women

The hospital has been registered with the Care Quality Commission since April 2009 to carry out the following regulated activities:

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

• Treatment of disease, disorder or injury.

The Care Quality Commission last carried out a comprehensive inspection of this hospital in April 2018. At that inspection we rated the service as 'requires improvement' overall, with the hospital in breach of five regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We told the provider it must make the following improvements:

- Ensure that the privacy and dignity of patients was maintained when being admitted to the psychiatric intensive care
- Ensure that appropriate consent to treatment procedures were in place on the psychiatric intensive care unit and the specialist personality disorder service
- Ensure all four wards completed robust risk assessments that were reviewed in a timely manner following incidents, ensure ligature risks were managed appropriately and that staff could observe patients adequately in the seclusion facility and ensure appropriate physical health monitoring was carried out following admission and rapid tranquilisation
- Ensure staff used and recorded the least restrictive approach to restraint to administer intra-muscular medication and to exit seclusion and ensure that efforts were made to reduce the use of prone restraint and that blanket restrictions were only used when absolutely necessary
- Ensure effective systems to provide assurance about the quality of services delivered.

At the last inspection, we also identified a number of areas where the provider should take action to improve the service. We reviewed these breaches of regulation and the areas where the provider should improve during this inspection and found the provider had made improvements and addressed these areas of concern.

At the time of our inspection, the hospital had a registered manager in place. The registered manager, along with the registered provider, is legally responsible and accountable for compliance with the requirements of the Health and Social Care Act 2008 and the associated regulations including the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and the Care Quality Commission (Registration) Regulations 2009.

Our inspection team

The team that inspected the service comprised of six CQC inspectors including the team leader, one CQC assistant inspector, a CQC pharmacist specialist, one expert by experience who had experience of using, or caring for someone who uses mental health services, and four specialist advisors; three mental health nurses, and a psychologist.

Summary of this inspection

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 for information and sought feedback from patients and staff at seven focus groups.

During the inspection visit, the inspection team:

- visited all four wards at the hospital, looked at the quality of the ward environment and observed how staff were caring for patients
- spoke with 16 patients who were using the service
- spoke with the hospital manager, clinical manager, general manager, and all four ward managers
- spoke with 33 other staff members; including doctors, nurses, health care support workers, occupational therapists, psychologists, social workers, and support staff
- received feedback about the service from one commissioner
- spoke with an independent advocate
- attended and observed a range of meetings and patient groups
- collected feedback from 11 patients using comment cards
- looked at 15 care and treatment records of patients and 27 medication records
- carried out a specific check of the medication management on all four wards
- looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the service say

During inspection we offered all patients the opportunity to speak with us. We spoke with 16 patients in person and received feedback via comment card from 11 patients. Prior to the inspection we conducted four patient focus groups where we spoke with 20 patients.

On all wards we observed staff interacting with patients in a kind and respectful manner; providing patients with appropriate practical and emotional support.

On the psychiatric intensive care unit all patients except for one told us that they felt cared for by staff who were knowledgeable, professional and reliable. Two patients told us staff had a genuine interest in their mental health, wellbeing and recovery. One patient raised concerns about staff attitudes.

On the low-secure forensic wards all patients we spoke with apart from one told us that staff supported them to feel safe on the wards. Patients said staff treated them well and behaved appropriately towards them.

On the specialist personality disorder ward patients gave mixed feedback about staff. Patients stated that staff were respectful and polite, although noted that not all staff knocked on the doors when entering the bedrooms. They also told us that staff were not always available to accompany patients to use the outdoor courtyard space.

Patients on all wards told us they were involved in their care planning, felt informed about their care and treatment, and could give feedback about the services they received.

Summary of this inspection

During the inspection we also spoke with five carers to obtain their feedback. Feedback from carers of patients on all four wards was positive, with carers telling us staff were caring, kind, helpful, approachable and proactive. All carers told us they were involved in the patient's care including care planning and professionals' meetings. One carer told us they felt the service could be better at explaining what happens when carers come to visit the hospital; but the majority of carer's felt well-informed about the services.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Requires improvement 

We rated safe as **requires improvement** because:

- On the psychiatric intensive care unit and low-secure forensic wards staff did not always keep accurate records of the treatment patients received and did not consistently administer medication in the manner prescribed. For example, a patient continued to be administered medication after the prescription had finished. Consent to treatment documents were not always signed by patients or the responsible clinician and were not all reviewed in a timely manner. On the psychiatric intensive care unit and specialist personality disorder ward we found staff were storing patient specific medication that was either no longer prescribed or was for patients no longer on the wards and on the specialist personality disorder ward staff were storing general skin creams in the clinic room that were not prescribed to individual patients but used for any patient on the ward and as such could be an infection control risk.. On the psychiatric intensive care unit staff did not follow systems and processes to accurately record, store and dispose of illicit substances brought onto the ward.
- On the psychiatric intensive care unit independent multi-disciplinary reviews did not always take place as required by the Mental Health Act 1983 during episodes of seclusion and seclusion was terminated by the nurse in charge with no record of a conversation with the patient's doctor.
- On all wards a blanket restriction was identified with regards to the type of e-cigarettes patients could use. This had not been individually risk assessed and was not noted on any of the ward blanket restriction logs at the time of inspection.
- It was unclear if actions relating to additional staff training following fire evacuation drills had been completed as required as the same issue had reoccurred and there was no record kept of completed actions.
- The ground-floor seclusion room did not fully comply with guidance in the Mental Health Act code of practice as the externally controlled lighting did not include subdued lighting for night time.
- On the low-secure forensic wards not all staff were clear on the policy for searching patients on return from section 17 leave with some staff understanding the randomiser process in place and others telling us all patients would be searched.

Summary of this inspection

- On the female low-secure forensic ward patient paper-based care records did not contain the most up-to-date records as stored on the electronic system. This could cause issues for ad-hoc agency staff without electronic system access who would not have access to the most up-to-date patient information.

However:

- The service had enough nursing and medical staff, who knew the patients and received basic training to keep patients safe from avoidable harm.
- Staff assessed and managed risks to patients and themselves well and followed best practice in anticipating, de-escalating and managing challenging behaviour. Staff used restraint and seclusion only after attempts at de-escalation had failed. Staff completed a risk assessment of every patient on admission and updated it regularly, including after any incident.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse, and they knew how to apply it.
- The wards had a good track record on safety. The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

Are services effective?

Good

We rated effective as **good** because:

- Staff assessed the physical and mental health of all patients on admission. They developed individual care plans, which they reviewed regularly through multidisciplinary discussion and updated as needed. Care plans reflected the assessed needs, were personalised, holistic and recovery-oriented.
- Staff provided a range of care and treatment interventions suitable for the patient group and consistent with national guidance on best practice. They ensured that patients had good access to physical healthcare and supported patients to live healthier lives.
- Staff used recognised rating scales to assess and record severity and outcomes. They also participated in clinical audit, benchmarking and quality improvement initiatives.
- The ward teams included or had access to the full range of specialists required to meet the needs of patients on the wards.

Summary of this inspection

Managers made sure they had staff with a range of skills need to provide high quality care. They supported staff with appraisals, supervision and opportunities to update and further develop their skills. Managers provided an induction programme for new staff.

- Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care. The ward teams had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation.
- Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice and discharged these well. Managers made sure that staff could explain patients' rights to them.
- Staff supported patients to make decisions on their care for themselves. They understood the provider's policy on the Mental Capacity Act 2005 and assessed and recorded capacity clearly for patients who might have impaired mental capacity.

However:

- On the psychiatric intensive care unit and male low-secure forensic wards staff did not always create specific care plans for patients in relation to long-term physical health conditions.

Are services caring?

Good

We rated caring as **good** because:

- Staff treated patients with compassion and kindness. They respected patients' privacy and dignity. They understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition.
- Staff involved patients in care planning and there was clear evidence of the patient voice within records. They ensured that patients had easy access to independent advocates.
- Patients and carers could give feedback about the service they received in a number of ways; staff made changes as a result of this feedback to improve services for patients.
- Staff informed and involved families and carers appropriately and offered support to carers for their own wellbeing.

However:

- Patients on the specialist personality disorder ward gave mixed feedback about staff telling us that not all staff knocked on patient's doors when entering their bedrooms.

Summary of this inspection

Are services responsive?

Good

We rated responsive as **good** because:

- Staff managed beds well. This meant that a bed was available when patients required admission, and that patients were not moved between wards unless this was for their benefit. Staff planned for patients' discharge, including good liaison with care co-ordinators who were regularly invited to patient care review meetings. Discharge plans were clearly documented in patients' care records.
- The design, layout, and furnishings of the service supported patients' treatment, privacy and dignity in the majority of cases. Since our last inspection a separate entrance to the hospital had been installed to maintain the privacy and dignity of patients being admitted to the psychiatric intensive care unit. On all wards each patient had their own bedroom with an en-suite bathroom and could keep their personal belongings safe. There were quiet areas for privacy.
- The food was of a good quality and patients could make hot drinks and snacks at any time.
- The service met the needs of all patients who used the service – including those with a protected characteristic. Staff helped patients with communication, advocacy and cultural and spiritual support.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team and the wider service.

However:

- Patients were only able to access outdoor space with the supervision of staff due to outdoor space being communal and some wards being located on the first floor of the building. Patients told us that access to this space could be limited as staff were not always available when access was requested. This was listed on the blanket restriction audit on all wards, but it was unclear if alternative arrangements had been explored to assess if there were other ways of managing this access.
- There was no ability to screen off the window into the en-suite bathroom in the ground-floor seclusion room to maintain the privacy and dignity of patients. Staff passing through this area could see through the window.

Are services well-led?

Good

We rated well-led as **good** because:

Summary of this inspection

- Leaders had the skills, knowledge and experience to perform their roles, had a good understanding of the services they managed, and were visible in the service and approachable for patients and staff.
- Staff knew and understood the provider's vision and values and how they were applied in the work of their team.
- Staff generally felt respected, supported and valued in their roles and felt positive and proud about working for the provider and their team.
- Our findings from the other key questions demonstrated that governance processes operated effectively at ward level and that performance and risk were managed well.
- Ward teams had access to the information they needed to provide safe and effective care and used that information to good effect. For example,at ward level, ward managers were responsible for reviewing monthly data packs relevant to their ward and feeding back any areas of concern, areas for action, or compliments to ward staff as well as to the monthly governance meetings.
- Staff engaged actively in local and national quality improvement activities. There was commitment towards continual improvement and innovation, with wards participating in accreditation schemes and staff having opportunities to participate in research. Staff at the hospital had recently won an award at the 'Association of Psychological Therapies Awards' for the hospital's Relaxation Workshop and had introduced the 'finding your way' substance misuse programme.

However:

- Some audits of clinic rooms, medications management and aspects of the Mental Health Act failed to acknowledge areas of concern found during this inspection or accurately reflect blanket restrictions in place.
- Staff on Bronte ward raised concerns with us about the culture on the ward and told us they felt unable to raise concerns.

Detailed findings from this inspection

Mental Health Act responsibilities

Staff participated in mandatory training in the Mental Health Act. All staff on Denholme ward (psychiatric intensive care unit) and Bowling ward (specialist personality disorder ward), and 91% of staff on Bronte and Shelley wards (low secure forensic inpatient wards) had completed this training. Staff we spoke with had a good understanding of the Mental Health Act, the Code of Practice and the guiding principles

Staff had easy access to local Mental Health Act policies and procedures via the staff intranet and to the Code of Practice that reflected the most recent guidance.

Staff had easy access to administrative support and legal advice on implementation of the Mental Health Act and its Code of Practice within the hospital. Staff knew who their Mental Health Act administrators were. The Mental Health Act administration team oversaw admission paperwork, ensured accuracy of section papers, monitored dates for patients' tribunal meetings and renewals, and gave reminders to staff when action was required. Staff could also access support from the corporate Mental Health Act lead.

Staff ensured that patients were able to take Section 17 leave (permission for patients to leave hospital) when this has been granted. Patient's section 17 leave records were stored within their individual patient paper files on the wards and when a patient took section 17 leave this was clearly recorded. Staff explained to patients their rights under the Mental Health Act in a way that they could understand, repeated it as required and recorded that they had done it in patient's paper files. Staff requested an opinion from a second opinion appointed doctor when necessary.

Patients had easy access to information about independent mental health advocacy. Advocates visited the wards weekly and information on how to contact the advocates outside of these times was displayed on the wards. Advocates would attempt to speak with all patients and would liaise with ward staff to let them know of any patients who refused to interact so that staff could support them to access advocacy at a later date should they wish.

Staff carried out audits to monitor compliance with the Mental Health Act which were found to be generally effective in identifying issues. However, whilst appropriate consent to treatment paperwork was in place for all patients, audits had failed to identify that on the low-secure forensic wards one form had not been signed by the relevant responsible clinician and one form had not been reviewed since 2013, and on the psychiatric intensive care unit two forms had not been signed by the relevant patient.

Mental Capacity Act and Deprivation of Liberty Safeguards

Staff participated in mandatory training in the Mental Capacity Act and Deprivation of Liberty Safeguards. All staff on Denholme ward (psychiatric intensive care unit), 94% of staff on Bowling ward (specialist personality disorder ward), and 81% of staff on Bronte and Shelley wards (low secure forensic inpatient wards) had completed this training.

The provider had a policy on the Mental Capacity Act, including Deprivation of Liberty Safeguards which staff knew how to access. Staff we spoke with had a good understanding of the Mental Capacity Act and its five statutory principles. Managers conducted monthly 'quality walks' of the wards, part of which involved questioning staff about their understanding of the Act to ensure staff knowledge was appropriate.

Staff took all practical steps to enable patients to make their own decisions. For patients who might have impaired mental capacity, staff assessed and recorded capacity to consent appropriately. They did this on a decision-specific basis with regard to significant decisions. When patients lacked capacity, staff made

Detailed findings from this inspection

decisions in their best interests, recognising the importance of the person's wishes, feelings, culture and history. Capacity assessments and best interests' decisions were documented in patients' notes.

There were no Deprivation of Liberty Safeguards applications made by the hospital in the last 12 months prior to inspection.

Overview of ratings

Our ratings for this location are:

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

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

Good

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

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

Requires improvement

Safe and clean environment

Denholme ward is a 15-bed psychiatric intensive care unit for women. At the time of this inspection there were nine patients admitted to the ward, all were detained under the Mental Health Act. The ward was safe, clean and well maintained. Staff completed regular risk assessments of the care environment. The service had up to date risk assessments relating to health and safety, fire, infection control and legionella. Risk assessments were accompanied by action plans where required and were reviewed regularly.

In February 2018, the hospital received a fire enforcement notice from the West Yorkshire fire brigade, due to a number of concerns relating to risk following the completion of their fire risk assessment. The hospital was required to undertake large-scale remedial works to rectify some of the issues, particularly in relation the fire damper system throughout the hospital, including on the psychiatric intensive care unit, which needed replacing to ensure the control of the spread of fire and smoke throughout the building, should a fire occur. The majority of work was completed at the time of inspection with some minor remaining works in non-ward areas. The general manager had a schedule for remaining works and conducted regular risk assessments throughout the project. Work was completed and signed off by an Inspector from West Yorkshire fire brigade on 10 December 2019.

Staff conducted weekly tests of fire alarms, fire extinguishers, and emergency lighting. These were reviewed between January and November 2019 and all checks had been completed with no areas of concern identified. The hospital also carried out regular full fire evacuation drills, with some of these drills occurring out-of-hours. Between 29 January 2019 and 3 October 2019, the service had carried out six evacuation drills. On two occasions it was noted that staff were attempting to gather personal possessions before exiting the building. The subsequent actions included additional training for staff; however, hospital managers explained that this was ad-hoc and not a recorded training session. Therefore, it was not clear if staff had received this training to effectively address the area of concern identified in the evacuation drills as the same issue had re-occurred.

Staff completed the annual ligature risk assessment of the ward in October 2019. All ligature risks recorded on the ligature risk assessment matched those identified on the ward. Staff mitigated ligature risk through patient observation and regular reviews of patient risk assessments. All bedroom doors were anti-barricade, they prevented barring, holding and blocking by patients. Staff completed regular checks of the care environment; including daily security checks at the change of each shift.

The layout of the ward allowed for clear lines of sight for staff to observe patients. Staff mitigated patient risk through individual patient risk assessment and management plans which identified appropriate levels of

observation. Bedroom corridors and communal areas were monitored regularly by allocated staff on the ward and the use of closed-circuit television strengthened the safety of both patients and staff.

Staff were issued with a personal alarm whilst on duty. These were tested and issued to staff before the commencement of duty. Patients had easy access to nurse call alarms in the event of an emergency.

The ward complied with the Department of Health and the Mental Health Act 1983 Code of Practice guidance on eliminating mixed-sex accommodation as the ward was single-sex.

Maintenance, cleanliness and infection control

The ward was visually clean, had good furnishings and generally well maintained. The ward had a daily and weekly cleaning schedule in place to ensure the cleanliness of the ward was maintained. During our inspection we saw domestic staff carrying out regular cleaning. Due to the large-scale improvement works carried out, which were necessary to meet the requirements of the fire enforcement notice issued to the hospital, there were areas of the ward that required some additional maintenance; largely re-painting. The general manager had a planned schedule for redecoration which addressed all ward areas and was due to start in January 2020.

Staff adhered to infection control principles, including handwashing, and hand sanitiser was available for people to use. Personal protective equipment was available and was stored securely. Staff carried out an infection control audit in May 2019 which showed an overall compliance of 94%. The audit identified areas where action was required, including a lack of handwashing signs in some areas and the need for additional handwashing facilities. An electronic action plan showed that required actions had been addressed in a timely manner.

Seclusion room

The ward had access to two seclusion rooms; one of which was based on the ward and a second was located on the ground floor. The seclusion room on the ward offered clear observation of patients, had an intercom that allowed for two-way communication and patients were able to see a clock which showed the correct time. Patients in seclusion had access to natural light. Patients had access to en-suite toilet and shower facilities. Anti-ligature bedding was provided to patients in the seclusion room.

At the previous inspection we told the provider they must have a protocol or risk assessment in place for the movement of patients from Denholme ward down stairs to the seclusion room on the ground floor. Following a review in September 2018, staff updated the ward's operational policy to include a local protocol and risk assessment for staff to follow.

Clinic room and equipment

The ward had a clinic room, which was clean and tidy and had the necessary equipment to carry out physical examinations. There were adequate medicines and equipment for use in a medical emergency, and systems were in place to regularly check they were fit for use.

At the previous inspection we identified oxygen cylinders within the emergency grab bag were not dated or replaced appropriately following an emergency. During this inspection we found that staff ensured oxygen was available in the emergency grab bag and this was in date.

Checking of the clinical fridge temperatures was routinely carried out and records demonstrated this. The clinic room was visibly clean.

Safe staffing

At the time of inspection, there were three vacancies for qualified nurses and three vacancies for healthcare support workers on Denholme Ward. The provider used a staffing calculator to determine the required number of staff for the ward. Recruitment was ongoing for qualified nurses and regular agency staff provided cover for these vacancies. At the time of this inspection the provider had recruited to the vacant healthcare support worker posts; including one additional post. Induction to the service for the four healthcare support workers was scheduled for December 2019. Staff worked day or night shifts, from 07:30 until 20:00 and 19:30 until 08:00. The provider staffed the ward during the day and night with a minimum of two qualified nurses and two healthcare support workers. The acting ward manager told us they could adjust the staffing levels to meet the changing needs of patients. In addition, another qualified nurse worked on the days of the multi-disciplinary meetings and Mental Health Act meetings, such as

tribunals, to provide additional staffing capacity to support patients. Patients and carers did not raise any concerns about the availability of staff to speak with on the wards; patients could access one to one time with named nurses.

The acting ward manager reviewed staffing numbers regularly to ensure staffing was adequate and to ensure patients could be supported safely. Oversight of the daily staffing compliment was monitored through the hospital wide morning meeting. When shortfalls in staffing were identified, staff worked flexibly across the wards.

There were adequate numbers of staff to carry out physical interventions safely, including observations and restraint. The number of staff members trained in physical interventions was 87%, with staff allocated to respond to incidents across the wards.

The ward planned Section 17 leave in advance to ensure sufficient staff remained on the ward. Staff shortages rarely resulted in staff cancelling or rearranging escorted leave. Between 1 September 2019 and 30 November 2019, Section 17 leave had not been cancelled or changed. The patients we spoke with during this inspection confirmed this and raised no concerns regarding access to escorted leave or activities.

The sickness rate for the service was 8.3% between 1 September 2018 and 31 August 2019. The sickness rate reported during this inspection was higher than the 6% reported at the last inspection. Managers told us this was due to a member of staff being on long-term sickness leave for non-work-related issues. Managers supported staff who were off sick through the employee assistance programme and also reviewed sickness levels regularly as part of the senior management team meeting agenda. Managers followed the hospital's attendance management policy where necessary.

The service used bank and agency staff to maintain safer staffing numbers on each shift to meet the needs of all patients. Between 1 May 2019 and 31 July 2019 bank and agency use on Denholme ward was the highest in the hospital, with an average of 33 shifts per week being covered by bank or agency staff. At the time of this inspection, agency staff were blocked booked to work shifts and were familiar with the hospital and patients. Bank and agency staff received the same induction as regular staff prior to working on the ward; this included a shadow shift with a regular staff member.

Medical staff

There was adequate medical cover for the ward day and night. The ward had one locum consultant psychiatrist to work with patients and one specialist interest doctor. The hospital used an on-call rota; in the event of a psychiatric emergency doctors could respond within approximately 30 minutes. For physical health emergencies, staff contacted the local emergency department or dialled 999 for an ambulance.

Mandatory training

Staff on Denholme ward completed mandatory training in 17 areas. The provider set a compliance target of 90% for the completion of mandatory training. Of these 17 training courses; six failed to achieve the provider target for training compliance and of those, three courses were below 75% for staff compliance. These were recovery star, clinical risk management and risk assessment training. Compliance in key training such as safeguarding, immediate life support and Mental Capacity Act ranged from 78% to 100%. Whilst staff compliance in clinical risk management and risk assessment training was low prior to the inspection, however as of 6 December 2019, training improved with all of staff trained in clinical risk management and 80% of staff trained in risk assessment.

Managers monitored compliance with mandatory training through an established framework of meetings; including monthly governance meetings, staff meetings and individual supervision.

Assessing and managing risk to patients and staff

Assessment of patient risk

During this inspection we reviewed three care records in detail. The service used a nationally recognised risk assessment tool; short term assessment of risk and treatability. The risk assessment covered a range of issues such as; violence to others, harm to self, self-neglect, substance misuse, external triggers and patient specific risks. Alongside this risk assessment, staff completed a daily risk assessment of each patient. The daily risk assessment template enabled staff to record risk behaviour regularly, including after incidents, and provided a red, amber or green rating of daily patient risk. Staff discussed this rating during clinical handovers, a daily morning meeting, and multi-disciplinary meetings.

Risk assessments were up to date and had been reviewed regularly. Staff recorded the risk history of all patients in detail and current risks were clearly documented. Staff consistently updated risk assessments following incidents and included the reference numbers of the incident reports submitted.

Management of patient risk

Staff were aware of and dealt with specific risk issues. Staff completed specific risk assessments, including physical health needs and physical intervention, to identify some of the more complex and challenging additional needs of the patients; this enabled staff to manage them appropriately.

Staff identified and responded to the changing needs of patients. The provider had an engagement and observation policy to support and protect patients and staff. We observed staff regularly and consistently undertake observations of patients as required by the providers policy. Due to the varied needs of the patient group, patients were supported by staff on a range of different observation levels; from continuous observation to less frequent checks. Staff recorded their observations in the patient care records. Staff discussed patient observation levels regularly, including during daily clinical handovers, the ward morning meeting, and weekly multi-disciplinary team meetings. We observed the clinical team and multi-disciplinary team discussing observation levels during a patient's weekly ward round and the daily ward morning meeting.

Staff did not routinely search patients or their bedrooms. Staff told us searching of patients was based on individual risk. The provider had a search policy to guide staff, which had been subject to full review in June 2019 to ensure compliance with the Mental Health Act Code of Practice and national guidance. Between 1 September 2019 and 30 November 2019, staff completed 11 searches of patients.

In the care records reviewed, we saw reducing restrictive practice care plans; these detailed specific individual patient restrictions, such as patient preference for physical intervention to be carried out by female staff. The ward had a blanket restriction log, staff told us this was reviewed regularly by staff and current patients on the ward.

Current restrictions focussed on specific items, these included e-cigarettes, mobile phones, mail and patient access to the ward kitchen. To promote a smoke free environment, the hospital allowed the use of e-cigarettes within the communal courtyard and patient bedrooms. Patients had access to their own mobile phones, including smart phones. Staff restricted the use of mobile phones to individual patient bedrooms; to maintain privacy, dignity and security of all patients on the ward. However, the blanket restriction log on display on the ward had not been updated and therefore identified restrictions that were not in place on the ward, such as staff supervising patients when opening mail. This could have been confusing for staff and patients and did not reflect the least-restrictive practice that was actually taking place.

We also identified a restriction related to smoking which was not detailed on the blanket restrictions audit. Whilst the provider's policy stated that rechargeable e-cigarettes could be considered on an individually risk assessed basis, the hospital had a local protocol which ran alongside the provider's policy which stated patients could only smoke specific e-cigarettes purchased from the hospital tuck shop. Patients we spoke with during focus groups conducted prior to the inspection were unhappy at this decision due to the cost implications of purchasing disposable e-cigarettes rather than being able to have access to re-chargeable ones. Staff had not completed individual risk assessments to establish if patients could safely have re-chargeable cigarettes and this blanket restriction was not something noted on the hospital's blanket restrictions audits. However, post-inspection managers explained that the restriction was due to the fire enforcement notice currently in place at the time of inspection and stated that the restriction had since been added to the ward blanket restrictions log and was due to be reviewed.

Use of restrictive interventions

The use of restrictive interventions has remained the same. Prior to this inspection the provider submitted data regarding the use of restrictive interventions between 1 February 2019 and 31 July 2019. The use of restrictive interventions was monitored through a range of governance meetings, locally and at provider level.

There had been 44 instances of seclusion over the reporting period. Staff used restraint on 148 occasions, involving 34 different patients. More recent data shows the use of physical intervention remains similar to that previously reported within the service. Between 1 August 2019 and 31 October 2019, staff used physical intervention on 81 occasions. The majority of physical intervention

utilised secondary interventions (physical intervention that does not require the relocation of the patient to the floor). Between 1 February 2019 and 31 July 2019, staff used prone restraint on 21 different occasions. Between 1 August 2019 and 31 October 2019, the frequency of prone restraint increased to 22. The service analysed data and identified one complex and challenging admission had contributed to increase in incidents and the use of prone restraint. In addition, we reviewed the provider's monthly ward managers' reports between August and October 2019 and staff had on all occasions attempted least restrictive interventions prior to prone restraint; the frequency and time in prone restraint had reduced month on month.

Between 1 August 2019 and 31 October 2019 there were 35 incidences of rapid tranquilisation. August 2019 recorded the highest number of incidents of rapid tranquilisation with 17, September 2019 recorded 14 and October 2019 four incidences.

There have been no instances of mechanical restraint over the reporting period which was the same as the number of incidences from the previous 12-month period (none). There have been no instances of long-term segregation between 1 February 2019 and 31 July 2019.

Staff we spoke with understood the definition of seclusion and that restraint should be used only after other de-escalation attempts had been made. Staff were able to describe methods they would use to manage incidents prior to attempting restraint. Staff told us they would only use restraint if it was necessary for the safety of patients and staff. During this inspection we observed staff on several occasions de-escalating patients who were agitated, frustrated or in distress. Staff were calm, reassuring and encouraged patients to use their coping strategies. These incidents were diffused by competent and respectful staff.

During this inspection we reviewed ten restrictive interventions records, including restraint, seclusion and rapid tranquilisation. At the previous inspection we identified a number of issues relating to restrictive interventions. These included ward staff not always carrying out appropriate monitoring of a patient's physical health following the use of rapid tranquilisation. At this inspection we reviewed five records of rapid tranquilisation. All records reviewed included physical health monitoring following the administration of rapid tranquilisation, as required by the provider policy. Of these records, one record included completed physical observations. The remaining four records identified the patient declined physical health monitoring, although staff had recorded rates of respiration for each patient. In addition, staff recorded if the patient was alert or asleep.

We previously identified that patients were not always protected from abuse and improper treatment because acts to control or restrain service users were not always proportionate to the risk presented. At this inspection we reviewed seven records of restraint; in all cases the use of restraint by staff was proportionate to the risk presented by patients.

We previously identified that staff used planned prone restraint for the administration of intra-muscular medication and for exit from seclusion; without recording which other interventions were attempted. At this inspection we reviewed five records of prone restraint. Of these, four records included evidence of primary interventions with patients, including verbal de-escalation, re-direction to a low stimulus environment and the offer of oral medication. One record did not include this information.

During this inspection we reviewed five records of seclusion. The paper-based record included all the required documentation templates for commencing, monitoring and ending seclusion. The records clearly showed the clinical picture prior to the decision to use seclusion. Staff recorded the required nursing, medical and multi-disciplinary reviews. However, of the five records reviewed, three episodes of seclusion required an independent multi-disciplinary review, as each episode of seclusion lasted beyond eight hours. None of these records included an independent multi-disciplinary review as required by the Mental Health Act 1983 Code of Practice. The ward seclusion audit tool indicated staff had completed these independent multi-disciplinary reviews, though there was no evidence of this. Four records indicated seclusion was terminated by the nurse in charge, with no record of any attempt to have a conversation with the patient's doctor as required by the Mental Health Act Code of Practice.

Safeguarding

A safeguarding referral is a request from a member of the public or a professional to the local authority or the police

to intervene to support or protect a child or vulnerable adult from abuse. Commonly recognised forms of abuse include: physical, emotional, financial, sexual, neglect and institutional.

Each authority has their own guidelines as to how to investigate and progress a safeguarding referral. Generally, if a concern is raised regarding a child or vulnerable adult, the organisation will work to ensure the safety of the person and an assessment of the concerns will also be conducted to determine whether an external referral to Children's Services, Adult Services or the police should take place.

The provider required all staff to complete safeguarding training for adults and children and 93% of staff had completed this training. Staff also completed 'Prevent' training, a training module to safeguard vulnerable people from being radicalised to supporting terrorism or becoming terrorists themselves.

Staff had easy access to safeguarding information through the providers intranet and on display on the ward. The provider had a safeguarding policy to support staff in identifying, understanding and reporting abuse. The hospital had an identified safeguarding lead and staff were aware of who this was and how to contact them. Staff met regularly to discuss safeguarding within the hospital and to review themes and trends identified in the data. The hospital had an established framework of meetings to discuss safeguarding, including hospital wide governance meetings. Staff discussed safeguarding issues regularly as part of daily clinical handover meetings, ward morning meeting and during staff meetings.

Staff we spoke with identified potential safeguarding concerns relevant to the patient group and were confident about how they would respond to such a concern.

The ward made 12 safeguarding referrals between 1 August 2019 and 31 October 2019, all of which concerned adults, including patient on patient assaults. The service had a dedicated social worker. As part of their role they provided advice and guidance to staff and patients.

Staff followed safe procedures for children visiting the hospital as detailed in the provider's policy. A dedicated visits room off the main clinical area was available for visits.

Staff access to essential information

The hospital used a combination of paper and electronic patient records as the electronic system was not capable of storing all patient information. Daily notes and care plans were recorded electronically, with care records also being printed out and stored in individual patient paper files along with other records including patient risk assessments, mental health act paperwork and physical health information. Agency staff who undertook regularly work at the hospital were given access to electronic systems but adhoc agency staff were not and staff with electronic access uploaded their notes.

Recording information in more than one system did not appear to cause any difficulty for staff.

Medicines management

We reviewed nine medicines charts and found that staff did not always keep accurate records of the treatment patients received. During this inspection we identified that two medicine charts did not record that patients had accepted their medication. One medicine chart did not record that a medicine was not available.

We reviewed consent to treatment documentation for all nine patients and found medicines were prescribed in accordance with the provisions of the Mental Health Act. We saw evidence that treatment was regularly reviewed, for example Section 61 review of treatment certificates were in place. However, documentation to consent to treatment had not been signed by two patients.

We checked physical health monitoring for patients who were prescribed antipsychotic medicines. Blood tests and physical observations were carried out in accordance with national guidance and best practice recommendations. One patient was prescribed a medicine which required regular monitoring of blood levels to ensure the treatment remained safe and effective. We saw this monitoring had been completed at the appropriate intervals, and the results were recorded in the patient's file. At the time of inspection, there were no patients who were prescribed high dose antipsychotic treatment.

Staff did not always use systems and processes to accurately record and store medication. During this inspection we identified that staff had failed to follow the hospitals procedure in the management of illicit substances. Staff did not record the illicit substances correctly in the controlled drugs register, there was no record of the accountable officer being informed, staff did

not continue to check the safe storage of the illicit substances and staff did not dispose of the illicit substances as per procedure. The ward audit for controlled drugs failed to identify the requirement for the illicit substances to be destroyed. Staff continued to store patient specific medication for three patients no longer on the ward, including two items that were out of date.

Track record on safety

Between 1 August 2018 and 31 July 2019 there were three serious incidents on Denholme ward. Incidents related to a medication error, a patient assault on a staff member and an allegation against staff regarding incorrected usage of dialectical behaviour therapy techniques. When serious incidents occurred, the provider conducted full investigations and also took steps to minimise the risk of similar incidents occurring, such as meeting with the multi-disciplinary team to agree restricting and reviewing patients' section 17 leave and dismissing staff.

Reporting incidents and learning from when things go wrong

All staff recognised incidents and reported them appropriately. Staff received feedback about incidents and learning from incidents was evident.

The provider had a paper-based recording system for reporting all incidents. The hospital incident policy was issued in March 2019 and provided staff with guidance on what type of incidents to report; including restraint, seclusion, verbal and physical violence. The reporting of incidents was monitored daily via the ward morning meeting and the hospital wide daily meeting, this ensured an accurate picture of incidents was established and reporting was timely. However, during this inspection we identified an area of concern in relation to illicit substances on the ward, staff did not report this as an incident.

We reviewed incident data, between 1 August 2019 and 31 October 2019, staff reported 243 incidents. These included violence, aggression and deliberate self-harm. Of the 243 reported incidents, 101 incidents related to violence and aggression included verbal threats, disruptive behaviour, attempted assault and physical violence, involving staff and patients. Deliberate self-harm accounted for 101 reported incidents.

Staff received feedback about incidents from a range of sources and discussed learning from incidents, including in staff meetings, supervision, email, daily ward meetings and clinical handovers. Investigations external to the hospital, such as those undertaken provider-wide, were shared with staff through a monthly quality newsletter and an annual lessons learnt newsletter. These identified findings from investigations, actions and lessons learnt, for example learning in relation to the use of ligatures and risks associated with concealed weapons in jewellery.

Patients and staff received de-briefs following incidents. Staff recorded on Incident forms when patients were offered a de-brief following an incident, and staff recorded if patients accepted or declined. Staff told us they received daily de-briefs at the end of each shift; this provided staff with the opportunity to reflect and identify effective work by the team or areas of improvement for that day. Staff we spoke with viewed this as a positive experience.

The duty of candour is the requirement that staff are open and honest to patients/or carers when things go wrong with care and treatment, including a written apology follow incidents that meet specific criteria. Staff were able to describe their duty of candour as the need to be open and honest with patients and carers when things went wrong. We saw one example of good practice whereby staff had offered an apology to a patient when things had gone wrong; this was in line with the providers policy.

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

(for example, treatment is effective)

Good

Assessment of needs and planning of care

We reviewed in detail three care and treatment records. Staff completed a comprehensive mental health assessment for all patients upon admission, incorporating pre-admission information and taking into consideration the patients physical, psychological and social needs. At the previous inspection staff did not follow the provider's physical health policy by ensuring that all newly admitted patients had a timely physical health assessment on admission. In addition, staff did not record that they had undertaken risk assessments when patients refused physical health checks. During this inspection we found

that staff assessed the physical health needs of patients in a timely manner after admission; when patients refused this, staff ensured patients were followed up and offered further review.

Staff developed individual care plans that met the needs of patients identified during the assessment. Care plans within the records reviewed were detailed, drawing together patient risk and evidenced a multi-disciplinary approach to care.

Care plans were personalised, holistic and recovery orientated; although there were some common elements across care plans. Care records clearly evidenced the different stages of recovery each patient had achieved. For example, one care record focussed on managing immediate risk through engagement, group work and medication, whilst others included the use of regular Section 17 leave and visits to another ward in the hospital as a step down within the service. Care plans for patients in seclusion included an appropriate exit plan. Staff updated, and reviewed, care plans regularly. However, staff did not record on admission or develop a specific care plan for one patient in relation to a long-term health condition.

Best practice in treatment and care

Interventions and treatments recognised by National Institute for Health and Care Excellence were promoted alongside medication regimes. The service used a nationally recognised outcome measures and rating scale; the Health of the Nation Outcome scales. Although not nationally recognised, other outcome measures were used throughout the providers different locations. Measures included quality of life, physical health, social inclusion and risk. Staff completed outcome measures regularly and these were monitored locally and nationally by the provider.

Staff provided patients with access to a range of psychological and occupational interventions. Due to the nature of the ward and minimal lengths of stay, interventions were short term. Patients accessed a range of ward based and community activities. Psychology worked with patients in groups and on an individual basis. We saw one positive example of how psychology supported a patient in preparation for their transition to another ward within the hospital. Psychological approaches used included recovery focussed sessions, such as mindfulness and coping skills. Occupational and social interventions included budgeting skills, cooking, craft and accessing the local community. During this inspection we observed patients participating in a karaoke session and painting art work in the communal areas of the ward with staff.

Staff ensured patients had good access to physical healthcare. Patients had a comprehensive physical health examination and assessment upon admission. Due to the short-term length of stay on Denholme ward, the majority of patients remained registered with their own GP. However, patients were able to access a local GP for physical healthcare needs when required. Staff referred patients to specialist services when required, including the dietician and the general hospital for investigations.

Staff assessed and met patients' needs for food and drink. Care records reviewed demonstrated that staff recorded and monitored the nutritional and hydration needs of patients where required.

Staff supported patients to live healthier lives. The service was supported by a physical health nurse, who worked across all wards providing advice, support and health information to staff and patients. To increase levels of physical activity, patients had access to outdoor space where there was exercise equipment and a basketball hoop for patients to use. Patients could access the hospital gym and use section 17 leave to go into the local community. The service provided smoking cessation information and treatment. The physical health nurse maintained records for the hospital for national screening programmes such as smears and breast screening. Healthier food choices were available on the daily menu. Staff used technology to have prompt access to blood results; these were available in individual electronic patient care records.

Staff completed a range of local audits to monitor and improve the quality and safety of care. These included care plans, emergency equipment and application of the Mental Health Act. The interim ward manager and the pharmacist audited medicines and related documentation regularly. However, despite these audit systems and processes, there remained some issues with the management and storage of medicines which audits had not identified.

The service monitored audit activity and outcomes through the governance structure. Staff discussed outcomes and actions in staff meetings and ward managers at monthly governance meetings. Staff had access to audit information through the monthly managers ward packs. In addition,

managers completed monthly quality walk arounds on the wards across the hospital. In November 2019, managers completed this on Denholme ward. This process allowed for a focussed review of the ward and the opportunity for identified issues to be actioned in a timely way.

Following our last inspection, we found that the provider did not have a policy in place to guide staff in how to support a patient who was admitted within the post-partum period (within six weeks of childbirth) and instead referred us to the generic physical health policy. At this inspection there were no patients admitted who were within the post-partum period, but the provider now had a policy in place to meet the needs of any future patients.

Skilled staff to deliver care

Patients had access to a comprehensive multi-disciplinary team. These included a consultant psychiatrist, speciality doctor, nurses, support workers, advocacy and administration. Alongside this, the ward had access to a number of allied health professionals. These included occupational therapy assistants, a psychologist and a social worker. Staff could also access additional specialist knowledge and support through the hospitals Mental Health Act office.

Staff were experienced and qualified and had the specialist skills to meet the needs of the patient group. Staff told us there had been recent changes in the leadership of the ward. At the time of inspection, the ward had an interim manager, although they were an experienced member of staff from within the service. At the time of this inspection recruitment was progressing.

The hospital employed both registered mental health nurses and a registered general nurse. Nurses received some specialist training; this recently included training on alternative sites for the administration of injections. Healthcare support workers received some specialist training, including personality disorder and responding to emergencies. Managers could access leadership training. Managers provided staff with appropriate induction, which included a range of on-line and face to face training sessions. The hospital provided an induction for all staff, including agency staff.

Staff received an annual appraisal of their performance; all staff had had an appraisal within the last 12 months. The doctor we spoke with during this inspection confirmed they had an annual appraisal. Staff received regular supervision appropriate to their role. Staff did not raise any concerns about not being able to access supervision. Between 1 August 2018 and 31 July 2019, the hospital recorded a rate of 100% for clinical supervision. Managers maintained oversight of supervision activity and reviewed this regularly during monthly governance meetings. Staff, including healthcare support workers, nurses and members of the multi-disciplinary team had access to regular team meetings and governance meetings.

Managers dealt with poor staff performance promptly and effectively.

Multi-disciplinary and inter-agency team work

Multi-disciplinary meetings were held regularly. Daily clinical handovers, ward morning meeting and the hospital wide morning meeting were held to review the previous 24 hours care and discuss individual patients, treatment and risk. We observed one ward-based morning meeting and it was evident that staff had the opportunity to discuss and share information regarding patient care; this included risks, observation levels and incidents. The meeting had purpose and value for those staff attending.

Multi-disciplinary team meetings were held weekly on the ward to review patients' care, treatment and discharge plan. Clinical, nursing and allied health professionals attended meetings. The independent mental health advocate and carers attended multi-disciplinary meetings to support patients and to ensure all viewpoints were represented. We observed one multi-disciplinary team meeting on the ward. The meeting was well attended by staff, including a social worker. During one patient review, a nurse from another ward within the hospital attended to discuss a potential transfer.

The majority of staff spoke positively about teamwork on Denholme ward. However, one member of staff told us they felt that there was a lack of understanding by the nursing team in relation to some roles within the multi-disciplinary team. The ward had established effective working relationships with teams outside the hospital, such as primary care, local authority and secondary care mental health services. Care records reviewed demonstrated regular contact with other mental health services, especially in relation to discharge and step-down services.

Adherence to the MHA and the MHA Code of Practice

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

Good

As of 31 July 2019, all staff on Denholme ward had received training in the Mental Health Act. This training was mandatory for staff in specific roles.

Staff had easy access to administrative support and legal advice on implementation of the Mental Health Act and its Code of Practice within the hospital. Staff knew who their Mental Health Act administrators were. The Mental Health Act administration team oversaw admission paperwork, ensured accuracy of section papers, monitored dates for patients' tribunal meetings and renewals, and gave reminders to staff when action was required. Staff could also access support from the corporate Mental Health Act lead. The hospital had up to date policies and procedures and these were easily accessible via the intranet. Staff stored copies of patients' detention papers and associated records appropriately and these were available to staff when they needed to access them. Staff we spoke with had a good understanding of the Mental Health Act and the Code of Practice guiding principles.

The ward had access to an independent mental health advocacy service. Staff told us they visited the hospital regularly and supported patients on a one to one basis and in meetings, including in ward rounds. Information was displayed on the ward about the advocacy service, including a photograph, name and contact details of the advocate. Advocates would attempt to speak with all patients and would liaise with ward staff to let them know of any patients who refused to interact so that staff could support them to access advocacy at a later date should they wish.

Staff explained to patients their rights under the Mental Health Act. Care and treatment records recorded when patients received their rights under the Mental Health Act, and staff completed these at regular intervals.

At the previous inspection we identified the registered person did not act in accordance with the Mental Health Act because appropriate consent to treatment was not in place. At this inspection we identified that staff had addressed these concerns. We reviewed consent to treatment documentation for all nine patients and found medicines were prescribed in accordance with the provisions of the Mental Health Act. However, two of the nine consent to treatment forms we reviewed had not been signed by the patient.

Staff had requested an opinion from a second opinion appointed doctor and the appropriate paperwork was in place to evidence these decisions. Staff completed Mental Health Act documentation audits and the managers monitored the outcomes of these audits. However, we noted the hospital seclusion audit tool failed to pick up the lack of independent multi-disciplinary reviews. Between August 2019 and October 2019, audit scores improved in relation to the Mental Health Act.

Staff ensured that patients were able to take Section 17 leave and staff told us this was rarely cancelled. Leave for patients was an important part of their care and promoted engagement with families, the community and prepared patients for discharge. Section 17 leave was planned each morning on the ward by staff and patients; this ensured enough staff were available to support patients.

Staff discussed Section 117 aftercare with patients. Care records reviewed demonstrated planning for aftercare provision for patients commenced on admission. We noted the ward was assertive in contacting other providers in preparation for a patient discharge to other services.

The CQC completed a Mental Health Act monitoring visit to the ward in October 2018. Issues identified included records relating to seclusion, recording of patient input into care plans and availability if information on how to complaint to the CQC. During this inspection we reviewed these actions and were assured the service had addressed the issues identified.

Good practice in applying the MCA

As of 31 July 2019, all staff on Denholme ward had received training in the Mental Capacity Act. The service stated that this training was mandatory for staff in specific roles. Staff we spoke with had a good understanding of the Mental Capacity Act and its five statutory principles.

Care records demonstrated that staff had assessed and recorded capacity assessments for patients who may have impaired mental capacity; these were time and decision specific. Staff did not make decisions in isolation relating to capacity, and discussion and decisions were documented in medical and multi-disciplinary reviews. For example, we saw assessment of capacity recorded in care records relating to attending the emergency department for urgent treatment and consent to treatment. Staff recorded the outcome of assessment clearly in the patient's care record.

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

Good

The provider had up to date policies and procedures on the Mental Capacity Act. Staff were aware of these and they were easily accessible via the intranet. Staff told us they would speak to the nurse in charge or the Mental Health Act office for advice on the Mental Capacity Act.

There was no deprivation of liberty safeguards applications at the time of this inspection.

Staff audited the application of the Mental Capacity Act. The outcome and subsequent action plan for this audit was monitored by the Mental Health Act office and through the hospital wide monthly governance meeting. Between August 2019 and October 2919, audit scores improved in relation to the Mental Capacity Act.

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

Good

Kindness, privacy, dignity, respect, compassion and support

During inspection we spoke with four on Denholme ward. We also received feedback via comment card from six patients. Prior to inspection we also conducted focus groups at the hospital which were attended by eight patients on Denholme ward.

We observed staff interacting with patients in a kind and respectful manner, providing patients with appropriate practical and emotional support. Staff were patient, calm and supportive during challenging situations. Except for one patient, who raised concerns about staff attitudes, feedback from patients was positive. Patients felt cared for by staff; they said staff were knowledgeable, professional and reliable. Two patients told us staff had a genuine interest in their mental health, wellbeing and recovery. We spoke with three carers during this inspection and feedback was overwhelmingly positive, describing staff as 'compassionate, responsive and caring.' One carer told us they had confidence in the abilities of staff at all levels.

At the previous inspection we identified that the admission process to the ward did not ensure the dignity and privacy of the patient was respected because patients were admitted via a main hospital entrance. During this inspection we found that staff had developed a local procedure to ensure the privacy and dignity of patients was maintained during the admission process. During core working hours, patients no longer accessed the ward through the hospital's main reception; staff admitted patients via a rear staircase to the ward.

Staff supported patients to understand and manage their care, treatment or condition. Staff developed individual care plans focussing on specific issues such as deliberate self-harm and violence and aggression. Staff acknowledged the acuity of some patients on admission within care plans and staff updated these when a patients' mental health had improved.

Staff directed patients to other services when appropriate and, if required, supported them to access those services. We noted in care records that staff had referred patients to other services, such as the dietician and the emergency department at the local hospital.

Staff were confident they could raise concerns about disrespectful, discriminatory or abusive behaviour without fear of the consequences. The hospital had a policy to guide and support staff to raise concerns. Staff also had access to a whistle-blowing telephone line to raise any concerns.

At the previous inspection we identified that patient information was not always stored securely. During this inspection, staff ensured all patient information was securely stored and confidentiality maintained.

Involvement in care

Involvement of patients

Staff used the admission process to inform and orientate patients to the ward. Staff told us patients toured the ward, were introduced to the wider patient group and received an information pack about the ward.

Staff involved patients in care planning and risk assessment. At the previous inspection we asked the provider to ensure that the involvement of patients in their care planning was clear and recorded in the patient's own words. Alongside historical narratives, staff observed and monitored behaviour to develop care plans and inform risk assessment. We saw examples in care records of patient specific needs, such as deliberate self-harm, nutrition and trauma and how changes in patient behaviour could be interpreted to meet individual needs. Care plans included

direct quotes from patients in relation to their care and treatment. Staff supported patients to attend multi-disciplinary meetings, including ward rounds. This approach provided patients with the opportunity to share their thoughts and contribute to discussions about their care and treatment. Electronic care records demonstrated that staff offered copies of care plans to patients.

Staff communicated with patients so that they understood their care and treatment, including finding ways to communicate with patients with communication difficulties. Staff used interpreters for patients when English was not their first language. Staff could access interpretation services via the telephone and in person to attend the ward.

Staff enabled patients to give feedback on the service they received. Patients could give feedback via the annual friends and family test survey but could also give feedback more regularly via monthly ward meetings and daily morning meetings. The hospital also employed a service user involvement lead whose role was to hold monthly meetings with patient representatives from each ward and listen to their ideas on how to improve services. A 'you said, we did' board was present in the reception area of the hospital and detailed suggestions from patients and how these had been actioned, for example patients sharing they would like to make calendars, and the hospital purchasing cameras for patients to take their own photographs. This board was last updated in September 2019 and was next due to be updated in January 2020.

The ward held regular community meetings to enable patients to have their say on what was important to them. We observed one community meeting and reviewed minutes from previous meetings. Patients engaged well in this meeting and discussed issues such as food, activities and section 17 leave. Patients had the opportunity to complete a patient survey on discharge from the service.

Cygnet Health Care Ltd also employed an expert by experience lead who covered the North region and visited patients at the hospital to talk to them about their care and treatment. They provided feedback to senior managers to ensure the patient voice was heard across the organisation. The last visit to the hospital was 13 September 2019. The expert by experience lead received positive feedback from patients and also spoke with staff to find out how they felt the environment and service could be improved for patients. As a result of this visit, senior managers created an action plan to drive improvement for patient care.

Staff ensured that patients could access advocacy. An advocate visited the ward every week and patients we spoke with told us they knew about advocacy. We spoke with the advocate who gave positive feedback about the hospital and stated they regularly attended hospital governance meetings which enabled them to clearly communicate any areas of concern shared by patients.

Involvement of families and carers

Staff informed and involved families and carers appropriately and provided them with support when needed. Staff provided carers with an information pack when a patient was admitted to the ward. Staff supported carer and family involvement and provided the opportunity to contribute to the care, treatment and recovery of patients. This included the opportunity to attend multi-disciplinary meetings, including ward rounds.

Feedback from families and carers we spoke with was excellent regarding their level of engagement with the ward. Families and carers told us they were kept informed by the ward, including during ward rounds and visits to the ward and through regular updates on the telephone. One carer told us they had confidence in staff and a caring attitude was present at all levels on the ward. We saw good evidence of family and carer involvement in care records; staff recorded carer views during a multi-disciplinary meeting. The hospital had a carers' lead and Denholme ward had a staff member who was identified as the carers link person on the ward. However; during this inspection we did not observe any information on display on the ward to reflect this role. We saw within the reception area of the hospital that friends and family leaflets were available which gave information on visiting, named contacts, and how to access a carer's assessment.

Families and carers could provide feedback to the service informally through staff, through carers events and through the providers website.

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

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

Good

(for example, to feedback?)

Good

Access and discharge

Bed management

The ward provided 12 psychiatric intensive care beds for female patients. The service provided information regarding average bed occupancy between 1 February 201 and 31 July 2019. The service reported an average bed occupancy of 62%. Referrals to the ward were initially managed via the provider's central referral line and the wards operational procedure supported senior nurses in their decision to accept admissions to the ward. Hospital managers maintained oversight of bed occupancy through the daily hospital wide morning meeting.

Admissions to Denholme ward were short term. Between the 1 August 2018 and 31 July 2019, the average length of stay for patients was 29 days. Patients always had a bed to return to following Section 17 leave.

Staff co-ordinated discharges for patients and moves between wards at an appropriate time of day. Staff moved patients to other wards within the hospital, these decisions were based on clinical reasons and in the best interest of patients.

Discharge and transfers of care

Between 1 January 2016 and 31 July 2019, no patients experienced a delayed discharge from the ward. Staff planned for patients' discharge in an effective way. Staff took a proactive approach to patients' discharge. Discharge planning commenced on admission and this was reflected within all care records reviewed. We saw examples of ongoing communication with bed managers of different providers, care co-ordinators and GPs. Staff reviewed discharge plans regularly.

Staff supported patients during referrals and transfers between services, including the local emergency department. During this inspection we observed a multi-disciplinary meeting; staff discussed with the patient the progress made towards their transfer to another ward within the hospital.

Facilities that promote comfort, dignity and privacy

The ward had facilities that allowed patients to be comfortable and ensured the care they received maintained their dignity and privacy. All patients had their own bedrooms and were able to personalise these. All bedrooms had an en-suite bathroom, with toilet and shower facilities. Patients also had access to a shared bathroom on the ward, which included toilets and a bath. All patients could store their possessions safely in their bedrooms; each bedroom had a safe for patients to use.

The ward had a full range of facilities and equipment to support treatment and care, including space for therapeutic activities. These rooms were based off the ward and patients required staff to support them in their use. There were quiet areas available for patients to use, including a shared outdoor space for the hospital. Patients had access to a gym, sensory room and multi-purpose room, which included computers, music and provided a space for social events. Patients could receive visits on the ward, although there was specific visits room. The hospital had a dedicated visitors room located off the main clinical areas and this was appropriate for children to use.

All patients could make private telephone calls and if required, staff supported patients to do this. Patients could use their own mobile phones and the ward telephone to make private calls.

Hot and cold drinks were available twenty-four hours a day. A variety of healthier snacks were available to patients, including fruit. Patients did not have access to the ward-based kitchen as this was a working kitchen for the preparation of meals. However, patients had access to a therapy kitchen, which was based off the ward and patients were individually risk assessed in relation to accessing this.

Patients we spoke with were positive regarding the quality of food and were satisfied with the available choices. During this inspection we observed staff and patients sitting together to share a meal. Staff and patients engaged well during this time.

Patients' engagement with the wider community

Patients were supported to maintain contact with their community, families and carers. Patients had access to Section 17 leave and this was utilised regularly by patients.

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Good

Staff supported patients to participate in a range of individual and group activities. Patient activities were meaningful and linked to recovery goals. For example, the psychologist and occupational therapy team provided a range of practical skill based short courses, such as mindfulness and budgeting.

Activities covered seven days, and these extended into the evening. Staff recorded and monitored purposeful activity for all patients. As of 27 November 2019, the ward achieved above the minimum 25 hours of meaningful activity for each patient. We sampled three care records and noted staff had recorded activities for each patient, including fitness, recovery skills, self-care and activity group.

Staff supported patients to maintain contact with their families and carers. Patients had access to regular visits, mobile phones and the use of the internet to maintain contact with family and friends.

Meeting the needs of all people who use the service

The hospital was accessible; a lift for visitors and patients to access the building and first floor was available. The ward had one accessible bedroom for patients to use, this included a larger en-suite bathroom with grab bars, a suitably located bed and wider door frames.

During the inspection, we saw information on display on the ward for patients, including information about how to complain, advocacy and access to legal advice in relation to the Mental Health Act. Information was also available to patients regarding mutual expectations of the ward and the recovery star model to support patients to measure their own progress. Staff told us that information could be easily obtained in different languages and formats via the internet to support patients where English was not their first language. Staff told us they used an interpreting service to support the specific needs of patients.

Patients had access to spiritual support; the hospital had a multi-faith room and the interim manager told us the hospital welcomed and planned for local religious leaders to attend the hospital if required. Patients had a selection of food options to choose from daily, including culturally appropriate options and those that met patients' specific dietary requirements.

Listening to and learning from concerns and complaints

The hospital received 34 complaints between 1 August 2018 to 31 July 2019. Of these 18 were in relation to Denholme ward; 15 were not upheld and 3 partially upheld. Managers reviewed complaints during monthly governance meetings and identified themes and trends. Current themes identified were staff attitudes and care and treatment received by patients. Following this inspection, the hospital provided a review of complaints from 2018. Themes for Denholme ward included the quality of care and staff attitudes. We reviewed a sample of these complaints from patients; investigations were completed, and feedback provided to the complainant.

Patients had easy access to complaint forms and information was visible in relation to making a complaint to the CQC for those patients detained under the Mental Health Act. Patients and carers we spoke with confirmed they knew how to make a complaint and were confident to do so. Staff we spoke with told us they were confident to deal with complaints in the first instance and would escalate any complaints to managers. Staff discussed complaints and concerns raised by patients and received feedback on the outcome of investigations of complaints in staff meetings.

The ward received 12 compliments between 1 August 2018 to 31 July 2019. Senior managers also undertook an annual thematic review of complaints and compliments across all four wards at the hospital. The last thematic review was conducted in 2018 and looked at types, outcomes and sources of complaints per ward, as well as reviewing timescales for resolution and any overall learning identified. Any specific actions identified went onto the hospital's overarching local action plan and communicated to staff through team meetings and bulletins. With regards to compliments the review identified sources of compliments across the four wards as well as giving specific examples of compliments given to staff. Data relating to compliments was hospital-wide and not broken down to specific core service level.

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

Good

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

Good

Leadership

Each ward at the hospital was led by a ward manager who was overseen by the clinical manager and hospital manager. All leaders had the skills, knowledge and experience to perform their roles and had a good understanding of the services they managed. They could explain clearly how the teams were working to provide high quality care.

The interim ward manager on Denholme ward had been in post for less than one month at the time of inspection. However, they were an established member of staff from the existing ward team. The interim manager understood the service they managed and how the teams worked to provide high quality care. Staff spoke positively about their leaders, felt supported and listened to. Staff, patients and carers told us managers were approachable.

Leadership development opportunities were available, including opportunities for staff below team manager level. Staff gave examples of healthcare assistants being supported to train as nurses, and a ward manager from another Cygnet hospital had recently been successful in being appointed to clinical manager at this hospital as the current clinical manager was leaving.

Vision and strategy

The providers' values were displayed across the hospital and on Denholme ward. Information was also available to staff on the intranet and the public via the internet. Staff awareness of the providers values was mixed; however, during discussions with staff, they were aware of how they applied to the service and care provided. We observed how this translated into the delivery of care; staff were committed to their roles and worked collaboratively with patients in a caring and respectful manner.

Senior managers had incorporated the provider's values into employee interview questions, induction, and appraisal structure. The values were also part of the 'employee of the month' award; with an explanation of how the successful staff member had met the values in their work. Staff knew and understood the provider's vision and values and how they were applied in the work of their team. To support staff's understanding information on vision and values was displayed across the hospital site, and staff had recently had the opportunity to access training on the values, with approximately 80% of staff across the hospital attending one of the four sessions available.

Staff could explain how they were working to deliver high quality care within the budgets available. The hospital had recently undergone large-scale remedial works to rectify issues in relation to the fire safety system throughout the hospital. Senior managers had taken the decision to reject new referrals as ward space was affected and staff were aware of the need to maintain high-quality care for patients already admitted. Despite the cost of these works the hospital were still making plans for improvement in other areas and had recently installed patient-accessible computers on all wards following patient feedback.

Culture

The majority of staff spoke positively about their team, immediate managers and senior managers. Staff supported each other within the service and this made a positive difference to staff. Staff we spoke with during this inspection felt valued, respected and listened to. Staff reported good working relationships with the multidisciplinary team. We saw that staff were committed to their roles and managed the daily challenges of providing care. Staff worked well together and where there were difficulties, managers dealt with them appropriately.

All staff we spoke with felt able to raise concerns without the fear of retribution. Staff were familiar with the providers whistleblowing policy and were confident in using it. Most staff were aware of the providers whistleblowing telephone line.

Staff had access to support for their own physical and emotional needs through the providers employee assistance programme.

The provider recognised staff success within the service through an 'employee of the month' award and 'random acts of kindness' award. Staff told us that senior managers

recognised their hard work and effort and had recently presented them with chocolates and a card to thank them. Staff were also invited to an upcoming Cygnet Christmas party which was funded by the provider.

Governance

The hospital had a clear governance structure in place. Senior managers attended regional governance meetings on a quarterly basis where information was escalated up to board level. At hospital level, governance meetings took place monthly and were attended by senior staff from the multidisciplinary team. Meetings involved discussion of items including incidents, restraint, seclusion, safeguarding, complaints, and compliance with a variety of audits. At a ward level, ward managers were responsible for reviewing monthly data packs relevant to their ward and feeding back any areas of concern, areas for action, or compliments to ward staff as well as to the monthly governance meetings. This ensured a clear framework of what must be discussed at a ward, team or directorate level in team meetings to ensure that essential information, such as learning from incidents and complaints, was shared and discussed, and a smooth pathway of communication from ward to board. The service had made improvements in their governance systems since our last inspection. Previous breaches of regulation and areas where we had identified the provider should take action to improve the service had been addressed.

The provider had systems, processes and a range of policies and procedures that ensured managers could accurately assess, monitor and improve the safety and quality of the service; this included sharing and discussing information with staff. Feedback from staff, managers and a review of meeting minutes evidenced how essential information was shared and recommendations from reviews of incidents implemented.

The hospital monitored and reported on a range of key performance indicators such as staffing, training and the use of restrictive interventions. Managers attended monthly governance meetings to understand progress and current themes and issues within the hospital and on Denholme ward. Therefore, managers were aware of key areas for improvement within the service, such as recruitment of staff. The provider also had a programme of audits; these improved quality and safety on the ward.

Systems and processes were effective at ensuring staff received supervision and appraisal, incidents were reported, investigated and learning identified.

Staff undertook or participated in local clinical audits. The audits were generally sufficient to provide assurance and staff acted on the results when needed. The hospital followed a corporate audit schedule as well as creating bespoke audits relevant to the hospital. Corporate audits included infection control, health and safety, restraint, care records and physical health. Additional local audits included those developed in response to incidents including a monthly quality walk round and closed-circuit television audit to review staff and patient interactions. However, we did identify areas of concern relating to medicines management on Denholme ward which relevant audits had not identified. This included the requirement for two illicit substances to be recorded and destroyed as per hospital protocol, the storage of patient specific medication for three patients no longer on the ward, and two out-of-date medications, and missed recordings on patient medication charts. We also identified a blanket restriction relating to the use of specific e-cigarettes which audits had not acknowledged.

Staff had implemented recommendations from reviews of deaths, incidents, complaints and safeguarding alerts at the service level. These were communicated via email bulletin and meant that staff could also learn from incidents at other hospital sites both internal and external to Cygnet.

Staff had worked hard to maintain the safe running of the hospital during the large-scale improvement works carried out to meet the requirements of the fire enforcement notice issued to the hospital. Senior managers had conducted risk assessments throughout the project and made necessary decisions such as reducing admissions to maintain safety. Senior managers had kept staff and patients informed throughout the project and were available to hear any concerns or queries in relation to the works.

Management of risk, issues and performance

The hospital had a risk register and managers discussed risk with staff during ward-based staff meetings. Staff could raise concerns at ward level and this could be escalated by the interim ward manager. We reviewed the hospital risk register and there were no specific items for Denholme

ward in line with our findings and what staff told us. Risks were monitored during monthly governance meetings and updated with actions planned, actions taken, and dates for completion. Senior managers told us they felt supported at a corporate level when raising concerns via the risk register, for example by being given financial support to make necessary and additional improvement works following receipt of a fire enforcement notice.

The service had plans for emergencies via a comprehensive business continuity plan which addressed potential emergency situations including adverse weather conditions, insufficient staffing levels, loss of heating, lighting or water, and other environmental issues. Plans clearly addressed responsibilities and actions required.

Where cost improvements were taking place, they did not compromise patient care. Senior managers acknowledged that whilst environmental works were taking place in relation to the fire notice received by the hospital a number of areas were unavailable to patients including therapy areas and the gym, which was closed at the time of inspection. Managers kept staff and patients up-to-date with progress of works and endeavoured to re-open such areas as soon as possible to reduce disruption to patient care. Staff conducted the majority of therapy sessions and activities in other available spaces whilst work took place.

Information management

The ward mostly had effective systems to collect, review and monitor data about the service. This meant data collection was not over burdensome for frontline staff. However, the incident reporting system remained paper-based and staff anticipated this would be more efficient with the planned introduction of the electronic incident recording system.

The interim manager had access to information to support them in their role relating to the performance of the service, staffing and patient care via monthly ward data packs specific to each ward. Data packs included information on incidents, restraint, seclusion, enhanced observation, blanket restrictions, safeguarding, medicines management, complaints, staff supervision and audits.

Staff had access to the equipment and information technology needed to do their work.

Staff made notifications to external bodies as needed, including the Care Quality Commission and the local authority safeguarding board.

Engagement

The service engaged positively with staff, patients and carers. Up to date information was available through different mechanisms. For staff this included team meetings, emails and the providers' intranet. Staff could also receive feedback directly from the board via the 'ask the board' option on the intranet.

Patients and carers were kept informed and engaged with the service through community meetings, information on notice boards, the advocacy service and carer events. Carers had access to information and resources through the providers website; including the friends and family satisfaction survey and how to make a complaint or raise a concern.

Patients and carers had the opportunity to provide feedback about the service and this was used to make improvements. Patients could provide feedback through community meetings, directly to staff members and by completing a discharge survey. There was a 'you said, we did' board in reception which reflected suggestions made by patients and changes made as a result, such as patients wanted to create calendars and staff purchasing a number of cameras to allow patients to take and print their own photos.

Staff told us managers were accessible and approachable to have open and honest discussions with.

Senior leaders engaged with external stakeholders on a quarterly basis including contract review meetings with NHS England and meetings with clinical commissioning groups and local authority safeguarding boards. Senior leaders shared any pertinent information with staff and also escalated concerns from staff through established governance frameworks.

Learning, continuous improvement and innovation

Healthcare providers can participate in a number of accreditation schemes whereby the services they provide are reviewed and a decision is made whether to award the service with an accreditation. A service will be accredited if they are able to demonstrate that they meet a certain standard of best practice in the given area. An accreditation usually carries an end date (or review date) whereby the

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Good

service will need to be re-assessed to continue to be accredited. In December 2018 the ward achieved the nationally recognised accreditation of inpatient mental health services; the ward successfully met 97% of the required standards for psychiatric intensive care units.

Staff were given the time and support to consider opportunities for improvements and innovation and this led to changes, for example staff from across the hospital lead on projects which were then nominated for awards at the 'Association of Psychological Therapies Awards' including for the hospital's Relaxation Workshop.

Staff also had opportunities to participate in research, for example staff from the psychology department had been involved in research relating to substance misuse and had begun running the 'find your way' substance misuse programme at the hospital. They also had an article published in an international journal for applied research in the field of co-occurring substance use, mental health conditions and complex needs.

Good

Forensic inpatient or secure wards

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

Are forensic inpatient or secure wards safe?

Requires improvement

Safe and clean environment

Safety of the ward layout

The hospital had two low-secure forensic wards consisting of Shelley ward; a 16-bed male ward, and Bronte ward; a 16-bed female ward (only 12 of which were in use at the time of inspection). At the time of inspection there were 14 patients admitted to Shelley ward and 10 patients admitted to Bronte ward.

Staff completed regular risk assessments of the care environments, including a general building risk assessment, window restrictor risk assessment, climb risk assessment for the main courtyard and Shelley ward garden, and risk assessments relating to health and safety, fire, infection control and legionella. Risk assessments were accompanied by action plans where required and were reviewed regularly.

In February 2018, the hospital received a fire enforcement notice from the West Yorkshire fire brigade, due to a number of concerns relating to risk following the completion of their fire risk assessment. The hospital was required to undertake large-scale remedial works to rectify some of the issues, particularly in relation the fire damper system throughout the hospital, including on the forensic wards, which needed replacing to ensure the control of the spread of fire and smoke throughout the building, should a fire occur. The majority of work was completed at the time of inspection with some minor remaining works in non-ward areas. The general manager had a schedule for remaining works and conducted regular risk assessments throughout the project. Work was completed and signed off by an Inspector from West Yorkshire fire brigade on 10 December 2019.

Staff conducted weekly tests of fire alarms, fire extinguishers, and emergency lighting. These were reviewed between January and November 2019 and all checks had been completed with no areas of concern identified. The hospital also carried out regular full fire evacuation drills, with some of these drills occurring out-of-hours. Between 29 January 2019 and 3 October 2019, the service had carried out six evacuation drills. On two occasions it was noted that staff were attempting to gather personal possessions before exiting the building. The subsequent actions included additional training for staff; however, hospital managers explained that this was ad-hoc and not a recorded training session. Therefore, it was not clear if staff had received this training to effectively address the area of concern identified in the evacuation drills as the same issue had re-occurred.

Ward layout did not allow staff to observe all parts of ward and there were potential ligature anchor points on both wards (a ligature point is something that a patient intent on self-harm could tie something to in order to strangle themselves) although staff managed the risks well. Staff completed a ligature audit on both wards; this was up-to-date and available to staff on the wards and was regularly reviewed. These audits identified the location of ligature risks and scored them for the level of risk posed. Staff were aware of the ligature points and mitigated these through individual risk assessment and patient observation, and the use of mirrors and closed-circuit television cameras to monitor communal areas.

The ward complied with the Department of Health and the Mental Health Act 1983 Code of Practice guidance on eliminating mixed-sex accommodation as each ward was single-sex.

Staff carried personal alarms, which when activated showed up on a panel to indicate to other staff the location of the incident. Patients had easy access to nurse call systems in bedrooms and communal areas. Staff checked alarms on a daily basis to ensure they were working effectively.

Maintenance, cleanliness and infection control

All ward areas were clean and had good furnishings and during our inspection we saw domestic staff carrying out regular cleaning. Due to the large-scale improvement works carried out which were necessary to meet the requirements of the fire enforcement notice issued to the hospital there were a number of areas within the hospital, including on the low-secure forensic wards, that required some maintenance; largely re-painting. The general manager had a planned schedule for redecoration which addressed all ward areas and was due to start in January 2020.

Staff adhered to infection control principles, including handwashing. Staff carried out an infection control audit in May 2019 which showed an overall compliance of 94%. The audit identified areas where action was required, including a lack of handwashing signs in some areas and the need for additional handwashing facilities. An electronic action plan showed that required actions had been addressed in a timely manner.

Seclusion room

There was a seclusion room on the ground floor of the hospital outside Shelley ward. This seclusion room could be used by patients from any of the four wards within the hospital. At our last inspection we were concerned that patients could use the mattress within the seclusion room, which was not fixed at any point, to restrict staff observation as there was only one observation panel. At this inspection we found that the seclusion room had been refurbished to accommodate an additional viewing panel. However, the seclusion room did not fully comply with guidance in the Mental Health Act code of practice as the externally controlled lighting did not include subdued lighting for night time. Managers told us that this would be managed by turning off the lighting in the seclusion room and leaving the light in the corridor outside on, but there was no facility to dim any of the lights which could cause discomfort to patients using the facility. We raised this as a concern and managers told us they would raise this with the hospital's estates team to address this.

At our last inspection we also raised concerns that in order for staff and patients from Bronte ward to access the seclusion room they would need to do so via a set of stairs; Bronte ward was located on the first floor of the building and at the time of inspection the first-floor seclusion room was closed for upgrading works. During this inspection we found that the first-floor seclusion room was now in use, meaning patients from Bronte ward could access seclusion without the need to use stairs, if this was required. Managers had also introduced a protocol for staff to follow when moving patients to seclusion rooms using stairs to ensure risk was assessed and safety maintained.

Clinic room and equipment

Clinic rooms were fully equipped with accessible resuscitation equipment and emergency drugs that staff checked regularly. Staff had access to emergency resuscitation equipment including oxygen, defibrillators, ligature cutters and medication to treat allergic reactions. Staff did not have access to Flumazenil; an emergency medication use to reverse the effects of benzodiazepines should a patient experience side-effects or overdose. The provider had fully risk assessed the decision not to stock this drug and had mitigated risks through staff training. The decision not to stock this drug was reviewed annually. Staff checked emergency resuscitation bags weekly to ensure the contents were present and in working order. Clinic rooms contained equipment for carrying out examinations and physical health checks, including an examination couch, blood pressure machine and weighing scales. Staff maintained equipment well and kept it clean.

Safe staffing

Managers calculated the number and grade of nurses and healthcare assistants required using an in-house staffing tool based on the acuity of patients admitted to the wards. The number of nurses and healthcare assistants matched this number on all shifts. Ward managers told us they could adjust staffing levels daily to take account of case mix and gave examples of where they had increased staffing levels to ensure patient leave from the hospital could take place. Staff shortages rarely resulted in staff cancelling escorted

leave or ward activities. Staff recorded incidents where planned leave did not take place and between 1 September 2019 and 30 November 2019 there were no instances of cancelled leave recorded. There were enough trained staff to carry out physical interventions such as observations, restraint and seclusion safely, and staffing levels allowed patients to have regular one-to-one time with their named nurse.

As at 31 August 2019 the provider told us there were no staff vacancies on Shelley ward and one qualified nurse and one health care assistant vacancies on Bronte ward. Between 1 September 2018 and 31 August 2019 staff sickness levels were 4.2% on Bronte ward and 3.4% on Shelley ward which were lower than the average hospital staff sickness rate of 6%. When necessary, managers deployed agency and bank nursing staff to maintain safe staffing levels and to cover vacancies whilst permanent staff were recruited. Between 1 May 2019 and 31 July 2019 there were 163 shifts covered by bank staff on Bronte ward and 24 shifts on Shelley ward. There were also 40 shifts covered by agency staff on Bronte ward and 107 shifts on Shelley ward in the same time period. When agency and bank nursing staff were used, those staff received an induction and were familiar with the ward. Ward managers told us that bank and agency staff were regular and knew the patients on the wards.

Managers supported staff who were off sick through the employee assistance programme and also reviewed sickness levels regularly as part of the senior management team meeting agenda. Managers followed the hospital's attendance management policy where necessary.

There was adequate medical cover day and night and a doctor could attend the ward quickly in an emergency. Each ward had a junior doctor assigned to them and in addition Bronte and Shelley wards were covered by the same responsible clinician. Staff could contact an assigned junior doctor via telephone at all times, including out-of-hours, for support and advice. There was also a responsible clinician on-call at all times to support the junior doctor. If emergency attendance was required a doctor could attend the hospital within 30 minutes.

Staff had received and were up to date with appropriate mandatory training. Prior to inspection we requested staff compliance rates for mandatory training and found that staff on both wards were above 75% compliance in the majority of training courses. However, staff compliance with 'short-term assessment of risk and treatability' training was only 50% on both wards, and with 'risk management and assessment' was only 56% on Bronte ward. Managers explained that the structure for these training courses had been recently changed at a corporate level meaning that all staff needed to re-take these training courses. Following inspection, the provider updated these figures to demonstrate staff compliance with 'short-term assessment of risk and treatability' training had increased to 81% across the hospital. Staff compliance with 'risk management and assessment' training was still only 63% but managers had scheduled monthly training sessions to take place and were booking all remaining staff onto upcoming courses.

Assessing and managing risk to patients and staff

During the inspection the inspection team reviewed six care records across the two wards. Staff completed a risk assessment of every patient on admission and updated it regularly, including after any incident using the 'short-term assessment of risk and treatability' risk assessment tool. Staff identified and responded to changing risks to, or posed by, patients through discussion in a risk assessment meeting held on each ward daily during the week Monday-Friday. These meetings were attended by the ward manager and clinical team lead from the ward as members of the multi-disciplinary team including occupational therapy, psychology and social work staff. Staff discussed specific risk issues, including any incidents, physical health concerns, medication, and observation level and agreed an overall level of risk for each patient. This allowed ward staff to feedback risk information to multi-disciplinary team staff following daily ward handover meetings.

Staff followed good policies and procedures for the use of observation (including to minimise risk from potential ligature points) and for searching patients or their bedrooms. Staff used a system of randomisation to decide if a patient required searching on return from unescorted leave by asking patients to select a ball from within a bag and depending on the colour of the ball decided whether the patient was searched or not. The majority of staff we spoke with could explain this process to us. However, one staff member told us that all patients were searched on return from unescorted leave.

Staff applied blanket restrictions on patients' freedom only when justified. Identified blanket restrictions were logged on a blanket restrictions audit which was shared between Bronte ward and Shelley ward. Blanket restrictions

included supervised access to the courtyard, counting cutlery in and out at mealtimes and limited access to laundry facilities. Staff audited blanket restrictions with patients every three months and agreed any actions, changes or additions. However, we identified a restriction related to smoking which was not detailed on the blanket restrictions audit. Whilst the provider's policy stated that rechargeable e-cigarettes could be considered on an individually risk assessed basis, the hospital had a local protocol which ran alongside the provider's policy which stated patients could only smoke specific e-cigarettes purchased from the hospital tuck shop. Patients we spoke with during focus groups conducted prior to inspection were unhappy at this decision due to the cost implications of purchasing disposable e-cigarettes rather than being able to have access to re-chargeable ones. Staff had not completed individual risk assessments to establish if patients could safely have re-chargeable cigarettes and this blanket restriction was not something noted on the hospital's blanket restrictions audits. However, post-inspection managers explained that the restriction was due to the fire enforcement notice currently in place at the time of inspection and stated that the restriction had since been added to the ward blanket restrictions log and was due to be reviewed.

Staff adhered to best practice in implementing a smoke-free policy. The provider's smoke free policy detailed interventions available to support patients who wished to stop smoking, and for those that wished to continue smoking the policy detailing specific areas within the hospital where patients could smoke e-cigarettes in order not to affect other patients.

At the time of the inspection all patients on both wards were detained under the Mental Health Act but the ward continued to display notices so that any informal patients knew they could leave at will.

Between 1 February 2019 and 31 July 2019 there was one episode of seclusion on Bronte ward and none on Shelley ward. There were no incidents of long-term segregation on either ward. We reviewed the one episode of seclusion and found that staff used seclusion appropriately and followed best practice when they did so. Staff kept records for seclusion in an appropriate manner.

Between 1 February 2019 and 31 July 2019 there were four episodes of restraint on Bronte ward involving three different patients. One of these incidents resulted in the usage of both prone restraint and rapid tranquilisation. Between the same dates there were six episodes of restraint on Shelley ward involving two different patients. There were no instances of the use of prone restraint or rapid tranquilisation. At our last inspection we found that over a similar six-month time period there had been 12 episodes of restraint with two of these involving prone restraint on Bronte ward, and 11 episodes of restraint with three of these involving prone restraint on Shelley ward. This would indicate that the use of restraint, including prone restraint, has reduced over time. Since our last inspection the provider had introduced training in alternative injection sites to encourage staff to reduce the use of prone restraint to administer intramuscular medication. At the time of inspection 19 out of 25 eligible nursing staff members had completed the training, with six further staff booked on a course in December 2019.

Staff used restraint only after de-escalation had failed and used correct techniques. Staff we spoke with on inspection were clear that restraint was only used a last resort and could explain how they would use de-escalation techniques in the first instance. The provider had recently introduced 'Reinforce Appropriate, Implode Disruptive (RAID)' training for staff; teaching a least restrictive practice approach when working with patients who display challenging behaviour, with the aim of the approach for staff to focus on 'green' positive behaviours and reduce opportunities for 'red' challenging, behaviours. The approach had been introduced over the last seven months prior to inspection, with 89% of staff trained at the time of inspection, including non-ward-based staff. However, whilst managers were confident the approach was embedded on the wards, a few staff members we spoke with were unsure about the responsibilities regarding the approach and it was not clear within the patient care records that we reviewed that this was being utilised. The provider had a plan to review the approach after 12 months to see where changes or further support was required.

During the inspection we reviewed two incident reports; one of which resulted in restraint and rapid tranquilisation. It was evident that staff had attempted de-escalation during both incidents and when this was unsuccessful had used proportionate restraint to maintain the safety of those in the vicinity. The provider had a rapid tranquilisation policy for staff to follow, and the episode was recorded as an incident and the patient received a debrief afterwards. National Institute of Health and Care Excellence guidance

states that when rapid tranquilisation has been administered staff should monitor the patient for side effects, pulse, blood pressure, respiratory rate, temperature, level of hydration and level of consciousness, or if full monitoring is impractical, staff should clearly document the reason why and ensure as a minimum they observe respiration and level of consciousness. However, on this occasion staff had only recorded level of consciousness and had not observed respiration; the patient was however noted to be alert.

Safeguarding

Staff were trained in safeguarding, knew how to make a safeguarding alert, and did so when appropriate. Staff undertook safeguarding adults and children training and staff on Shelley ward were 100% compliant and staff on Bronte ward were 94% compliant. Between 31 October 2018 and 31 October 2019, the provider submitted 71 safeguarding notifications.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act and knew how to identify adults and children at risk of, or suffering, significant harm. This included working in partnership with other agencies such as the local authority. There was a dedicated safeguarding lead at the hospital who was a social worker. This member of staff attended the local authority safeguarding adults board meetings on a quarterly basis and had additional monthly contact to review any open safeguarding notifications. Staff on the wards could seek advice from the safeguarding lead within the hospital or from Cygnet's corporate safeguarding lead from whom they could also seek safeguarding supervision.

Staff followed safe procedures for children visiting the ward as detailed in the child visiting process within the hospital's visitor's policy.

Staff access to essential information

The hospital used a combination of paper and electronic patient records as the electronic system was not capable of storing all patient information. Daily notes and care plans were recorded electronically, with care records also being printed out and stored in individual patient paper files along with other records including patient risk assessments, mental health act paperwork and physical health information. Agency staff who undertook regularly work at the hospital were given access to electronic systems but adhoc agency staff were not and staff with electronic access uploaded their notes.

Whilst there were very few staff without electronic access, recording information in more than one system appeared to cause staff some difficulty in entering or accessing the most up-to-date information. We found that two of the three paper care records we reviewed on Bronte ward did not contain the most up-to-date patient care records as stored on the electronic system. Additionally, when reviewing one patient's physical health monitoring documents it appeared from the paper record that prescribed physical health checks had been missed but these were then found on the electronic system. However, all staff attended handover meetings prior to working a shift where up-to-date information was shared in relation to patient care so that all staff, even those without electronic access, had a good knowledge of patients on the ward.

Medicines management

We reviewed the medication administration cards for seven patients on Shelley ward and nine patients on Bronte ward. On both wards appropriate consent to treatment paperwork was in place for all patients. However, on Bronte ward one form had not been signed by the relevant responsible clinician and on Shelley ward consent to treatment had not been reviewed since 2013 for one patient. On Shelley ward another patient was prescribed medication that was not listed on the current consent to treatment certificate. The prescription chart stated that this was prescribed between 12 November 2019 and 19 November 2019, but nurses had continued to administer this medication on three occasions after the end date. This was highlighted to ward staff during inspection who stated they were unaware of the stop date due to illegible handwriting by the prescriber. However, once staff were alerted to this error they rectified the issue and amended the review date. Further to this, another patient was being given medication intra-muscularly which had only been prescribed for oral administration.

On Shelley ward a patient was prescribed medication for focal seizures. However, there was no mention of this within the patient's care plan and when queried with staff we were told the patient was prescribed this medication prior to admission. We could see no review of this

medication since admission to the hospital and staff seemed unsure why this was prescribed with some staff telling us it was for focal seizures and others telling us it was for anxiety.

On Bronte ward we observed a patient being administered a nicotine replacement spray. The patient approached the ward office and staff then sprayed the medication into the patient's mouth and made a note on a whiteboard to say this had been administered. There was no accurate recording of administration in the patient's care record or medication administration record and despite staff stating that the spray was ordered from the pharmacy for a specific patient the spray in use on Bronte ward was not labelled for a specific patient. On Shelley ward the urinalysis sticks stored in the clinic had expired in October 2019.

The hospital had a robust self-administration policy in place. On Bronte ward we reviewed one patient who was self-administering medication and saw that staff acted accordingly during stage one of the process when a patient refused medication on a number of occasions by reverting back to staff administration. However, it was not always clear during stage one whether medication was self-administered by the patient on all occasions or whether the nurse administered it due to the way this was not clearly recorded.

There was no use of covert medication and no controlled drugs prescribed on either ward.

Staff reviewed the effects of medication on patients' physical health regularly and in line with National Institute of Health and Care Excellence guidance, especially when the patient was prescribed a high dose of antipsychotic medication.

Track record on safety

Between 1 August 2018 and 31 July 2019 there was one serious incident on Bronte ward and two serious incidents on Shelley ward. The incident on Bronte ward related to a patient going absent without official leave whilst on unescorted ground leave and the two incidents on Shelley ward related to patients testing positive for contraband drugs. When serious incidents occurred, the provider conducted full investigations and reported incidents to the ministry of justice where required. The provider also took steps to minimise the risk of similar incidents occurring, such as meeting with the multi-disciplinary team to review a patient's section 17 leave.

Reporting incidents and learning from when things go wrong

All staff knew what incidents to report and how to report them and staff reported all incidents that they should report. Incidents were recorded via a paper-based system and all staff we spoke with knew how to use this. Incidents were discussed daily at ward handover and multi-disciplinary team risk meetings. Ward managers reviewed all incidents and escalated them to the clinical manager where necessary. Managers completed 24-hour and 72-hour reports following any serious incidents in order to identify any immediate concerns or learning. These reports were reviewed by the corporate risk manager made the decision as to whether a full investigation was required in line with the policy. Any actions required following investigations were placed on the hospital's 'overarching local action plan' which was reviewed at monthly governance meetings.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong. The provider had a duty-of-candour policy for staff to refer to and staff were reminded about their responsibilities under duty of candour through hospital newsletters. Even when incidents or complaints did not meet the threshold for duty of candour we saw evidence of staff offering apologies to patients when they were unhappy with their care or treatment.

Staff were debriefed and received support after a serious incident. Staff we spoke with gave an example where they had been supported following a recent patient death. Staff had access to employee support services and occupational health and told us that psychology staff at the hospital would provide additional support and supervision sessions following incidents if this was required.

Staff received feedback from investigation of incidents, both internal and external to the service via a monthly quality newsletter which included lessons learnt from incidents in both independent and NHS services. Staff also discussed incidents and lessons learnt in supervision and received email bulletins. Staff were encouraged to contribute any shared learning to the quality newsletter that they felt might benefit other staff members. There was evidence that changes had been made as a result of feedback, for example following an incident of patient

Good

Forensic inpatient or secure wards

self-harm on another ward, feedback to staff was that they needed to give a handover of risk at every shift handover and we observed this to happen in practice whilst on inspection.

Are forensic inpatient or secure wards effective?

(for example, treatment is effective)

Good

Assessment of needs and planning of care

During inspection the inspection team reviewed six care records across the two wards. Staff had completed a comprehensive mental health assessment and physical health assessment of the patients in a timely manner at, or soon after, admission.

Care plans were personalised, holistic and recovery-oriented and staff updated care plans when necessary. Care plans were specific to patient need and included personalised plans to address areas including relationships, offending and sexualised behaviours, life skills, and alcohol and substance misuse. The majority of patients with physical health needs had specific 'staying healthy' care plans in place to address concerns including weight, blood pressure, hearing and dietary intake.

Patients had 'moving on' care plans which detailed proposed discharge dates where applicable and contained information about future plans such as where the patient may want to live and what support they may need. Care plans contained a section for the patient's view and we saw patients contributing their views to their care plans.

Best practice in treatment and care

Staff provided a range of care and treatment interventions suitable for the patient group. The interventions were those recommended by, and were delivered in line with, guidance from the National Institute for Health and Care Excellence. Patients had access to a team of psychologists and psychology assistants within the hospital who offered both group and individual therapies relevant to the individual need of the patient, such as coping skills and dialectical behaviour therapy. Each ward also had their own occupational therapist or therapy assistant who engaged patients in assessments including the Model of Human Occupation Screening Tool and occupational self-assessment. The occupational therapy team also engaged patients in numerous activities and escorted patients on therapy leave in the local community.

Staff ensured that patients had good access to physical healthcare, including access to specialists when needed. Since our last inspection the hospital had employed a registered general nurse to oversee the physical health needs of patients across all four wards. They had also registered all patients who wished to register with the local GP practice, who offered dedicated clinic time for patients every week. The nurse was able to attend GP appointments with patients and feedback information to doctors within the hospital to ensure good information sharing and recording of information on the hospital's electronic patient record system. We saw within patients' care records that their physical health, including weight, was being regularly monitored, and that patients were being referred to specialists, such as dieticians where necessary. Staff monitored and reported on patients' weight and activity levels and from the care records we reviewed we saw that patients were generally engaging in at least 25 hours of meaningful activity per week, with some achieving much more than this. Patients with physical healthcare needs generally had specific care plans to address their needs. However, one patient prescribed medication for focal seizures did not have a care plan in place in relation to this. staff were unclear as to why this medication was prescribed as it had been reconciled when the patient was admitted and not required since admission. Another patient did have a care plan in relation to low blood pressure, but we could not see that staff had followed protocol when scores were concerning. For example, the Modified Early Warning Scores document used to record vital signs stated that if a certain score was achieved then staff should call the emergency services, but staff had not done so and had instead repeated the tests over two hours later and then again 83 minutes later until they were within normal limits.

Staff assessed and met patients' needs for food and drink and for specialist nutrition and hydration. Staff also supported patients to live healthier lives through participation in smoking cessation schemes, healthy eating advice, and supporting patients with issues relating to substance misuse.

Staff used recognised rating scales to assess and record severity and outcomes including Health of the Nation

Outcome Scales. Staff also used additional tools including the 'Recovery Star' to measures patient progress with individual goals in areas including living skills, relationships, and work, as well as tools devised to measure progress with daily living skills.

Staff used technology to support patients effectively, for example, for prompt access to blood test results and online access to self-help tools. Since our last inspection each ward had introduced its' own patient-accessible computer and patients could access the internet via these computers or via their own devices. There were also additional computers in therapy areas.

Staff participated in clinical audit, benchmarking and quality improvement initiatives. Staff had access to results and actions required from audits through monthly ward manager packs. Following our previous inspection managers had also begun to complete monthly quality walks of each ward whereby they reviewed ward information and spoke with staff about their understanding and knowledge, for example in relation to restraint and the Mental Capacity Act. This helped staff to establish where improvements were required on the wards and to make the required changes.

Skilled staff to deliver care

The team included or had access to the full range of specialists required to meet the needs of patients on the ward, including doctors, nurses, occupational therapists, clinical psychologists, social workers, and healthcare assistants. Staff were experienced and qualified and had the right skills and knowledge to meet the needs of the patient group.

Managers provided new staff, including temporary staff, with an appropriate induction, and provided ongoing supervision for all staff to reflect on and learn from practice, as well as for personal support and professional development. The percentage of staff that received regular supervision was 99% on Bronte ward and 100% on Shelley ward. At our last inspection we found that supervision of staff from social work and occupational therapy departments did not follow the provider's own policy which stated all health professionals should have monthly supervision. During this inspection we found this had improved as over 97% of staff within the occupational therapy, social work and psychology teams received regular supervision. All staff also received an annual appraisal of their work performance; all staff had had an appraisal in the last 12 months.

Managers ensured that staff had access to regular team meetings, including a daily general handover, more specific multi-disciplinary risk meetings, and monthly ward meetings. There were additional meetings for the senior management team and specific meetings for other departments such as the estates department.

Managers identified the learning needs of staff and provided them with opportunities to develop their skills and knowledge; they ensured that staff received the necessary specialist training for their roles. Staff were being trained in the principles of 'Reinforce, Appropriate, Implode Disruptive (RAID)' training and staff could also attend introductory sessions on working psychologically to support them in working with the patient group.

Managers dealt with poor staff performance promptly and effectively through thorough investigation of complaints and incidents. We saw examples whereby staff had been dismissed and received formal warnings following poor performance.

Multi-disciplinary and inter-agency team work

Staff held regular and effective multidisciplinary meetings. Between Monday to Friday each ward had a morning daily risk assessment meeting attended by the ward manager, nursing staff, doctor and multidisciplinary team members including psychology, social work and occupational therapy staff. We observed one of these meetings on each ward and saw that staff discussed each patient individually including a review of patient risk, care plan adjustments, any incidents, and measures in place to manage risk. All members could contribute to the meetings and appeared to work together effectively.

Staff also shared information about patients at effective handover meetings within the team. Ward staff attended twice daily handover meetings to ensure those working with patients on the next shift were aware of any incidents, change in presentation or risk, and knew the plan for the day, for example in terms of patient leave or any appointments outside the hospital.

The ward teams had effective working relationships with teams outside the organisation, for example, local

authority social services and GPs. The hospital employed a physical health nurse who liaised between the wards and the GP surgery to ensure patients received timely physical health care. The lead social worker within the hospital took the lead in liaising with the local authority to manage and monitor any ongoing safeguarding incidents or concerns.

Adherence to the MHA and the MHA Code of Practice

Staff were trained in and had a good understanding of the Mental Health Act, the Code of Practice and the guiding principles. At the time of inspection 91% of staff had had training in the Mental Health Act. Staff had easy access to local Mental Health Act policies and procedures via the staff intranet and to the Code of Practice that reflected the most recent guidance.

Staff had easy access to administrative support and legal advice on implementation of the Mental Health Act and its Code of Practice within the hospital. Staff knew who their Mental Health Act administrators were. The Mental Health Act administration team oversaw admission paperwork, ensured accuracy of section papers, monitored dates for patient's tribunal meetings and renewals, and gave reminders to staff when action was required. Staff could also access support from the corporate Mental Health Act lead.

Staff ensured that patients were able to take Section 17 leave (permission for patients to leave hospital) when this has been granted. Patient's section 17 leave records were stored within their individual patient paper files on the wards and when a patient took section 17 leave this was clearly recorded. Staff explained to patients their rights under the Mental Health Act in a way that they could understand, repeated it as required and recorded that they had done it in patients' paper files. Staff requested an opinion from a second opinion appointed doctor when necessary.

Patients had easy access to information about independent mental health advocacy. Advocates visited the wards weekly and information on how to contact the advocates outside of these times was displayed on the wards. Advocates would attempt to speak with all patients and would liaise with ward staff to let them know of any patients who refused to interact so that staff could support them to access advocacy at a later date should they wish.

At the time of inspection all patients on both wards were detained under the Mental Health Act but the wards still displayed a notice to tell any informal patients that they could leave the ward freely.

Staff did regular audits to ensure that the Mental Health Act was being applied correctly, including auditing of section 17 leave and compliance with consent to treatment documentation.

Good practice in applying the MCA

Staff had a good understanding of the Mental Capacity Act, in particular the five statutory principles. At the time of inspection 81% of staff had had training in the Mental Capacity Act. Managers conducted monthly 'quality walks' of the wards, part of which involved questioning staff about their understanding of the Act. Feedback from quality walks in August, September and October showed there were no concerns with staff understanding.

The provider had a policy on the Mental Capacity Act, including deprivation of liberty safeguards. Staff were aware of the policy and had access to it. Staff knew where to get advice from within the provider regarding the Mental Capacity Act, including Deprivation of Liberty Safeguards. At the time of inspection all patients on both wards were detained under the Mental Health Act which meant that staff did not provide care and treatment to patients under Deprivation of Liberty Safeguards.

Staff took all practical steps to enable patients to make their own decisions. For patients who might have impaired mental capacity, staff assessed and recorded capacity to consent appropriately. They did this on a decision-specific basis with regard to significant decisions. When patients lacked capacity, staff made decisions in their best interests, recognising the importance of the person's wishes, feelings, culture and history. Capacity assessments and best interests' decisions were documented in patients' notes.

Staff audited the application of the Mental Capacity Act. The outcome and subsequent action plan for this audit was monitored by the Mental Health Act office and through the hospital wide monthly governance meeting.

Are forensic inpatient or secure wards caring?

Good

Forensic inpatient or secure wards

Good

Kindness, privacy, dignity, respect, compassion and support

During inspection we spoke with nine patients across the two wards. We also received feedback via comment card from one patient. Prior to inspection we also conducted focus groups at the hospital which were attended by seven patients across the two wards.

Staff attitudes and behaviours when interacting with patients showed that they were discreet, respectful and responsive, providing patients with help, emotional support and advice at the time they needed it. Staff appeared to have a good knowledge of each individual patient and their needs. Patients said staff treated them well and behaved appropriately towards them. All patients we spoke with apart from one told us that staff supported them to feel safe on the wards.

Staff supported patients to understand and manage their care, treatment or condition. Patients were given information on treatments available to them and could access advocacy support on a weekly basis. Staff understood the individual needs of patients, including their personal, cultural, social and religious needs. There was a multi-faith room available within the hospital which patients could access, and some patients told us that staff had supported them to attend places of worship outside the hospital.

Staff said they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards patients without fear of the consequences. All staff told us they would feel comfortable to raise concerns. However, some staff on Bronte ward told us they felt they could not escalate concerns to some senior members of staff.

Staff maintained the confidentiality of information about patients. Patients' care records were stored securely on both electronic systems which were accessible via secure and individual staff login details, and paper-based records which were stored in locked cabinets within ward offices in non-patient areas.

Involvement in care

Involvement of patients

Staff used the admission process to inform and orient patients to the ward and to the service. Welcome packs were available to patients which contained information including staffing, routines on the wards, and activities and facilities available. Information was displayed on ward corridors to support new patients including staff structures, patient rights and advocacy details.

Staff involved patients in care planning and risk assessment. Staff and patients worked together to complete a 'patient's views' section of each patient's care plan, and the majority of patients we spoke with had a copy of their care plan or had been offered one. Patients were involved in regular multidisciplinary team reviews of their care and their views were recorded as part of this meeting.

Staff communicated with patients so that they understood their care and treatment, including finding effective ways to communicate with patients with communication difficulties. Staff told us they could easily access interpreters and signers for those that needed them, and we saw within a patient's care record that their first language was not English and there was a plan around how to best support this patient to enable them to understand their care.

Staff involved patients when appropriate in decisions about the service, for example, in the recruitment of staff. Staff gave a recent example whereby a patient representative had recently been involved in the recruitment of a member of staff to the therapy team.

Staff enabled patients to give feedback on the service they received. Patients could give feedback via the annual friends and family test survey but could also give feedback more regularly via monthly ward meetings and daily morning meetings. The hospital also employed a service user involvement lead whose role was to hold monthly meetings with patient representatives from each ward and listen to their ideas on how to improve services. A 'you said, we did' board was present in the reception area of the hospital and detailed suggestions from patients and how these had been actioned, for example patients sharing they would like to make calendars, and the hospital purchasing cameras for patients to take their own photographs. This board was last updated in September 2019 and was next due to be updated in January 2020.

Good

Forensic inpatient or secure wards

Cygnet Health Care Ltd also employed an expert by experience lead who covered the North region and visited patients at the hospital to talk to them about their care and treatment. They provided feedback to senior managers to ensure the patient voice was heard across the organisation. The last visit to the hospital was 13 September 2019. The expert by experience lead received positive feedback from patients and also spoke with staff to find out how they felt the environment and service could be improved for patients. As a result of this visit, senior managers created an action plan to drive improvement for patient care.

Staff ensured that patients could access advocacy. An advocate visited across the two wards three days a week and patients we spoke with told us they knew about advocacy, with one patient telling us the advocate had helped them to raise concerns to staff on the ward. We spoke with the advocate who gave positive feedback about the hospital and stated they regularly attended hospital governance meetings which enabled them to clearly communicate any areas of concern shared by patients.

Involvement of families and carers

During the inspection we attempted to contact a number of family members and carers of patients across the two wards but only one carer provided any feedback. We did however review family and carer involvement in care records and speak with patients about their family's involvement.

Staff informed and involved families and carers appropriately and provided them with support when needed. The carer we spoke with had been sent a carer's pack through the post and we saw within the reception area of the hospital that friends and family leaflets were available which gave information on visiting, named contacts, and how to access a carer's assessment. Some of the patients we spoke with told us their family members visited regularly. The carer we spoke with told us that staff were kind and always helpful if they asked for any support.

Staff enabled families and carers to give feedback on the service they received via annual surveys or feedback boxes in the hospital reception. Carers could also attend carers events at the hospital. In the last 12 months prior to inspection the hospital had organised four carer's events, with one being cancelled due to no attendance. Each ward had two carer's links who carers could contact for support or advice and these staff members worked as links between carers and the overall carers lead for the hospital to ensure information was communicated both to and from carers and the hospital.

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

(for example, to feedback?)

Good

Access and discharge

From 1 February 2019 to 31 July 2019 the average bed occupancy for Bronte ward was 92% and for Shelley ward was 100%. Staff and patients told us there was always a bed available when patients returned from leave and for new admissions. Patients were not moved between wards during an admission episode unless it was justified on clinical grounds and was in the interests of the patient, for example if a patient required a higher-level of support. When patients were moved or discharged, this happened at an appropriate time of day. Staff supported patients during referrals and transfers between services, for example, if they required treatment in an acute hospital or temporary transfer to a psychiatric intensive care unit.

In the last 12 months prior to inspection, there were no reported delayed discharges from either ward. There was a total of nine discharges; five from Bronte ward and four from Shelley ward. At the time of inspection, the average length of stay for patients on Bronte ward was 23.6 months and on Shelley ward was 55.5 months. Staff planned for patients' discharge, including good liaison with care co-ordinators who were regularly invited to patient care review meetings. Patient care records evidenced that staff were working towards the discharge of patients to less secure settings. The majority of patients we spoke with were aware of their discharge plan and how they were moving towards it and discharge plans were in place.

The facilities promote recovery, comfort, dignity and confidentiality

Patients had their own bedrooms which they could personalise. Patients had somewhere secure to store their possessions in their room or within a locked room on each of the wards. All bedrooms had an en-suite bathroom, with

toilet and shower facilities. However, there was no ability to screen off the window into the en-suite bathroom in the ground-floor seclusion room to maintain the privacy and dignity of patients using the facility by ensuring that staff walking past could not see in. The Mental Health Act Code of Practice states that 'hospital staff should make conscious efforts to respect the privacy and dignity of patients as far as possible while maintaining safety'. The window into the first-floor seclusion room en-suite could be covered using glazed secure vision panels but it did not appear this has been considered for the ground-floor seclusion room.

Staff and patients had access to the full range of rooms and equipment to support treatment and care, including clinic rooms to examine patients, and activity and therapy rooms. Each ward had a communal lounge containing items including a television and games, as well as a designated quiet lounge. Each ward also had a computer for patients to access, as well as a dining area, activity room and kitchen. Off the ward patients had access to a therapy corridor with rooms including a multi-purpose room with a tuck shop, a sensory room, kitchen, music room and a general group room. There was also a gym on this corridor which was closed at the time of inspection due to ongoing estates works but was due to re-open soon once works were complete. Whilst work was ongoing patients could access gym equipment in the communal courtyard. Patients could also access a multi-faith room and patients on Bronte ward could access a communal garden space shared with two other wards and patients from Shelley ward had access to their own garden area.

There were two rooms available off the wards where patients could meet visitors in which there was a range of toys and books available for any child visitors.

Patients could make a phone call in private on the ward, but most patients told us they had access to their own mobile phone.

The majority of patients told us the food was of a good quality, but one patient was unhappy that all chicken dishes provided were halal. Staff told us that there was always a meat option, separate halal option, and a vegetarian option available to patients at mealtimes. Patients were able to order takeaway food to the ward. Patients had access to hot and cold drinks and snacks at all times of the day and night.

Patients' engagement with the wider community

When appropriate, staff ensured that patients had access to education and work opportunities. Ward managers told us that patients could access volunteering opportunities as well as attending a local community centre to engage in activities such as gardening. They also told us previous patients had attended a local college to obtain qualifications but that no current patients were accessing this. Patients could volunteer to work in the hospital's tuck shop to develop skills. The hospital also ran a 'Recovery College' which offered educational courses to patients to support and empower them in their recovery.

Staff supported patients to maintain contact with their families and carers. Managers told us that they would facilitate dial-in options for carers unable to attend patient review meetings, would consider the location of family and carers when arranging patient leave, and could look at arranging extended visits based on individual patient circumstances.

Meeting the needs of all people who use the service

The service made adjustments for disabled patients, for example, by ensuring disabled people's access to premises and by meeting patients' specific communication needs. The ground floor of the hospital was all level-access. Bronte ward was located on the first floor of the hospital. There was a lift available which was not generally used for patients but would be individually risk assessed should it be required.

Staff ensured that patients could obtain information on treatments, local services, patients' rights, and how to complain. Much information was displayed on boards on ward corridors and additional leaflets and posters were available in reception. Staff told us they could print off specific information for patients if they requested this. The information provided was in a form accessible to the particular patient group and staff told us they could provide information in languages other than English if required. Managers ensured that staff and patients had easy access to interpreters and/or signers.

Patients had a choice of food to meet the dietary requirements of religious and ethnic groups and staff ensured that patients had access to appropriate spiritual support either through accessing the multi-faith room on-site or by supporting patients to access places of worship.

Good

Forensic inpatient or secure wards

Listening to and learning from concerns and complaints

Between 2 November 2018 and 30 July 2019 there were nine complaints raised with the hospital across the two wards. Complaints related to lost property, food, staff attitudes, care and treatment and access to items during section 17 leave. Of the nine complaints received three were upheld, three were partially upheld and three were not upheld. We reviewed a sample of complaints and found that staff carried out thorough investigations and responded to complainants within Cygnet policy timescales.

Patients we spoke with knew how to complain or raise concerns and when patients complained or raised concerns, they received feedback in a suitable format. Staff protected patients who raised concerns or complaints from discrimination and harassment and knew how to handle complaints appropriately.

Staff received feedback on the outcome of the investigation of complaints via supervision or team meeting depending on the nature of the complaint and outcome. Staff provided examples of when feedback was provided via staff meeting following a complaint to ensure staff were aware of how to support patients to access snacks outside mealtimes.

Senior managers also undertook an annual thematic review of complaints and compliments across all four wards at the hospital. The last thematic review was conducted in 2018 and looked at types, outcomes and sources of complaints per ward, as well as reviewing timescales for resolution and any overall learning identified. Any specific actions identified went onto the hospital's overarching local action plan and communicated to staff through team meetings and bulletins. With regards to compliments the review identified sources of compliments across the four wards as well as giving specific examples of compliments given to staff. Data relating to compliments was hospital-wide and not broken down to specific core service level.

Are forensic inpatient or secure wards well-led?

Good

Leadership

Each ward at the hospital was led by a ward manager who was overseen by the clinical manager and hospital manager. All leaders had the skills, knowledge and experience to perform their roles and had a good understanding of the services they managed. They could explain clearly how the teams were working to provide high quality care.

Leaders were visible in the service and approachable for patients and staff. Whilst some staff on Bronte ward told us they did not feel comfortable to approach senior ward-based staff with some concerns, all staff told us they would feel comfortable to approach senior managers who were regularly present on wards and had an open-door policy. Staff told us that leaders were proactive and involved in the day-to-day running of the service.

Leadership development opportunities were available, including opportunities for staff below team manager level. Staff gave examples of healthcare assistants being supported to train as nurses, and a ward manager from another Cygnet hospital had recently been successful in being appointed to clinical manager at this hospital as the current clinical manager was leaving.

Vision and strategy

The provider's senior leadership team had successfully communicated the provider's vision and values to the frontline staff in this service and we observed staff acting in line with these values. Senior managers had incorporated the provider's values into employee interview questions, induction, and appraisal structure. The values were also part of the 'employee of the month' award; with an explanation of how the successful staff member had met the values in their work. Staff knew and understood the provider's vision and values and how they were applied in the work of their team. To support staff's understanding information on vision and values was displayed across the

hospital site, and staff had recently had the opportunity to access training on the values, with approximately 80% of staff across the hospital attending one of the four sessions available.

Staff could explain how they were working to deliver high quality care within the budgets available. The hospital had recently undergone large-scale remedial works to rectify issues in relation to the fire safety system throughout the hospital. Senior managers had taken the decision to reject new referrals as ward space was affected and staff were aware of the need to maintain high-quality care for patients already admitted. Despite the cost of these works the hospital were still making plans for improvement in other areas and had recently installed patient-accessible computers on all wards following patient feedback.

Culture

Staff told us they generally felt respected, supported and valued in their roles and felt positive and proud about working for the provider and their team. Staff told us that whilst they felt stressed at times they felt well supported by their teams and felt the majority of staff got along well. However, prior to inspection we carried out some staff focus groups whereby some staff members from Bronte ward told us there were staff cliques on the ward with some staff feeling left out, but staff were confident this did not affect patient care. Some staff also raised concerns about pay as they told us different staff members were on different levels of pay for the same roles. We raised this with senior managers who told us they were aware of staff concerns and the fact some staff were on different contracts due to Cygnet taking over other providers. These concerns had been raised to a corporate level and options for how to address this were being considered.

The majority of staff we spoke with told us that they felt able to raise concerns without fear of retribution. However, some staff on Bronte ward told us they did not always feel comfortable approaching senior ward staff with concerns and would prefer to speak to a nurse or senior manager. Staff knew how to use the whistle-blowing process.

Managers dealt with poor staff performance when needed. Managers suspended staff as appropriate when complaints or concerns were raised about their performance and conducted thorough investigations. Managers were open and honest with staff about processes that had to be followed and aimed to educate staff and improve performance where possible. Where staff were suspended the reasons for this were clear and correct processes were followed as per the provider policy.

Staff appraisals included conversations about career development and how it could be supported. Staff gave examples of where they had been supported to access additional training courses and said they could raise requests through supervision and appraisal processes.

Staff had access to support for their own physical and emotional health needs through an occupational health service as well as through an employee assistance programme. Staff told us that they could access incident debrief and group supervision sessions through the psychology team at the hospital as well as support through supervision.

The provider recognised staff success within the service through an 'employee of the month' award and 'random acts of kindness' award. Staff told us that senior managers recognised their hard work and effort and had recently presented them with chocolates and a card to thank them. Staff were also invited to an upcoming Cygnet Christmas party which was funded by the provider.

Governance

The hospital had a clear governance structure in place. Senior managers attended regional governance meetings on a quarterly basis where information was escalated up to board level. At hospital level, governance meetings took place monthly and were attended by senior staff from the multidisciplinary team. Meetings involved discussion of items including incidents, restraint, seclusion, safeguarding, complaints, and compliance with a variety of audits. At a ward level, ward managers were responsible for reviewing monthly data packs relevant to their ward and feeding back any areas of concern, areas for action, or compliments to ward staff as well as to the monthly governance meetings. This ensured a clear framework of what must be discussed at a ward, team or directorate level in team meetings to ensure that essential information, such as learning from incidents and complaints, was shared and discussed, and a smooth pathway of communication from ward to board. The service had made improvements in

their governance systems since our last inspection. Previous breaches of regulation and areas where we had identified the provider should take action to improve the service had been addressed.

The service had a number of key performance indicators which allowed them to measure safety and quality, including safeguarding notifications, restraint, medication errors, staff turnover, vacancies and sickness, staff training, and incidents. The service measured their performance against other Cygnet hospitals which helped indicate any outliers requiring attention.

Staff undertook or participated in local clinical audits. The audits were generally sufficient to provide assurance and staff acted on the results when needed. The hospital followed a corporate audit schedule as well as creating bespoke audits relevant to the hospital. Corporate audits included infection control, health and safety, restraint, care records and physical health. Additional local audits included those developed in response to incidents including a monthly quality walk round and closed-circuit television audit to review staff and patient interactions. However, we did identify areas of concern relating to medicines management on Bronte and Shelley wards which relevant audits had not identified including in relation to consent to treatment documentation, and a blanket restriction in relation the use of specific e-cigarettes.

Staff had implemented recommendations from reviews of deaths, incidents, complaints and safeguarding alerts at the service level. These were communicated via email bulletin and meant that staff could also learn from incidents at other hospital sites both internal and external to Cygnet.

Staff had worked hard to maintain the safe running of the hospital during the large-scale improvement works carried out to meet the requirements of the fire enforcement notice issued to the hospital. Senior managers had conducted risk assessments throughout the project and made necessary decisions such as reducing admissions to maintain safety. Senior managers had kept staff and patients informed throughout the project and were available to hear any concerns or queries in relation to the works.

Management of risk, issues and performance

The hospital had a local risk register, which fed into the corporate risk register and ward staff could submit items to the local risk register via their ward managers. Risks on the register reflected those highlighted by staff including fire safety deficiencies. Risks were monitored during monthly governance meetings and updated with actions planned, actions taken, and dates for completion. Senior managers told us they felt supported at a corporate level when raising concerns via the risk register, for example by being given financial support to make necessary and additional improvement works following receipt of a fire enforcement notice.

The service had plans for emergencies via a comprehensive business continuity plan which addressed potential emergency situations including adverse weather conditions, insufficient staffing levels, loss of heating, lighting or water, and other environmental issues. Plans clearly addressed responsibilities and actions required.

Where cost improvements were taking place, they did not compromise patient care. Senior managers acknowledged that whilst environmental works were taking place in relation to the fire notice received by the hospital a number of areas were unavailable to patients including therapy areas and the gym, which was closed at the time of inspection. Managers kept staff and patients up-to-date with progress of works and endeavoured to re-open such areas as soon as possible to reduce disruption to patient care. Staff conducted the majority of therapy sessions and activities in other available spaces whilst work took place.

Information management

The service used systems to collect data from wards and directorates that were not over-burdensome for frontline staff and staff had access to the equipment and information technology needed to do their work. At the time of inspection staff were still inputting some information onto paper, such as incident reports. Staff commented that they felt it would be better to be able to input this information electronically, which was something managers were considering going forwards.

Information governance systems included confidentiality of patient records as records where either stored electronically on systems requiring individual secure logins, or on paper records which were stored in locked cabinets in the ward office which was not accessible to patients.

Good

Forensic inpatient or secure wards

Team managers had access to information to support them with their management role. This included information on the performance of the service, staffing and patient care via monthly ward data packs specific to each ward. Data packs included information on incidents, restraint, seclusion, enhanced observation, blanket restrictions, safeguarding, medicines management, complaints, staff supervision and audits.

Staff made notifications to external bodies as needed, such as local authority safeguarding notifications. As above, safeguarding alerts raised were detailed in monthly ward manager packs and were broken down into number and type to allow managers to have oversight of any particular areas of concern on each ward.

Engagement

Staff, patients and carers had access to up-to-date information about the work of the provider and the services they used. Staff received information through the intranet, bulletins and team meetings and could also receive feedback directly from the board via the 'ask the board' option on the intranet. Patients and carers received information through ward meetings, service user forums, advocacy and carers events. Patients and carers had opportunities to give feedback on the service they received in a manner that reflected their individual needs, through formal complaint or informal discussion with staff. Managers and staff had access to the feedback from patients, carers and staff and used it to make improvements.

Patients and carers were involved in decision-making about changes to the service such as staff recruitment. There was a 'you said, we did' board in reception which reflected suggestions made by patients and changes made as a result, such as patients wanted to create calendars and staff purchasing a number of cameras to allow patients to take and print their own photos.

Senior leaders engaged with external stakeholders on a quarterly basis including contract review meetings with NHS England and meetings with clinical commissioning groups and local authority safeguarding boards. Senior leaders shared any pertinent information with staff and also escalated concerns from staff through established governance frameworks.

Learning, continuous improvement and innovation

Staff were given the time and support to consider opportunities for improvements and innovation and this led to changes, for example staff at the hospital had recently won an award at the 'Association of Psychological Therapies Awards' for the hospital's Relaxation Workshop which was co-developed by a member of staff and a patient and were finalists at the awards for their implementation of the 'Reinforce Appropriate, Implode Disruptive' approach on Bronte and Shelley wards.

Staff also had opportunities to participate in research, for example staff from the psychology department had been involved in research relating to substance misuse and had begun running the 'find your way' substance misuse programme at the hospital. They also had an article published in an international journal for applied research in the field of co-occurring substance use, mental health conditions and complex needs.

Wards participated in accreditation schemes relevant to the service and learned from them. Shelley and Bronte wards participated in the Quality Network for Forensic Mental Health Services and at their last peer review visit were found to be 90% compliant with low-secure standards.

Good

Personality disorder services

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

Are personality disorder services safe?

Requires improvement

Safe and clean environment

Cygnet Hospital Bierley had one specialist personality disorder ward, Bowling ward. Bowling ward had 16 beds available for patients. At the time of the inspection, eight patients were admitted to the ward.

Staff completed regular risk assessments of the care environments, including a general building risk assessment, window restrictor risk assessment, climb risk assessment for the main courtyard and Shelley ward garden, and risk assessments relating to health and safety, fire, infection control and legionella. Risk assessments were accompanied by action plans where required and were reviewed regularly.

In February 2018, the hospital received a fire enforcement notice from the West Yorkshire fire brigade, due to a number of concerns relating to risk following the completion of their fire risk assessment. The hospital was required to undertake large-scale remedial works to rectify some of the issues, particularly in relation the fire damper system throughout the hospital, including on the specialist personality disorder ward, which needed replacing to ensure the control of the spread of fire and smoke throughout the building, should a fire occur. The majority of work was completed at the time of inspection with some minor remaining works in non-ward areas. The general manager had a schedule for remaining works and conducted regular risk assessments throughout the project. Work was completed and signed off by an Inspector from West Yorkshire fire brigade on 10 December 2019.

Staff conducted weekly tests of fire alarms, fire extinguishers, and emergency lighting. These were reviewed between January and November 2019 and all checks had been completed with no areas of concern identified. The hospital also carried out regular full fire evacuation drills, with some of these drills occurring out-of-hours. Between 29 January 2019 and 3 October 2019, the service had carried out six evacuation drills. On two occasions it was noted that staff were attempting to gather personal possessions before exiting the building. The subsequent actions included additional training for staff; however, hospital managers explained that this was ad-hoc and not a recorded training session. Therefore, it was not clear if staff had received this training to effectively address the area of concern identified in the evacuation drills as the same issue had re-occurred.

The ward complied with guidance and there was no mixed sex accommodation. The ward was a single sex ward.

Staff knew about any potential ligature anchor points and mitigated the risks to keep patients safe. The ward layout did not allow staff to observe all parts of ward and there were potential ligature anchor points on the ward (a ligature point is something that a patient intent on self-harm could tie something to in order to strangle themselves) although staff managed the risks well. Staff completed a ligature audit which was up-to-date and available to staff on the ward and was regularly reviewed. Audits identified the location of ligature risks and scored them for the level of risk posed. Staff were aware of the

ligature points and mitigated these through individual risk assessment and patient observation, and the use of mirrors and closed-circuit television cameras to monitor communal areas.

Staff had access to alarms and patients had access to nurse call systems. Staff carried personal alarms, which when activated showed up on a panel to indicate to other staff the location of the incident. Patients had access to nurse call systems in bedrooms and communal areas. Staff checked alarms daily to ensure they were working effectively.

Maintenance, cleanliness and infection control

Ward areas were clean, well maintained, well-furnished and fit for purpose. Staff made sure cleaning records were up-to-date and the premises were clean. Staff followed infection control policy, including handwashing. Staff received training in infection control. Data provided prior to the inspection indicated a compliance rate of 100%. Staff were aware of their responsibilities in respect of infection control processes. Staff carried out an infection control audit in May 2019 which showed an overall compliance of 94%. The audit identified areas where action was required, including a lack of handwashing signs in some areas and the need for additional handwashing facilities. An electronic action plan showed that required actions had been addressed in a timely manner.

Due to the large-scale improvement works carried out, which were necessary to meet the requirements of the fire enforcement notice issued to the hospital, there were areas of the ward that required some additional maintenance; largely re-painting. The general manager had a planned schedule for redecoration which addressed all ward areas and was due to start in January 2020.

Seclusion room

Bowling ward did not have a seclusion room, although had access to the other seclusion rooms on the site. Staff noted that seclusion was not often used on Bowling ward.

Clinic room and equipment

The clinic room was generally fully equipped, with accessible resuscitation equipment that staff checked regularly. We observed that an alcometer (a piece of equipment to measure blood alcohol content) was present in the clinic room which had been due to be calibrated in May 2019, but we could not see that this had been done. Staff told us that this was not used. A tendon hammer was not available, and staff noted that this was a long-standing issue. A medical equipment checklist was available in the clinic room, but staff informed us that this was no longer in use and were not sure of the current process for checking equipment.

We reviewed the clinic room temperature records. We observed that there were four days where the temperature had not been recorded, including three days in a row in October. We reviewed a copy of the Bowling ward clinic room audit for October and the room temperature monitoring was green with no identified issues recorded.

Safe staffing

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

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants for each shift. The service had a staffing matrix indicating the minimum staffing levels required for the number of patients on the ward. The ward manager could adjust staffing levels according to the needs of the patients. The ward manager explained that the ward was working above the recommended numbers as the manager and staff felt that the recommended numbers were too low on the matrix for the patient group on the ward. The ward manager felt supported by senior managers in being given approval to have higher staffing numbers on the ward. Staff noted that, if the staffing numbers were reduced to the recommended numbers on the matrix, they would not consider the ward to have safe staffing levels.

At the time of the inspection, the ward had two qualified nurses and two health care support workers on the day shift. There were two qualified nurses and two health care support workers on the night shift.

On Bowling ward there were 10 whole time equivalent qualified nursing posts and 20 whole time equivalent health care support worker posts. At the time of the inspection, there were three vacant qualified nursing posts and five vacant health care support worker posts. The provider was actively recruiting to the qualified nursing posts, however, had suspended recruitment to the health care support worker posts. The provider noted that this was due to the low occupancy on the ward.

Between 01 May 2019 and 31 July 2019, 20 shifts were filled by bank staff members and 239 shifts were filled by agency staff members to cover sickness absence or vacancies. The ward manager explained that the ward planned agency usage to try to ensure that regular agency staff members could be booked. The ward had a regular agency staff member that covered night shifts. The ward could access staff from other wards in the hospital if the ward required additional cover. Managers made sure all bank and agency staff had an induction and understood the service before starting their shift.

Between 1 September 2018 and 31 August 2019, Bowling ward had 10 substantive staff leavers during this period. The total percentage of staff vacancies during this period was 32% and the staff sickness rate was 8.3% for Bowling ward. The staff sickness rate was joint highest of the four wards in the hospital. The ward manager was aware of the reasons as to why a number of staff had left the ward during this period and were actively recruiting to vacant posts.

Managers supported staff who were off sick through the employee assistance programme and also reviewed sickness levels regularly as part of the senior management team meeting agenda. Managers followed the hospital's attendance management policy where necessary.

Patients had regular one-to-one sessions with their named nurse. Patients rarely had their escorted leave or activities cancelled, even when the service was short staffed. The service had enough staff on each shift to carry out any physical interventions safely.

The service had enough daytime and night time medical cover and a doctor available to go to the ward quickly in an emergency. The ward consultant psychiatrist worked three days on the ward and was available for contact when not present on the ward. The ward also had a junior doctor. Bowling ward staff could access support from other wards as required. The provider had on-call systems in place to ensure that medical cover was available when needed.

Staff had completed and kept up-to-date with their mandatory training. The mandatory training programme was comprehensive and met the needs of patients and staff. Managers monitored mandatory training and alerted staff when they needed to update their training. Data provided prior to the inspection indicated that the overall average mandatory compliance rate for Bowling ward was 86%. This included 18 training courses that the provider considered mandatory for the staff on Bowling ward.

Staff received training in basic life support and intermediate life support. As of 13 September 2019, the compliance rate for the basic life support training was 92% and 83% for the intermediate life support training.

Assessing and managing risk to patients and staff

We reviewed three risk assessments of patients admitted to the ward. Staff completed risk assessments for each patient on admission, using a recognised tool, and reviewed this regularly, including after an incident. There was evidence that risk assessments were reviewed on a regular basis and notes were added when incidents occurred.

Patients had a specific risk management care plan alongside their risk assessment. The risk management care plan clearly indicated to staff how best to de-escalate and manage certain patient risks. The risk management care plans were individual to each patient. Patient views were incorporated into these risk management plans.

The ward held safety huddle meetings every week day. The meetings were used to review the risk level of patients. Staff in attendance also gave updates on the patients and allocated any actions that needed to be completed. We observed a safety huddle during the inspection. The meeting was attended by the ward manager, nurse in charge, consultant psychiatrist, clinical psychologist, social worker and occupational therapy assistant. Staff in attendance reflected on the current risk level of each patient and discussed additional support patients may need or actions to be taken.

Staff knew about any risks to each patient and acted to prevent or reduce risks. Staff identified and responded to any changes in risks to, or posed by, patients. Staff followed procedures to minimise risks where they could not easily observe patients.

Between 1 February 2019 and 31 July 2019, there were 32 incidents of restraint used by staff. Two of these incidents involved prone restraint and of these, one resulted in rapid tranquilisation.

We reviewed figures of restraint between August and October 2019. The figures for August indicated an increase in the use of restraint, with 19 incidents taking place, one of

which resulted in prone restraint. This higher figure was attributed to new admissions and therefore a number of more acute patients on the ward. Subsequent figures provided for September and October showed significant decreases in restraint of eight and one respectively demonstrating the ward acuity had become more settled.

Staff made every attempt to avoid using restraint by using de-escalation techniques and restrained patients only when these failed and when necessary to keep the patient or others safe. Staff described how de-escalation techniques were used on the ward and could describe how they would manage various situations. Patients explained that staff would attempt to de-escalate incidents prior to using restraint.

Staff were trained in the prevention and management of violence and aggression. As of 13 September 2019, the compliance rate for Bowling ward staff was 88%.

Staff generally followed National Institute for Health and Care Excellence guidance when using rapid tranquilisation. We reviewed 11 rapid tranquilisation records and observation charts following the use of rapid tranquilisation. Of these 11 records, four were related to intramuscular and seven related to oral. In one of the four records of intramuscular rapid tranquilisation, we observed that staff had not completed initial observations every 15 minutes in line with the provider's policy and the National Institute for Health and Care Excellence guidance. There were also some gaps in the recording during this incident. The other three records of intramuscular rapid tranquilisation were recorded correctly.

Between 1 February 2019 and 31 July 2019, seclusion was used once by Bowling ward. The ward manager reports for August to October 2019 indicated that seclusion had not been used during those months.

The ward had a blanket restriction audit that was reviewed on a regular basis. Patients were included in this process to ensure that their views were captured on any potential restrictions. The ward had made progress in reducing the number of blanket restrictions on the ward. Staff recorded the rationale where blanket restrictions were in place. However, we identified a restriction related to smoking which was not detailed on the blanket restrictions audit. Whilst the provider's policy stated that rechargeable e-cigarettes could be considered on an individually risk assessed basis, the hospital had a local protocol which ran alongside the provider's policy which stated patients could only smoke specific e-cigarettes purchased from the hospital tuck shop. Patients we spoke with during focus groups conducted prior to inspection were unhappy at this decision due to the cost implications of purchasing disposable e-cigarettes rather than being able to have access to re-chargeable ones. Staff had not completed individual risk assessments to establish if patients could safely have re-chargeable cigarettes and this blanket restriction was not something noted on the hospital's blanket restrictions audits. However, post-inspection managers explained that the restriction was due to the fire enforcement notice currently in place at the time of inspection and stated that the restriction had since been added to the ward blanket restrictions log and was due to be reviewed.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse, and they knew how to apply it. The compliance rate for safeguarding training for Bowling ward staff prior to the inspection was 100%.

Staff could give examples of safeguarding and how to protect patients from abuse. There was an identified safeguarding lead and posters were on the ward to inform staff of who this was. Staff were aware of how to access support and guidance around safeguarding. Staff knew how to make a safeguarding referral and who to inform if they had concerns. The ward manager had developed a safeguarding table to provide staff with a quick reference guide about safeguarding people and to signpost staff to essential information. The ward manager had recognised that if staff were not regularly using safeguarding procedures, they may not be fully informed if they did have a safeguarding concern. The ward manager developed the safeguarding table to address this issue and to provide additional support to staff. Safeguarding was included as a standard agenda item for the ward team meetings.

Staff access to essential information

The hospital used a combination of paper and electronic patient records as the electronic system was not capable of storing all patient information. Daily notes and care plans were recorded electronically, with care records also being printed out and stored in individual patient paper files

along with other records including patient risk assessments, mental health act paperwork and physical health information. Agency staff who undertook regularly work at the hospital were given access to electronic systems but adhoc agency staff were not and staff with electronic access uploaded their notes.

Staff noted that patient care plans were printed out as the electronic system did not yet have the option for documents to be electronically signed so staff had to print copies of care plans for patients to sign. The ward manager noted that this caused some duplication and was time consuming for staff. The ward did not have a set date for when the electronic signature facility would be in place.

Patient notes were comprehensive, and all staff could access them easily. Although the service used a combination of electronic and paper records, staff made sure they were up-to-date and complete. Records were stored securely.

Medicines management

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

Staff were storing general skin creams in the clinic room that were not prescribed to individual patients. The use of the creams was not monitored and could be used for any patient on the ward and therefore could be an infection control risk.

We observed that tramadol that had been previously prescribed for a patient was stored in the controlled drugs cupboard which had not been used for eight months and was no longer prescribed for the patient. The expiry date of a different medication in the controlled drugs cupboard had been removed from the end of the box.

We observed that leave medication from July and August for three patients remained in the leave medication cupboard and had not yet been disposed of.

Staff reviewed patients' medicines regularly and provided specific advice to patients and carers about their medicines. Staff stored and managed individual patient medicines and prescribing documents in line with the provider's policy. Staff followed current national practice to check patients had the correct medicines. Staff reviewed the effects of each patient's medication on their physical health according to the National Institute for Health and Care Excellence guidance.

Track record on safety

The service had a good track record on safety. Between August 2018 and July 2019, the service reported that there were six serious incidents on Bowling ward. These incidents included patients going absent without approved leave, self-harm and one incident where a patient's section had lapsed. When serious incidents occurred, the provider conducted full investigations and also took steps to minimise the risk of similar incidents occurring, such as meeting with the multi-disciplinary team to agree a review of a patient's section 17 leave and dismissing staff.

Reporting incidents and learning from when things go wrong

Staff knew what incidents to report and how to report them. Staff reported serious incidents clearly and in line with the provider's policy. Staff explained that incidents were discussed daily during handover. Staff also reflected on incidents in the safety huddle meetings.

Staff understood the duty of candour. They were open, transparent, and gave patients and families a full explanation if and when things went wrong.

Managers debriefed and supported staff after any serious incident. Following our last inspection, we told the provider they should ensure that staff have access to debriefs following incidents in the specialist personality disorder service. Staff we spoke with during this inspection stated that debriefs took place.

Staff received feedback following the investigation of incidents. Staff discussed incidents and lessons learnt at team meetings. Staff could give examples where lessons had been learnt from incidents and changes had been made following this feedback. The ward manager gave examples of where changes had been made because of feedback, such as learning in respect of observing patients when on escorted leave.

Are personality disorder services effective?

(for example, treatment is effective)

Good

Personality disorder services

Good

Assessment of needs and planning of care

We reviewed three care and treatment records. Staff completed a comprehensive mental health assessment of each patient either on admission or soon after. All patients had their physical health assessed soon after admission and regularly reviewed during their time on the ward.

Staff developed a comprehensive care plan for each patient that met their mental and physical health needs. Staff regularly reviewed and updated care plans when patients' needs changed. Care plans were personalised, holistic and recovery-orientated.

Best practice in treatment and care

Staff provided a range of care and treatment interventions suitable for the patient group. The interventions were those recommended by, and were delivered in line with, guidance from the National Institute for Health and Care Excellence. Patients had access to a team of psychologists and psychology assistants within the hospital who offered both group and individual therapies relevant to the individual need of the patient. The ward also had its own occupational therapist who engaged patients in assessments including the Model of Human Occupation Screening Tool and occupational self-assessment. The occupational therapy team also engaged patients in numerous activities and escorted patients on therapy leave in the local community. During inspection we observed a therapy dog visiting the ward. We observed patients responding well to the presence of the therapy dog and staff noted the positive impact this had on patients.

We undertook a focused review of four care records in terms of psychological input. There was evidence of comprehensive entries for group and individual dialectical behaviour therapy sessions in patient records. Patients received frequent contact from psychology staff and therapy assistants. Staff integrated dialectical behaviour therapy interventions into care plans and risk management plans. One of the four records reviewed was for a patient on the discharge to assess pathway; meaning they were only expected to be on the ward for a short period of time and would therefore have limited dialectical behaviour therapy input. Despite this we observed that discussions were held to see what support and intervention could be offered to the patient due to their levels of distress in order to support them effectively.

Staff ensured that patients had good access to physical healthcare, including access to specialists when needed. Since our last inspection the hospital had employed a registered general nurse to oversee the physical health needs of patients across all four wards. They had also registered all patients who wished to register with the local GP practice, who offered dedicated clinic time for patients every week. The nurse was able to attend GP appointments with patients and feedback information to doctors within the hospital to ensure good information sharing and recording of information on the hospital's electronic patient record system. We saw within patients' care records that their physical health, including weight, was being regularly monitored, and that patients were being referred to specialists, such as dieticians where necessary. All patients whose care plans we reviewed had a specific physical health care plan within their records. This care plan was individualised and addressed any physical health needs that were identified for the patient.

Staff helped patients live healthier lives by supporting them to take part in programmes or giving advice and information. The ward had agreed mutual expectations to promote a positive living environment on the ward.

Staff took part in clinical audits, benchmarking and quality improvement initiatives. The audits were included in the monthly ward manager governance packs. The ward manager reflected on and used the results from the audits to make improvements.

Staff used recognised rating scales to monitor and record outcomes for patients including the health of the nation outcome scale.

Skilled staff to deliver care

The service had access to a full range of specialists to meet the needs of the patients on the ward. The ward had a consultant psychiatrist, clinical psychologist, nurses, health care support workers, a social worker and an occupational therapist and assistant. The ward also had access to an external dietician, chiropodists and other physical health support as required.

Managers ensured staff had the right skills, qualifications and experience to meet the needs of the patients in their care, including bank and agency staff. Managers gave each new member of staff a full induction to the service before they started work. The ward had an induction booklet to support staff when starting on the ward.

Staff received regular supervision from managers. Between 1 August 2018 and 31 July 2019, the hospital recorded a rate of 97% for clinical supervision. Staff were positive about the level of supervision and access to managers when needed. Managers supported staff through regular, constructive appraisals of their work. As of 31 July 2019, the provider reported that all staff had an appraisal where this was required.

Managers made sure staff attended regular team meetings or gave information from those they could not attend. The ward manager held a monthly team meeting that staff could attend. The minutes of these meetings were available for staff to access if they could not attend. The meetings followed a standard agenda covering a number of areas.

The ward manager identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. The ward manager explained that additional training could be organised and facilitated for the ward. Following the last inspection, the provider had undertaken a specific review of the specialist personality disorder training that Bowling ward staff received. The provider had a clear training plan in place for Bowling ward staff and reviewed staff feedback on the training to ensure it was appropriate and providing the correct knowledge. Staff could also access additional sessions with psychology staff, including separate monthly case consultation and reflective practice meetings.

Managers recognised poor performance, could identify the reasons and dealt with these. The ward manager was able to reflect on how they would monitor and observe staff to identify if additional support was required. The ward manager gave examples where poor performance had been identified and the actions taken to address this.

Multi-disciplinary and inter-agency team work

Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care.

The ward held safety huddle meetings every week day. The meetings were used to review the risk level of patients. Staff in attendance also gave updates on the patients and allocated any actions that needed to be completed. We observed a safety huddle during the inspection. The meeting was attended by the ward manager, nurse in charge, consultant psychiatrist, clinical psychologist, social worker and occupational therapy assistant. Staff in attendance reflected on the current risk level of each patient and spoke about where additional support or actions may be needed for patients. Staff also provided positive updates for patients. All attendees were given the opportunity to contribute to the meeting and engage in discussions about the patients.

Staff held regular multidisciplinary meetings to discuss patients and improve their care. Patients had a ward round every two weeks and patients were invited and involved in these meetings. Staff recorded minutes from the meetings on the patient's electronic care record. Patient and carer views were documented in these minutes where appropriate. The ward invited care co-ordinators to the ward rounds, although staff noted that attendance could be mixed.

Staff made sure they shared clear information about patients and any changes in their care, including during handover meetings. A staff handover took place at the morning and evening shift change. Staff followed an agenda to ensure each patient was discussed. The ward manager had added 'safewards' prompts to the handover to raise staff awareness and ensure these were reflected on. The ward manager attended the morning handover.

The ward manager attended a morning meeting with other managers across the hospital to discuss any issues and provide regular updates on the ward. This meant that information was shared across the hospital and actions could be taken when needed.

The ward manager noted that relationships with care co-ordinators could be difficult dependent on the area that patients were coming from. The ward manager explained how the ward attempted to involve care co-ordinators and ensure that communication was maintained.

Adherence to the MHA and the MHA Code of Practice

Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of

Good

Personality disorder services

Practice and discharged these well. Managers made sure that staff could explain patients' rights to them. At the time of the inspection, Bowling ward had seven detained patients admitted to the ward and one informal patient.

Staff received and kept up-to-date with, training on the Mental Health Act and the Mental Health Act Code of Practice and could describe the Code of Practice guiding principles. As of 13 September 2019, Bowling ward had a compliance rate of 100% for training in the Mental Health Act and Code of Practice.

Staff had easy access to administrative support and legal advice on implementation of the Mental Health Act and its Code of Practice within the hospital. Staff knew who their Mental Health Act administrators were. The Mental Health Act administration team oversaw admission paperwork, ensured accuracy of section papers, monitored dates for patients' tribunal meetings and renewals, and gave reminders to staff when action was required. Staff could also access support from the corporate Mental Health Act lead. The hospital had up to date policies and procedures and these were easily accessible via the intranet. Staff stored copies of patients' detention papers and associated records appropriately and these were available to staff when they needed to access them. Staff we spoke with had a good understanding of the Mental Health Act and the Code of Practice guiding principles.

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

Patients had easy access to information about independent mental health advocacy. Advocates visited the wards weekly and information on how to contact the advocates outside of these times was displayed on the wards. Advocates would attempt to speak with all patients and would liaise with ward staff to let them know of any patients who refused to interact so that staff could support them to access advocacy at a later date should they wish.

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

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

Informal patients knew that they could leave the ward freely. Informal patients were able to leave via the main entrance and a process was in place to enable them to do this, with a sign placed on the door informing them of this.

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

Good practice in applying the MCA

Staff supported patients to make decisions on their care for themselves. They understood the trust policy on the Mental Capacity Act 2005 and assessed and recorded capacity clearly for patients who might have impaired mental capacity. Staff gave patients all possible support to make specific decisions for themselves before deciding a patient did not have the capacity to do so. Staff consideration of capacity was recorded within the care records.

Staff received and kept up-to-date with, training in the Mental Capacity Act and had a good understanding of the five principles. As of 13 September 2019, Bowling ward had a compliance rate of 94% for training in the Mental Capacity Act and Deprivation of Liberty Safeguards.

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

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

Staff audited the application of the Mental Capacity Act. The outcome and subsequent action plan for this audit was monitored by the Mental Health Act office and through the hospital wide monthly governance meeting.

Are personality disorder services caring?

Good

Kindness, privacy, dignity, respect, compassion and support

During inspection we spoke with three patients and received feedback via four comment cards from patients on the ward.

We observed positive interactions between staff members and patients on the ward. Patients could approach staff members and discuss concerns. Staff took the time to listen to patients and offered solutions in how these could be managed.

However, patients gave mixed feedback about staff. Patients stated that staff were generally respectful and polite but noted that not all staff knocked on patient's doors when entering their bedrooms which patients told us they found intrusive. Patients told us they generally felt safe on the ward, but this was dependent on which staff were on duty and that they felt less safe in the presence of agency staff. Patients also told us that outdoor access could be an issue, as patients could only access the courtyard if accompanied by staff, and patients noted that staff were not always available to facilitate this.

Patient feedback from comment cards was generally negative about the ward. One patient raised concerns about staff making noise at night times and not being respectful that patients were sleeping when completing observations. A further patient felt that some staff members did not treat all patients fairly and did not always speak to patients in a respectful or dignified manner.

Patients reported that they were informed about their care and treatment. Patients felt listened to by staff and could access advice when they needed it.

Staff spoke respectfully about patients in the daily risk meeting that we observed. Staff understood each patient and reflected on patients as individuals. Staff included positive updates when discussing patients alongside any current issues. Staff considered any actions they needed to take to support patients and ensured that specific staff members were allocated actions to follow up.

Patients told us they were not that engaged with, or interested in, some of the activities available on the ward. However, patients were able to voice their preferences for activities through both morning meetings and monthly meetings and we saw evidence of patient suggestions related to activities being actioned via a 'you said, we did' board in the reception area of the hospital. During inspection we observed a therapy dog present on the ward at the time of the inspection. The ward manager had registered their own dog for this purpose and we observed patients responding well, with the dog having a positive impact on patients. We also observed a dialectical behaviour therapy group attended by four patients. Staff members present were supportive and encouraged the participation of those in attendance.

Involvement in care

Involvement of patients

We reviewed three care and treatment records. Staff involved patients and gave them access to their care planning and risk assessments. In each care plan, the patient's views were clearly recorded in the patient's own words. The ward manager encouraged this to ensure that the care plans were person-centred. Staff noted when patients disagreed with parts of their care plan but explained in a clear manner why these elements had been incorporated from a clinical perspective. At the time of the inspection, patients were not able to electronically sign their care plans, however, we saw evidence of staff printing paper copies of the care plans and asking patients to sign them. These were stored in each patient's paper file. All three records reviewed included signed patient care plans. Staff added a note on the patient's clinical notes to indicate when the care plan had been reviewed and signed by patients. Staff offered patients copies of their care plans, although noted that patients did not normally want to keep a copy for themselves. Staff described that patients could ask for access to their care plans at any time.

Staff introduced patients to the ward and the services as part of their admission. The ward had information available to new patients to introduce them to the ward and provide them with important information. The ward manager explained that, prior to the admission of a new patient, the other patients on the ward would write positive messages of support on a board in the new patient's bedroom.

Staff communicated with patients so that they understood their care and treatment, including finding effective ways to communicate with patients with communication difficulties. Staff could easily access interpreters and signers for patients that needed them.

At the time of the inspection, a patient that was due to be transferring to the ward from the psychiatric intensive care unit at the hospital visited the ward. This was to assist with the transfer process and introduce the patient to the ward. Staff from both wards also attended the ward round for the patient to assist with the transition.

Good

Personality disorder services

Staff involved patients in decisions about the service, when appropriate. Staff had considered patient feedback when decorating the ward and in respect of how certain information was displayed. The ward had agreed mutual expectations with patients to promote a positive environment for all patients on the ward. Patients had also been involved in the recruitment and interviewing of psychology staff.

Staff enabled patients to give feedback on the service they received. Patients could give feedback via the annual friends and family test survey but could also give feedback more regularly via monthly ward meetings and daily morning meetings. A specific dialectical behaviour therapy email was available for patients to provide feedback to staff. The hospital also employed a service user involvement lead whose role was to hold monthly meetings with patient representatives from each ward and listen to their ideas on how to improve services. A 'you said, we did' board was present in the reception area of the hospital and detailed suggestions from patients and how these had been actioned, for example patients sharing they would like to make calendars, and the hospital purchasing cameras for patients to take their own photographs. This board was last updated in September 2019 and was next due to be updated in January 2020.

Cygnet Health Care Ltd also employed an expert by experience lead who covered the North region and visited patients at the hospital to talk to them about their care and treatment. They provided feedback to senior managers to ensure the patient voice was heard across the organisation. The last visit to the hospital was 13 September 2019. The expert by experience lead received positive feedback from patients and also spoke with staff to find out how they felt the environment and service could be improved for patients. As a result of this visit, senior managers created an action plan to drive improvement for patient care.

Staff made sure patients could access advocacy services. An advocate visited the service on a weekly basis. Posters informing patients of how to access advocacy services were present. Staff noted that they would encourage patients to access advocacy when required. We spoke with the advocate who gave positive feedback about the hospital and stated they regularly attended hospital governance meetings which enabled them to clearly communicate any areas of concern shared by patients.

Involvement of families and carers

Staff informed and involved families and carers appropriately. In the care records reviewed, there was evidence of family and carer views being included as part of the multidisciplinary team meetings where appropriate. Staff used consent to share information forms to enable patients to indicate what information they wanted to share with their families and carers. Copies of these forms were in the three records reviewed.

Carers were given carer's packs and friends and family leaflets were available in the hospital reception which gave information on visiting, named contacts, and how to access a carer's assessment.

Staff enabled families and carers to give feedback on the service they received via annual surveys or feedback boxes in the hospital reception. Carers could also attend carers events at the hospital. In the last 12 months prior to inspection the hospital had organised four carer's events, with one being cancelled due to no attendance. Each ward had a carer's link who carers could contact for support or advice and these staff members worked as links between carers and the overall carers lead for the hospital to ensure information was communicated both to and from carers and the hospital.

We spoke with one carer who told us that they were involved in the patient's care including meetings and care planning, and commented that staff were approachable and proactive. However, they felt the service could be better at explaining what happens when carers come to visit the hospital.

Are personality disorder services responsive to people's needs?

(for example, to feedback?)

Good

Access and discharge

At the time of the inspection, there were eight patients admitted to Bowling ward. One patient was due to be discharged and another patient was due to be admitted to the ward. Between 1 February 2019 and 31 July 2019, the ward had an average bed occupancy level of 46%, which

was low. Senior managers explained this was due to low referral rates to the service. The service admitted out-of-area placements. When patients went on leave there was always a bed available when they returned.

Between 1 August 2018 and 31 July 2019, the average length of stay for patients discharged from the ward was 681 days. Managers monitored the number of delayed discharges and noted that there were two patients who had taken a longer time than expected to be discharged during this time period. This was due to external factors of finding appropriate accommodation or placements following discharge which affected the overall length of stay figure provided. The ward manager noted that staff had taken actions to address these issues and were proactive in discussions to resolve the delays. As of 31 July 2019, the average length of stay for patients currently on the ward was much lower at 277 days.

Staff planned for patients' discharge, including good liaison with care co-ordinators who were regularly invited to patient care review meetings. Patient care records evidenced that discharge plans were in place.

The ward had a pathway in place for patients moving to and from the psychiatric intensive care unit to Bowling ward. Staff supported patients with this process and assisted patients with their transition between the two wards. Patients were moved between wards only when there were clear clinical reasons, or it was in the best interest of the patient. Between 1 August 2018 and 31 July 2019, Bowling ward had five readmissions. The provider indicated that these patients had required a period of time on Denholme ward, the psychiatric intensive care unit in the hospital, and returned to Bowling ward when the patients were more settled.

The facilities promote recovery, comfort, dignity and confidentiality

The design, layout, and furnishings of the ward supported patients' treatment, privacy and dignity. Each patient had their own bedroom with an en-suite bathroom and could keep their personal belongings safe in a secure place. Patients could have a key to their bedroom if they wanted and bedrooms were open throughout the day. Patients were able to personalise their bedrooms and we observed evidence that patients had done so.

Staff used a full range of rooms and equipment to support treatment and care. The service had quiet areas and a room where patients could meet with visitors in private. We saw examples where patients had been able to provide input into the decoration of the ward. Staff described how patient opinions and feedback was sought in relation to this.

Patients could make phone calls in private. Patients could have their own mobile phones on the ward. A ward mobile phone was also available for patients if needed.

The service had an outside space that patients could access with staff supervision. Patients had to ask staff to take them to the outside space. Patients explained that access to this space could be limited dependent on staff availability. Managers had identified risks in the outside area that required staff to be present with patients. The ward manager had recorded this on the ward's blanket restriction audit. It was not clear if alternative arrangements had been explored to assess if there were other ways of managing this access.

Informal patients were able to leave via the main entrance and a process was in place to enable them to do this and a sign was placed on the door informing them of this.

Patients could make their own hot drinks and snacks and were not dependent on staff.

Patients' engagement with the wider community

Staff supported patients with activities outside the service, such as work, education and family relationships. Staff explained how staff could access opportunities and make educational links whilst admitted to the ward.

Staff helped patients to stay in contact with families and carers. Staff considered patient preference about contact with families and carers.

Staff encouraged patients to develop and maintain relationships both in the service and the wider community. Patients would be allocated a buddy on admission to the ward to assist with their transition. Prior to the admission of a new patient, the other patients on the ward would write positive messages of support on a board in the new patient's bedroom.

Meeting the needs of all people who use the service

Bowling ward was located on the ground floor of the hospital and was therefore accessible to those with

mobility difficulties. At the time of the inspection, none of the patients required any adjustments to be made. Staff described how adjustments could be considered and made when needed.

An advocate visited the ward on a regular basis. Posters were displayed on the ward informing patients about the advocacy services available. Staff encouraged patients to access advocacy support when needed.

Staff told us that interpreters or signers could be accessed if required. Staff were aware of how they could access this support. Information and leaflets available to patients were not routinely provided in different languages or in alternative accessible formats; however, staff explained that these could be accessed when required.

Listening to and learning from concerns and complaints

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team and wider service. Between 2 November 2018 and 30 July 2019 there were seven complaints raised with the hospital regarding Bowling ward. Complaints related to lost property, staff attitudes, poor communication with a carer, and medication stock checks. Of the seven complaints received two were upheld, two were partially upheld and three were not upheld. We reviewed a sample of complaints and found that staff carried out thorough investigations and responded to complainants within Cygnet policy timescales.

Patients knew how to complain or raise concerns. The service clearly displayed information about how to raise a concern in patient areas. Staff understood the policy on complaints and knew how to handle them.

The ward manager investigated complaints. The provider included data about complaints in the ward manager governance packs. The ward manager provided an update on any complaints for that month, including any learning and how the complaints had been resolved. Staff received feedback on the outcome of the investigation of complaints via supervision or team meeting depending on the nature of the complaint and outcome.

Senior managers also undertook an annual thematic review of complaints and compliments across all four wards at the hospital. The last thematic review was conducted in 2018 and looked at types, outcomes and sources of complaints per ward, as well as reviewing timescales for resolution and any overall learning identified. Any specific actions identified went onto the hospital's overarching local action plan and communicated to staff through team meetings and bulletins. With regards to compliments the review identified sources of compliments across the four wards as well as giving specific examples of compliments given to staff. Data relating to compliments was hospital-wide and not broken down to specific core service level.

Are personality disorder services well-led?

Good

Leadership

The ward manager understood the service they managed and the challenges that they faced as a ward. The ward manager attended a regular meeting with the other ward managers in the hospital to share information and discuss ward performance and issues. Staff felt supported by management and noted that they were visible and available.

Patients and staff could approach the ward manager with any concerns. We observed patients discussing issues and concerns with the ward manager. The ward manager took time to speak with patients and offer patients solutions.

Leadership development opportunities were available, including opportunities for staff below team manager level. Staff gave examples of healthcare assistants being supported to train as nurses, and a ward manager from another Cygnet hospital had recently been successful in being appointed to clinical manager at this hospital as the current clinical manager was leaving.

Vision and strategy

Staff were aware of the organisation's vision and values. Staff told us they felt proud to work for the organisation. The ward manager noted the importance of ensuring that staff on the ward shared the same vision and values to ensure that patients received the same level of care and treatment and we observed staff acting in line with these values.

Senior managers had incorporated the provider's values into employee interview questions, induction, and appraisal structure. The values were also part of the 'employee of the month' award; with an explanation of how the successful staff member had met the values in their work. To support staff's understanding information on vision and values was displayed across the hospital site, and staff had recently had the opportunity to access training on the values, with approximately 80% of staff across the hospital attending one of the four sessions available.

Staff could explain how they were working to deliver high quality care within the budgets available. The hospital had recently undergone large-scale remedial works to rectify issues in relation to the fire safety system throughout the hospital. Senior managers had taken the decision to reject new referrals as ward space was affected and staff were aware of the need to maintain high-quality care for patients already admitted. Despite the cost of these works the hospital were still making plans for improvement in other areas and had recently installed patient-accessible computers on all wards following patient feedback.

Culture

Staff felt respected, supported and valued by managers. Staff described a positive working environment and were proud of their work. Staff stated they would be able to raise any concerns without fear of victimisation and were aware of the whistleblowing process.

The ward manager gave examples of where staff performance had been monitored and managed. The ward manager was aware of how to support staff with their work and any physical or emotional needs staff might have. All staff reported that they received regular line management and clinical supervision. Staff could also attend regular reflective practice sessions. The ward compliance rate for appraisals was high.

The provider recognised staff success within the service through an 'employee of the month' award and 'random acts of kindness' award. Staff told us that senior managers recognised their hard work and effort and had recently presented them with chocolates and a card to thank them. Staff were also invited to an upcoming Cygnet Christmas party which was funded by the provider.

Governance

The hospital had a clear governance structure in place. Senior managers attended regional governance meetings on a quarterly basis where information was escalated up to board level. At hospital level, governance meetings took place monthly and were attended by senior staff from the multidisciplinary team. Meetings involved discussion of items including incidents, restraint, seclusion, safeguarding, complaints, and compliance with a variety of audits. At ward level, ward managers were responsible for reviewing monthly data packs relevant to their ward and feeding back any areas of concern, areas for action, or compliments directly to ward staff as well as to the monthly governance meetings. This ensured a clear framework of what must be discussed at a ward, team or directorate level in team meetings to ensure that essential information, such as learning from incidents and complaints, was shared and discussed, and a smooth pathway of communication from ward to board. The service had made improvements in their governance systems since our last inspection. Previous breaches of regulation and areas where we had identified the provider should take action to improve the service had been addressed.

The service had a number of key performance indicators which allowed them to measure safety and quality, including safeguarding notifications, restraint, medication errors, staff turnover, vacancies and sickness, staff training, and incidents. The service measured their performance against other Cygnet hospitals which helped indicate any outliers requiring attention.

Leaders ensured there were structures, processes and systems of accountability for the performance of the service. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and improve the performance of the service.

The ward manager received monthly reports providing key figures and information about their ward. The ward manager provided context and explanations within these reports, which the ward manager and the clinical manager then discussed at a meeting. The reports enabled the manager to reflect on any good practice and lessons to be learnt from the data. The ward manager used the report for oversight of the ward and to provide feedback to their team.

Bowling ward had high compliance rates for mandatory training, supervision and appraisals. The ward manager ensured that staff were supported in these areas and the compliance rates were monitored in the monthly ward manager packs.

The ward held regular team meetings. The ward manager shared key messages with staff during these meetings and gave staff the opportunity to reflect on practice and learning. We reviewed team meeting minutes and observed that meetings generally followed a set agenda. This included a discussion around lessons learnt from incidents and complaints.

The ward manager could give examples of where lessons had been learnt following incidents and what changes had been made because of this process. Staff were able to reflect on learning from incidents and noted how practice had changed because of this.

Staff undertook or participated in local clinical audits. The audits were generally sufficient to provide assurance and staff acted on the results when needed. The hospital followed a corporate audit schedule as well as creating bespoke audits relevant to the hospital. Corporate audits included infection control, health and safety, restraint, care records and physical health. Additional local audits included those developed in response to incidents including a monthly quality walk round and closed-circuit television audit to review staff and patient interactions. However, we did identify areas of concern in relation to medication management which relevant audits had not identified, for example missing clinic room temperature checks, medication no longer prescribed for a patient but still stored in the controlled drugs cupboard and storage of general skin creams that were not prescribed to individual patients but used for any patient on the ward and as such could be an infection control risk. We also identified a blanket restriction in relation the use of specific e-cigarettes which was not acknowledged on the blanket restrictions log and had not been individually risk assessed.

Staff had worked hard to maintain the safe running of the hospital during the large-scale improvement works carried out to meet the requirements of the fire enforcement notice issued to the hospital. Senior managers had conducted risk assessments throughout the project and made necessary decisions such as reducing admissions to maintain safety. Senior managers had kept staff and patients informed throughout the project and were available to hear any concerns or queries in relation to the works.

Management of risk, issues and performance

The hospital had a local risk register, which fed into the corporate risk register and ward staff could submit items to the local risk register via their ward managers. Risks on the register reflected those highlighted by staff including staffing vacancies on Bowling ward and fire safety deficiencies across the hospital. Risks were monitored during monthly governance meetings and updated with actions planned, actions taken, and dates for completion. Senior managers told us they felt supported at a corporate level when raising concerns via the risk register, for example by being given support to consider how best to recruit staff to Bowling ward via additional training opportunities and increased pay, and through financial support to make necessary and additional improvement works following receipt of a fire enforcement notice.

The service had plans for emergencies via a comprehensive business continuity plan which addressed potential emergency situations including adverse weather conditions, insufficient staffing levels, loss of heating, lighting or water, and other environmental issues. Plans clearly addressed responsibilities and actions required.

Where cost improvements were taking place, they did not compromise patient care. Senior managers acknowledged that whilst environmental works were taking place in relation to the fire notice received by the hospital a number of areas were unavailable to patients including therapy areas and the gym, which was closed at the time of inspection. Managers kept staff and patients up-to-date with progress of works and endeavoured to re-open such areas as soon as possible to reduce disruption to patient care. Staff conducted the majority of therapy sessions and activities in other available spaces whilst work took place.

Information management

The service used systems to collect data from wards and directorates that were not over-burdensome for frontline staff and staff had access to the equipment and information technology needed to do their work. At the time of inspection staff were still inputting some information onto paper, such as incident reports.

The service used systems to collect data from the ward. The ward manager was able to identify and provide information as it was requested. The ward manager had access to information to support them with their management role. This included information on the performance of the service through monthly data packs which included information on incidents, restraint, seclusion, enhanced observation, blanket restrictions, safeguarding, medicines management, complaints, staff supervision and audits.

Staff made notifications to external bodies as needed, such as local authority safeguarding notifications.

Engagement

The service engaged well with patients, staff, equality groups, the public and local organisations to plan and manage appropriate services. The provider used staff surveys to monitor staff satisfaction and to address any areas of concern. The ward manager encouraged staff to speak with themselves directly and wanted to ensure that staff felt engaged on the ward. Staff received information through the intranet, bulletins and team meetings and could also receive feedback directly from the board via the 'ask the board' option on the intranet.

Patients could provide feedback to staff and attend community meetings to provide feedback on the service. The service used surveys to gather feedback from patients about their care and treatment. Managers and staff had access to the feedback from patients, carers and staff and used it to make improvements.

Patients and carers were involved in decision-making about changes to the service such as staff recruitment. There was a 'you said, we did' board in reception which reflected suggestions made by patients and changes made as a result, such as patients wanted to create calendars and staff purchasing a number of cameras to allow patients to take and print their own photos.

Senior leaders engaged with external stakeholders on a quarterly basis including contract review meetings with NHS England and meetings with clinical commissioning groups and local authority safeguarding boards. Senior leaders shared any pertinent information with staff and also escalated concerns from staff through established governance frameworks.

Learning, continuous improvement and innovation

Staff were given the time and support to consider opportunities for improvements and innovation and this led to changes, for example staff at the hospital had recently won an award at the 'Association of Psychological Therapies Awards' for the hospital's Relaxation Workshop which was co-developed by a member of staff and a patient and were finalists at the awards for the advanced dialectical behaviour therapy skills group held on Bowling Ward.

staff from across the hospital lead on projects which were then nominated for awards at the 'Association of Psychological Therapies Awards' including for the hospital's Relaxation Workshop, advanced dialectical behaviour therapy skills group and implementation of the 'Reinforce Appropriate, Implode Disruptive' approach.

Staff also had opportunities to participate in research, for example staff from the psychology department had been involved in research relating to substance misuse and had begun running the 'find your way' substance misuse programme at the hospital. They also had an article published in an international journal for applied research in the field of co-occurring substance use, mental health conditions and complex needs.

Bowling ward had been one of the wards given an award internally by Cygnet for excellence in the implementation of 'Safewards'; a model of care designed to reduce conflict and containment through focusing on staff being aware of individual triggers and acting to reduce the impact of these on patients. The ward manager explained that staff had engaged the patients in its implementation and this had been led by the patients. The ward manager was proud of the work done by the patients and staff in this area and continued to monitor and ensure that the ward continued to maintain and improve on its use of 'Safewards'.

Outstanding practice and areas for improvement

Outstanding practice

Staff at the hospital had recently won an award at the 'Association of Psychological Therapies Awards' for the hospital's Relaxation Workshop which was co-developed by a member of staff and a patient. Staff were also finalists at the awards for their implementation of the 'Reinforce Appropriate, Implode Disruptive' approach on Bronte and Shelley wards and for the advanced dialectical behavior therapy skills group held on Bowling Ward.

Areas for improvement

Action the provider MUST take to improve

The provider must ensure all medicines are signed for and given to patients as prescribed, that creams are not used universally, and that illicit drugs are recorded and disposed of as per hospital policy.

The provider must ensure seclusion care records are contemporaneous and follow policy in that multi-disciplinary review meetings take place when required.

Action the provider SHOULD take to improve

The provider should ensure that blanket restrictions related to smoking and the use of e-cigarettes are individually risk assessed, reviewed and monitored.

The provider should ensure that they can clearly demonstrate that identified actions following the fire drills have been completed.

The provider should ensure all patients are assessed for and where required have a care plan relating to long term physical health conditions on the low-secure forensic wards and psychiatric intensive care unit.

The provider should ensure all staff on the low-secure forensic wards understand the provider's policy for searching patients.

The provider should ensure that the ground-floor seclusion room meets the Mental Health Act Code of Practice by improving the way in which the lighting could be fully subdued for patients in seclusion.

The provider should ensure that all paper-based patient care records on the low-secure forensic wards are the most up-to-date versions so that staff are accessing the most up-to-date information.

The provider should ensure they continue to embed and review the effectiveness of the 'Reinforce Appropriate, Implode Disruptive' approach on the low-secure forensic wards.

The provider should ensure that staff follow the correct process for escalating concerns with regards to patient's physical health observations on the low-secure forensic wards.

The provider should ensure that clinic room temperatures are monitored and recorded as per hospital protocol.

The provider should ensure that monitoring and observations following the use of rapid tranquilisation are fully completed in line with the provider's policy and guidance from the National Institute for Health and Care Excellence on the low-secure forensic and personality disorder wards.

The provider should ensure that patient's privacy and dignity is maintained whilst using the en-suite bathroom in the ground-floor seclusion room, and when staff enter patient bedrooms on the specialist personality disorder ward.

The provider should consider how patients can access an outdoor space without requiring staff supervision on the specialist personality disorder ward.

The provider should ensure that blanket restrictions audit logs accurately reflect restrictions in place on the psychiatric intensive care unit.

The provider should ensure that the governance systems and processes in place are effective and ensure proper assessment, monitoring and mitigation of risks.

Outstanding practice and areas for improvement

The provider should consider implementing a process that ensures appropriate equipment is available and clearly documents when the clinic rooms and equipment have been cleaned.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **How the regulation was not being met:** Care and treatment was not always provided in a safe way for service users. Staff did not do all that was reasonably practicable to mitigate risks and did not properly and safely manage medicines. On the psychiatric intensive care unit and low-secure forensic wards staff did not always keep accurate records of the treatment patients received and did not consistently administer medication in the manner prescribed. On the psychiatric intensive care unit and specialist personality disorder ward we found staff were storing patient specific medication that was either no longer prescribed or was for patients no longer on the wards and on the specialist personality disorder ward staff were storing general skin creams in the clinic room that were not prescribed to individual patients and could be an infection control risk. On the psychiatric intensive care unit staff did not follow systems and processes to accurately record and store illicit substances brought onto the ward. On the psychiatric intensive care unit staff did not follow systems and processes in relation to seclusion, including conducting multidisciplinary reviews. **This was a breach of regulation 12 (1) (2) (b) (g)**