Cygnet Hospital Sheffield

Quality Report

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

Ratings

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

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

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

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

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

Summary of findings

Overall summary

We rated Cygnet Hospital Sheffield as requires improvement because:

- Staff showed a disregard for safety policies and procedures in relation to infection control. The hospital did not follow policies and procedures that were in place to minimise the spread of infection. This included not ensuring that equipment was decontaminated. Staff did not follow hand washing procedures and guidance around clothing to reduce risk of infection.
- The provider did not ensure it adhered to code of practice guidelines regarding the Mental Health Act. One patient record did not contain valid consent to treatment or authorisation from a second opinion appointed doctor. This patient received treatment without valid consent or authorisation. Staff treated one patient without authorisation under section 62 of the Mental Health Act. Four seclusion records showed that staff did not end seclusion in a timely manner, and two seclusion records contained punitive language. We found blanket restrictions on some wards. Staff did not inform six patients of their rights under the Mental Health Act as soon as practicable after their detention. In addition, two records showed that staff did not inform two patients had not been informed of their rights under the Mental Health Act.
- Three patients on child and adolescent wards told us that staff did not treat them well and raised concerns about the care and treatment that they received. We raised these concerns with the registered manager who responded to these concerns appropriately. We also received six comment cards from patients which contained concerns about staff and care treatment. The hospital received 43 complaints about the care and treatment receive. Of these 14 were upheld, 12 were partially upheld, 12 were not upheld and five were withdrawn.
- Facilities did not uphold the dignity and respect of patients. The provider had removed the doors to en suite showers and did not provide a curtain on Haven Ward. Patients had damaged areas of the ward and the hospital had not completed repairs. Staff used a search room which was not clean and suitable for use because it had a strong odour. Staff administered medicines from a hatch to patients which did not promote privacy and dignity.
- Staff did not manage medicines correctly. They did not control the temperature of fridges and clinic rooms, to ensure medication remained safe to use. Four out of 12 records reviewed showed that staff did not always complete physical health monitoring after rapid tranquilisation as frequently or for as long as the hospital policy stated. Staff had not ensured medication was available to a patient when it was prescribed. When doses of medication were omitted advice was not sought.
- We had concerns regarding staffing across the wards. The hospital used a lot of agency staff due to a high level of overall vacancies across the wards. Staff turnover was also high. There were 38 shifts which were not covered by bank or agency staff. This left some shifts without the safe number of staff to treat patients. Attendance at mandatory training was low, this included training that was essential to ensure the safe running of the service. Not all staff received regular supervision and appraisal.
- Systems in place to monitor the quality of the service were not effective. Audits did not identify out of date equipment, issues with incorrect or missing mental health act documentation. The hospital operated with some policies from the previous provider. There was no single contemporaneous record relating to patient care and treatment. Some complaints received were upheld or partially upheld when investigated.

However:

- Observations of interactions between staff and patients showed that staff knew patients well and treated them with respect.
- Feedback from patients on the low secure ward and long stay rehabilitation was positive about the support they received from staff. Patients felt staff included them in decisions made about their care and treatment.

Summary of findings

Contents

Requires improvement

Cygnet Hospital Sheffield

Services we looked at

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

Summary of this inspection

Background to Cygnet Hospital Sheffield

Cygnet Hospital Sheffield is an independent mental health hospital that provides low secure and locked rehabilitation services for women, and child and adolescent mental health services for male and female adolescents aged between 11 and 18. The hospital is close to the city centre of Sheffield. Cygnet Hospital Sheffield was previously known as Alpha Hospital Sheffield until Cygnet NW Limited acquired all Alpha Hospitals in August 2015.

The hospital has capacity to provide care for 55 patients across four wards. These are:

- Spencer: 15 bed low secure ward for female patients
- Shepherd: 13 bed long stay rehabilitation ward for female patients
- Peak View: 15 bed mixed sex acute ward for children and adolescents
- Haven ward: 12 bed mixed sex psychiatric intensive care unit for children and adolescents.

Cygnet Hospital Sheffield aims to support women through a care pathway from low secure accommodation to long stay rehabilitation. The service aims to provide a multi-disciplinary team who provide care and treatment to patients to encourage independence, maintain personal relationships, and prepare for discharge. Care and treatment on low secure and long stay rehabilitation wards focuses on community access, therapy and meaningful activity.

Cygnet Hospital Sheffield provides both acute and intensive psychiatric mental health care to children and adolescents of both genders. These facilities are provided in two separate wards and admission to the wards is assessed on individual need of patients. A multidisciplinary team is available to provide care and treatment, which includes therapy and education.

At the time of our inspection, there was a registered manager and a controlled drugs accountable officer in post.

The hospital is registered to provide the following regulated activities:

- Nursing care.
- Treatment of disease, disorder or injury.
- Assessment or medical treatment for persons detained under the 1983 Mental Health Act.
- Diagnostic and screening procedures.

When we undertook a focussed inspection of Cygnet Sheffield Hospital in January 2016. We told the provider that it must make the following actions to improve Cygnet Hospital Sheffield:

- The provider must ensure that the medication policy is fit for purpose and suitable for use within the service level agreement of the supplying pharmacy. Secondary dispensing must only be used in emergency situations when there is no other alternative to provide the patient with required medication.
- Staff must ensure all medication errors are clearly recorded in patients' notes as soon as is practicable after the error has occurred.
- The provider must ensure that cupboards storing medication are locked securely when not in use.
- The provider must ensure that young people who are informal patients are able to leave the ward at any time or have a thorough understanding of how to leave the ward when doors are locked.
- The provider must ensure that the Mental Health Act policy is updated to include the requirements in the revised code of practice 2015.

We also told the provider that it should take the following actions to improve:

- The provider should ensure that there is a system in place to check seclusion rooms are ready for use and fit for purpose at all times.

We issued Cygnet Hospital Sheffield with three requirement notices. These related to:

- Regulation 12 HSCA (Regulated Activities) Regulations 2014 Safe care and treatment.
- Regulation 13 HSCA (Regulated Activities) Regulations 2014 Safeguarding service users from abuse and improper treatment.
- Regulation 17 HSCA (Regulated Activities) Regulations 2014 Good governance.

Summary of this inspection

On this inspection we found that the provider had addressed these concerns.

Our inspection team

The team comprised three inspectors, two pharmacy inspectors and one Mental Health Act reviewer from the Care Quality Commission. In addition, five specialist advisers joined our inspection. These were: a consultant psychiatrist, three mental health nurses and one psychologist.

This inspection was led by Carole Charman.

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 staff at three 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 23 patients who were using the service, and collected feedback from 25 patient comment cards
- spoke with the registered manager
- spoke with the managers or acting managers for each of the four wards
- spoke with 31 other staff members: including doctors, nurses, occupational therapists, support workers, teachers, a psychologist and a social worker
- spoke with an independent mental health advocate
- attended and observed eight meetings involving professionals and patients.
- carried out a review of seclusion facilities
- looked at 24 care and treatment records of patients
- reviewed the personnel files for six staff members
- spoke with four carers of people using the service
- carried out a specific check of the medication management on all four wards, including the review of 47 medication charts
- looked at a range of policies, procedures and other documents relating to the running of the service.

Summary of this inspection

What people who use the service say

We received variable feedback from patients who used the service. During our inspection we spoke with 23 patients and four of their carers, and received written feedback from 25 patients on comment cards.

Patients across all four wards told us that when they were first admitted, staff oriented them to their surroundings and they were provided with information about the service. Patients told us that the wards had community meetings where they could raise concerns and discuss any issues they experienced.

During our inspection we spoke with 13 patients on child and adolescent wards. We received mixed feedback from these patients about their experience of the service. All patients told us they had a named nurse who had written their care plans. Patients also told us that they had been involved with the completion of risk management plans. However, feedback that we received from three patients during the inspection and on six comment cards from child and adolescent mental health wards told us that they felt some staff were not supportive and were unapproachable. Some patients told us that they felt that staff used the use of seclusion and rapid tranquilisation as a threat against them. In addition, one patient told us and three comment cards stated that patients on child and adolescent wards told us that they did not like to be restrained by staff in their bedrooms.

During our inspection, we informed the registered manager of the concerns patients on child and adolescent mental health wards had about their treatment. The registered manager acted upon this information immediately.

We received mixed feedback from comment cards completed by patients on child and adolescent wards. Eight comment cards gave positive feedback about the staff supporting them and reported a reduction in restrictive practice on the ward. However, ten patients' comment cards stated that they felt staff did not respond well to incidents of self-harm and that there was a high use of agency staff on the wards. Patients also commented that they did not like to be restrained in their bedrooms. One comment card said that patients got no respect and one said that the ward was 'horrible'.

We received positive feedback from the carers of four patients that were using the service. All parents and carers spoke positively about their relationship with the hospital and the care provided. Parents and carers told us that they felt supported by staff and felt included in information about the patient's progress.

Detailed findings from this inspection

Mental Health Act responsibilities

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

During the inspection there were 45 patients detained under the Mental Health Act. This represented 88% of patients receiving care and treatment at Cygnet Hospital Sheffield. Across the wards this was represented as: low secure and long stay rehabilitation wards (25 patients) and child and adolescent wards (20 patients).

We reviewed the detention documentation to review the hospital's adherence to the Mental Health Act and Code of Practice (2015). There were concerns regarding the documentation which included:

- One patient record did not contain valid consent to treatment or authorisation by a second opinion appointed doctor using the correct procedures. In addition, one patient record did not contain a valid section 62 certificate for treatment provided in an emergency under the Mental Health Act. On these occasions these patients received treatment without the valid consent or authorisation under the Mental Health Act.
- Staff did not inform six patients of their rights as soon as practicable after their detention under the Mental Health Act as per section 132 of the Act. In addition, two records showed that staff did not inform these patients of their rights under the Mental Health Act. This was not in line with the Mental Health Act code of practice 2015.

The hospital had a Mental Health Act team that were responsible for the auditing and reviewing of the application of the act across the hospital. We saw the team carried out regular audits to check the correct Mental Health Act documentation was in place and up to date for the wards. The team sent reminders to staff in the hospital when they had identified actions that needed to be taken. However, we found this system did not ensure that the Mental Health Act was adhered to and was not effective. Staff told us that despite requesting documentation and information from doctors that they did not always receive this.

Mental Health Act training was mandatory, and this had been completed by 86% of staff. However, we spoke with 31 staff members during the inspection and their knowledge was variable. All staff we spoke with where able to state that they would seek support from colleagues should they need to about more complex issues.

Patients had access to independent mental health advocacy services. Staff and patients told us that patients could access Independent Mental Health Advocates. Some patients told us that advocates did not always visit the ward every week. There were two independent mental health advocacy services available to patients. One provided advocacy services to male patients and the other female patients. Advocates scheduled to visit the wards weekly. During our inspection we spoke with advocates and saw them interacting with patients on Peak View child and adolescent ward.

Mental Capacity Act and Deprivation of Liberty Safeguards

As part of our inspection we looked at the adherence to the Mental Capacity Act and the Deprivation of Liberty Safeguards. We do not rate providers on adherence to the act and associated guidance however; these form part of our overall judgements of the provider. The Mental Capacity Act applies to young people aged 16 and over. In order to establish decision making ability for young people under 16 competency is assessed under the guidance of Gillick competency framework.

At the time of our inspection, there were no patients admitted to the wards subject to Deprivation of Liberty safeguards. The hospital had a Deprivation of Liberty protocol in place which was reviewed annually and provided staff with guidance on whether the treatment to be carried out would amount to a deprivation of liberty. In the six month period from 01 October 2015 to 31 March

Detailed findings from this inspection

2016 the service had not made any applications under the Deprivation of Liberty Safeguards. At the time of our inspection there were six informal patients. All informal patients were on child and adolescent wards.

Training in the Mental Capacity Act was mandatory for staff. The provider told us that staff received this training in their induction. Staff across all wards had variable knowledge about the Mental Capacity Act and the Deprivation of Liberty Safeguards, however, all staff could told us that they would speak to their colleagues, managers and consultant psychiatrists if they needed advice around the Act. All staff we spoke with had a good knowledge around the definition of restraint and when this would be appropriate. However, none of the staff we spoke with were able to describe how the hospital monitored it's adherence to the Act.

We reviewed adherence to the Act and Gillick competency depending on the age of patients on child and adolescent wards in 11 patient records. Where a patient's capacity or competency had been assessed, there was an appropriate record of this assessment. Assessments related to a patients ability to make specific decisions which was in line with legislation and associated guidance.

On low secure and long stay rehabilitation wards, assessment of capacity was in accordance with legislation and guidance. Patients had assessments of capacity and there was evidence that patient capacity to consent was recorded in their files.

Overview of ratings

Our ratings for this location are:

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

Requires improvement

Forensic inpatient/secure wards

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

Summary of findings

We rated safe as requires improvement because:

- Staff did not always completed physical health monitoring to monitor medications. When staff omitted two doses of clozapine medication they did not seek advice from a pharmacy or the clozapine monitoring service.
- Training compliance rates showed that staff did not receive up to date training. Staff training was under the provider's target rate of 85% and some were below 75%. Some of this training included courses essential to ensure the safe running of the service such as immediate life support.
- Wards had high vacancy rates for qualified nurses and nursing assistants. The hospital used bank and agency staff to meet the minimum requirements. However, some shifts were not filled by bank or agency staff.

However:

- The hospital used an electronic incident reporting system and all staff knew how to report incidents.
- All patients had up to date risk assessments and risk management plans.

We rated effective as requires improvement because:

- Staff recorded patients' care and treatment on paper and electronic records. This meant that there was no single contemporaneous record. Staff did not record all information in both files.
- Positive behavioural support plans did not provide detail methods on prevention, de-escalation and diffusion strategies to manage actual or potential violence and aggression.
- Not all staff received regular appraisal. On the Spencer ward only 56% of staff had received a performance appraisal.
- The hospital did not audit or manage the use of the Mental Capacity Act and Deprivation of Liberty Safeguards.

However:

- Staff assessed and recorded patients' mental capacity to make decisions in line with legislation and guidance.
- Mental Health Act documentation was present and correct in line with legislation and guidance.

We rated caring as good because:

- Feedback from patients was positive. Patients felt supported by staff, reported to be included in the development of their risk assessments and care plans and felt involved in the care they received.
- It was clear that staff had detailed knowledge about patients' needs. Observations of staff and patient interactions showed that staff treated patients with respect and kindness.

We rated responsive as requires improvement because:

Requires improvement

Forensic inpatient/secure wards

- Medication administration did not promote privacy and dignity of patients. Staff administered medication through a hatch in a communal area. These could be seen by other patients, staff and visitors to the ward.

However:

- Staff encouraged patients' to personalise their bedrooms. We saw that patients' had their personal items displayed and had decorated their bedrooms with posters and their personal soft furnishings.
- Patients had access to their own basic mobile phones.

We rated well-led as requires improvement because:

- The provider's governance systems were not effective as it did not ensure that service was operating in a safe way for patients.
- Staff had not received up to date training, supervision and appraisal. Systems in place did not ensure that these occurred at the required intervals.
- Staff completed audits however, these did not identify issues with out of date equipment or in correct Mental Health Act documentation. Audits were not robust or comprehensive to ensure that they assessed, monitored and improved the service.
- The hospital operated using some of the previous provider's policies and procedures despite the current provider taking over in August 2015.

Are forensic inpatient/secure wards safe?

Requires improvement

Safe and clean environment

During our inspection, we visited both wards at Cygnet Sheffield Hospital. Throughout the hospital, a close circuit television system was in use in the communal areas. This enabled staff to view recordings to review observations completed and when investigating complaints or incidents. We found that each ward had a lounge and a separate quiet room that patients could use. Both wards had a clinic room, a kitchen with a serving hatch and a nurses station. All bedrooms were en suite and there were also communal bathrooms and toilets.

Wards had blind spots due to their layout. This meant that a clear line of sight of all patients was not always possible. This created a potential risk to patients; however, staff completed observations to ensure that they could see all areas of the wards at all times to mitigate this risk. We saw that both wards allocated staff to support individual patients when needed. Staff increased their observations where patients had been identified as being at increased risk to themselves or others.

Both wards had environmental risk assessments. The hospital completed these regularly. We saw that the hospital completed ligature audits of areas of the hospital that were accessible to patient every six months. Ligature points are something that people can use to tie something to in order to be able to strangle themselves. Staff attended the hospital governance meetings and where they discussed actions to take to reduce risks including risk of ligatures.

We saw that all wards had ligature points. However, the risk had been mitigated through staff observations. All wards had access to ligature cutters, which are equipment used to release a ligature quickly to prevent strangling. Clinic rooms and various places on the wards stored ligature cutters. This ensured that staff could access these quickly in an emergency. Multiple sets of ligatures cutters meant that staff could access more than one set of ligature cutters at the same time when needed. For example, where more than one patient ligatured at the same time or if one pair of ligature cutters had broken or failed to work.

Requires improvement

Forensic inpatient/secure wards

Prior to our inspection, four seclusion suites had been decommissioned and there was now only one seclusion suite in use at the hospital. Shepherd and Spencer wards did not use seclusion facilities at the time of our inspection.

Wards provided care and treatment to female patients only. This meant that they complied with guidance on eliminating mixed sex accommodation.

All wards had clinic rooms. In addition, the hospital also had a physical health clinic which was situated inside the main building of the hospital. We saw that all clinic rooms had grab bags which contained emergency equipment. Staff checked this equipment regularly to ensure that it was in working order. Medicines were stored appropriately in locked cupboards. There was a process in place to ensure that medicines which were no longer needed could be returned to the pharmacy safely.

Staff checked temperatures of both the clinic rooms and the clinic fridges daily. We reviewed these temperatures over one month and found that on low secure wards the temperatures were within the guidelines for the safe storage of medicine.

All clinic rooms had handwashing facilities and there was a good supply of hand sanitisers located throughout the hospital which were available for staff, patients and visitors to use. On secure wards we saw that staff used hand sanitisers appropriately to minimise the risk of potential spread of bacteria and infections.

We found furniture and furnishings were well maintained, in good condition and appropriate for the environment. The wards were tidy, with regular cleaning schedules being carried out by domestic staff. We looked at the cleaning rotas and found these gave details of which areas were to be cleaned on a particular day.

Staff used a mobile personal alarm system. We saw that all staff carried these alarms when accessing patient accessible areas. During our inspection we saw that staff used alarms appropriately to call for assistance from colleagues. Staff responded promptly to hearing the alarm sound.

Safe staffing

We reviewed information in relation to staffing across all wards. Both wards had a full-time ward manager in post. Wards had minimum staffing levels for day shifts and night shifts. Ward managers calculated minimum staffing levels using a matrix which corresponded to the amount of patients on the ward and the levels of staffing required. At the time of our inspection the staffing levels were as follows:

Day shift staffing

- Spencer ward, a low secure service – two qualified staff and five support staff
- Shepherd ward, a long stay rehabilitation ward – one qualified staff and five support staff

Night shift staffing

- Spencer ward, a low secure service– one qualified staff and four support staff
- Shepherd ward, a long stay rehabilitation ward - Shepherd – one qualified staff and three support staff

The hospital had a high vacancy rate for qualified nurses across wards. Information provided by Cygnet Hospital Sheffield showed that as of 31 March 2016 that there were 4 whole time equivalent vacancies, which was 34% of the qualified nurses. There were 11 nursing assistant whole time equivalent vacancies, which was 29%. The hospital also had a high staff turnover rate of 55% in the 12 months prior to 31 March 2016. We reviewed the ward rotas for June, July and August 2016 and saw that the hospital adjusted the staffing levels required dependent on patient need and risk. Where patients had increased observation levels additional staff members were deployed.

To meet the staffing levels that wards needed the hospital used bank and agency staff. The hospital employed a resource assistant who co-ordinated staff cover for wards. The provider aimed to use regular agency staff where possible. Information from the provider showed that bank and agency staff had filled 6819 shifts across all wards in the period from January 2016 to June 2016. Between 01 January 2016 and 31 March 2016, there were 38 shifts not filled by bank or agency staff. This meant that at these times, shifts were not fully staffed, increasing the risk of harm to patients of their needs not being met. High use of agency staff can mean that it is more difficult for patients to have a therapeutic relationship with the staff caring for them.

Sickness rates were low. Information from the provider showed that in the 12 months leading up to our inspection the sickness rates were: Spencer ward two percent and Shepherd ward was one percent.

Requires improvement

Forensic inpatient/secure wards

During our inspection we saw that both wards had staff present in communal areas. We spoke to patients that told us that they knew who their named nurse was and reported that they spent time with them regularly. We saw that patients had section 17 leave from wards escorted or unescorted depending on the individual patient risk. Between 20 January 2016 and 27 June 2016 there were 15 occasions where section 17 leave was cancelled. These related to Spencer ward (nine cancelled) and Shepherd ward (six cancelled). These occasions related to risk factors increasing as a reason for suspending section 17 leave.

There was adequate medical cover across wards from consultant psychiatrists. The hospital had an on call doctor on evenings and weekends. In addition, a hospital manager was on call out of hours should staff need to seek advice or support.

We reviewed staff training records and found that the following mandatory training compliance was below the provider's target of 85%, and some areas of training were below 75%. These were:

- Shepherd ward: immediate life support 53%, information governance 60%. Seventy three percent for suicide prevention, infection control, Mental Health Act and duty of candour, risk management, child and adolescent mental health, suicide prevention, infection control, food hygiene, control of substances hazardous to health, moving and handling and health and safety. Management of actual of potential aggression at 74%.
- Spencer ward: immediate life support 68%, suicide prevention 73% and breakaway training 74%.

The ward with the lowest area of compliance with mandatory training was Shepherd ward, and Spencer ward was the most compliant. The lowest attended mandatory training was immediate life support. This caused risk to patients; because techniques such as restraint, seclusion and rapid tranquilisation were being used on the ward. The National Institute for Health and Care Excellence guideline NG10 Guidance on violence and aggression: short-term management in health and community settings outlines that health and social care providers must provide staff trained in immediate life support and a doctor trained in resuscitation equipment should be available immediately available to attend in an emergency if restrictive interventions might be used.

Assessing and managing risk to patients and staff

We reviewed information sent to us by the provider relating to the management of violence and aggression. This information related to six month period between 1 October 2015 and 31 March 2016. The amount of incidents of seclusion reported was one. This related to Spencer ward and occurred prior to the seclusion suite being decommissioned. The long stay rehabilitation ward, Shepherd, had no incidents of seclusion reported during this time.

There were no reported incidents of long term segregation on the low secure ward and long stay rehabilitation wards. Long term segregation is where a patient is prevented from being able to mix freely with other patients on the ward. This was usually decided by a multidisciplinary team to minimise the risk from the patient segregated.

We reviewed information relating to the number of incidents of restraint being used. Between the 01 January 2016 and 11 July 2016, Spencer ward reported there were 31 incidents of restraint. There were 14 incidents of restraint on Shepherd long stay rehabilitation ward. None of these were reported as prone restraint. During our inspection we spoke to 31 staff members, staff told us that they initially try to use de-escalation techniques to diffuse incidents before using physical techniques.

We reviewed 13 patient care and treatment records. All records contained an up to date risk assessment and risk management plan. We saw that staff reviewed these regularly. The provider used a recognised risk assessment tool. This was the Salford tool for assessment of risk. Risk assessments showed that staff involved patients in identifying risks and in formulating a risk management plan which was appropriate to identified risks.

All wards had a restriction in relation to potentially hazardous items including: razors and glass. Staff held these items on the ward. However, patients had an individual risk assessment to identify the risk of self-harm which was in line guidance in the Mental Health Act code of practice. Patients could use restricted items under the supervision of staff.

Training in breakaway techniques and the management of potential and actual aggression was a mandatory staff training requirement. This training is aimed at preparing staff with the knowledge and skills required to safely de-escalate and if needed complete physical interventions to manage actual and potential aggression to reduce risk

to patients and staff. Breakaway training and training in the management of actual or potential aggression was not up to date on Spencer ward. These training courses had a compliance rate of 74%.

All staff demonstrated that they understood what would constitute a safeguarding concern and how they would report this. Records showed that staff reported safeguarding concerns promptly. The hospital had a social worker who was the safeguarding lead. Regular meetings took place to discuss safeguarding and the hospital manager attended these. Between the 12 April 2015 and 11 April 2016, there were 18 safeguarding concerns reported to CQC by the provider.

A pharmacist visited the wards each week. They completed an audit of medicines held in stock to ensure that stock was held correctly. The pharmacist operated under a service level agreement that the hospital held with a pharmacy. The pharmacist reported any discrepancies or concerns to the hospital and ward managers.

Medication charts had photographs of patients to allow staff to make a clear identification prior to the administration of medication. Provision had been made to allow patients to self-medicate where appropriate. This was discussed at multi-disciplinary team meetings and was based on individual needs and risk.

Staff administered prescribed medication to patients on the low secure ward Spencer via a hatch. Administering medication through a hatch meant that staff had a restricted view when they administered medications, meaning staff could not be certain that medication had been taken by patients. In addition, patients may not be able to speak privately with staff if they had questions about their medication.

Wards had discretionary medicines for the treatment of minor ailments which they could provide to patients when needed. The hospital had implemented a revised policy for the preparation and supply of leave medicines to help ensure that these could be safely and promptly provided.

Patients generally attended their ward rounds and medicines were discussed. However, pharmacist advice was not sought and documented when developing individualised pharmacological strategies for the short-term management of violence or aggression as advised by guidance from the National Institute of Health and Care Excellence (NG10) Violence and aggression: short-term management in mental health, health and community settings May 2015.

Monitoring of physical health is important to ensure people are physically well and that they receive the most benefit from their medicines. However, we saw two records that showed patients had missed one dose of Clozapine because the phlebotomist had not collected the bloods for monitoring. Advice was not sought from pharmacy or the clozapine patient monitoring service when deciding to omit the doses. Records did not show that any other alternative advice had been sought from doctors. However, we saw that where patients were prescribed high dose antipsychotics, the consultant actively reviewed this and side-effects were monitored accordingly

Both wards had up to date British National Formulary was held in the clinic rooms. This provided staff with information regarding medicines that were registered for use in the United Kingdom, doses and also which medicines should and should not be used together.

Track record on safety

Between 12 April 2015 and 11 April 2016, the hospital reported 84 incidents to the Care Quality Commission of these are as follows;

- Abuse or allegation - 13
- Serious injury - 44
- Police incident - 27

The recurrent themes reported by the provider were in relation to: self-harm, incidents with the police, hospitalisation and discharge of patients, and patient on patient alleged abuse.

Reporting incidents and learning from when things go wrong

The hospital had an electronic incident reporting system which all staff had access to. All staff could explain what types of occurrences they reported as incidents and how they did this using the electronic reporting system.

Patients on low secure and long stay rehabilitation wards told us that staff on the ward were very supportive during and after incidents. Patients told us that after an incident staff spent time with them and spoke to them about what had happened and offered them extra support when it was

Requires improvement

Forensic inpatient/secure wards

needed. Patients felt that staff did not rush or pressure them. Patients also told us that staff carried out debriefs following an incident. This involved staff talking to them about the incident and trying to establish if there was anything which triggered the behaviour.

Teams had a weekly reflective practice group session which was led by a psychologist. This gave staff the opportunity to reflect on incidents in a separate space off the ward. Staff also discussed incidents at handover and professional meetings. Teams had a handover when the shift changed over to pass on information to the team starting their shift. Staff told us they could use this time to discuss any concerns they had following incidents.

Wards submitted monthly data in relation to restraint and rapid tranquilisation. This information was analysed and used to determine if there were any trends or if intervention strategies were working effectively.

The hospital manager told us that there was a process in place which helped to review incidents. This involved the completion of a 24 hour report and 72 hour report into the events leading up to the incident. The hospital also used root cause analysis investigations in order to learn from incidents and this was fed into either individual action plans or an overarching local action plan.

Staff reported that they felt supported by their managers and could access additional support after incidents if needed.

Are forensic inpatient/secure wards effective?

(for example, treatment is effective)

Requires improvement

Assessment of needs and planning of care

We reviewed 13 patient care and treatment records. All records contained a comprehensive assessment of need. Staff recorded information around physical and mental health conditions and diagnoses. Assessments contained information about any additional support needs that patients had. Patients' records contained detailed about their background which included information about any relatives or carers. On admission staff completed a physical health assessment with patients. Twelve out of 13 patient records contained information about physical health on admission to the hospital.

All patients had an up to date, personalised and recovery-orientated care plan. We found that all care plans had been regularly reviewed by staff since admission. Patients had numerous care plans which related to different aspect of their individual needs and what support patients required from staff. Most patients had care plans in place for mental health and physical health. For example we saw care plans in place for patients who had physical health conditions such as, lupus, asthma and diabetes. These care plans helped ensure that staff were aware of patients' conditions and how they may affect them. Three of the care and treatment records that we reviewed related to patients who had a diagnosis of personality disorder and none of these had a specific care plan in relation to personality disorder. However, we found that one of these records referenced the patient's diagnosis of personality disorder in the care notes.

All the care records we looked at contained positive behaviour support plans. Positive behavioural support plans are aimed at providing information to staff about techniques and ways to support an individual to de-escalate and diffuse situations before an incident occurs. However, the plans in place did not contain information about techniques to de-escalate and prevent behavioural disturbances.

The hospital used electronic and paper based care records. An electronic patient records system was in place however, patients also had paper files on the wards which also contained information relating to their care and treatment. The system did not ensure that there was a single contemporaneous record of patient care and treatment. Staff would need to check both systems to ensure that they had checked the relevant information about patients. We found that the systems did not always match as there were some discrepancies between the paper and electronic notes.

This would increase the risk to patients as staff not familiar with the ward would not be able to access important information about patients quickly, for example, agency staff.

Best practice in treatment and care

Requires improvement

Forensic inpatient/secure wards

The hospital offered psychological therapies recognised by the National Institute for Health and Care Excellence which included dialectical behavioural therapy and cognitive behavioural therapy. During our inspection we saw that patients accessed individual one to one sessions with the psychologists.

The physical health team at the service comprised of one qualified nurse and one physical health support worker. Staff told us that the hospital had plans to restart well-being groups. These had temporarily suspended due to the previous physical health nurse leaving the hospital. A nurse had been recently appointed to lead physical health monitoring in the hospital. The physical health care team completed blood tests and electrocardiograms as part of the regular monitoring for some medications, carried out physical health assessments for new patients and were starting to provide smoking cessation advice for patients. The team arranged GP appointments for patients and carried out blood testing in order to monitor the effects of medications like lithium and clozapine, as well as ensuring annual health checks were completed. However, we saw that there had been two occasions where blood monitoring had not been completed for clozapine. This meant that the ward did not administer this medication to the patients involved for one dose. Blood monitoring was completed shortly afterwards prior to restarting the medication.

A GP visited the hospital each week to see patients about their physical health needs. However, the results of physical health monitoring were not consistently inputted into patients review documentation. The medical director had spoken with the GP about this and was taking action to address this.

The hospital had a physical health policy that included the Lester tool. NHS England in partnership with NHS Improving Quality, Public Health England and the National Audit for Schizophrenia devised the Lester Tool to improve physical health monitoring for patients with serious mental illness. However, staff responsible for physical health care told us that they were unaware of the Lester tool and it's use. In addition, the GP calculated QRISK scoring. We found was not routinely calculated by the GP and recorded on patient files. We were informed that at the time of our inspection that there had been a temporary breakdown in communication with the GP. We found that not all staff understood the use of QRISK scoring. QRISK is a risk assessment tool that uses a combination of traditional risk factors like age and smoking as well as things like family history, ethnicity and body mass index to predict the risk of developing cardiovascular disease. One staff member told us that they had started to complete QRISK scoring however, another staff told us they were unsure what this method of risk assessment was and had looked this up on the internet to find out.

The GP worked closely with the hospital to assist patients with a high body mass index to lose weight. We saw that the GP had referred to weight loss clinics and had prescribed Orlistat medication, which aids with weight loss. Staff told us that in the past kitchen staff and members of the physical health team met to discuss meals and healthy eating.

Both wards used recognised scales to assess and record severity and outcomes. Wards used the Health of the Nation Outcome scales. The Health of the Nation Outcome scale is a measure to assess the health and social functioning of people with severe mental illnesses. The scale is usually completed to measure the progress of treatment and outcomes for people receiving mental health care and treatment. Staff at the hospital used rating scales to assess and record the severity of patient illness and to monitor patient outcomes through their treatment.

The hospital also used the Outcome Star to measure patient outcomes. The Outcome Star is a recognised outcome measure which was developed based on the principles of the Mental Health Recovery Star model. The Mental Health Recovery Star model considers mental health recovery to be holistic and related to all aspects of an individual's life.

We found that some clinical audits were completed however; these did not always ensure that issues were identified or addressed. Staff completed audits of clinic room equipment and audits of Mental Health Act documentation. However, these did not always identify issues. During our inspection we found issues with Mental Health Act documentation on child and adolescent wards in relation to valid consent and authorisation of treatment under the Mental Health Act and in an emergency under section 62 of the Act. A physical health audit should have been carried out monthly however this had not been completed since January 2016 due to the absence of a physical health nurse. The hospital plans to re-introduce this audit now that a full team was in place. The pharmacist who visited the wards also completed audits.

Requires improvement

Forensic inpatient/secure wards

Skilled staff to deliver care

The hospital had a range of mental health disciplines and workers to provide input to the wards. The multidisciplinary team included: consultant psychiatrists, psychologists, an occupational therapist lead, occupational therapy assistants, a social work lead, nurses and support worker. Each week a pharmacist visited the hospital and provided information, advice and audits.

Not all staff received regular appraisal. Information provided by the hospital showed that on Spencer ward that only 56% of staff had been appraised in the last 12 months. Staff told us that they received supervision and appraisals. However, the frequency reported varied amongst staff.

All wards had regular team meetings. Staff reported that they attended team meetings as often as possible as this depended on the ward having adequate cover to facilitate this.

Multidisciplinary and inter-agency team work

Wards had regular and effective multiagency meetings. The minutes of staff team meetings showed that the multidisciplinary team was represented and staff had the opportunity to contribute in team meetings. Staff reported that meetings enable them to seek advice, support and guidance from their colleagues and other agencies. Staff told us that team meetings were used to share experiences and knowledge.

The hospital provided regular reflective practice group sessions. These provided permanent staff with the opportunity to gain support and knowledge when they had experienced any challenging clinical situations. Staff we spoke gave use positive feedback about these sessions and they told us that these helped them to manage working in a challenging environment.

During our inspection we attended care programme approach meetings. We observed that different agencies attended meetings regarding patient care, treatment and discharge.

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

Mental Health Act training was a mandatory training requirement for all staff. Information provided by the provider stated that 86% of staff had received training in the Mental Health Act. During our inspection, staff demonstrated a variable understanding of the Mental Health Act and the Mental Health Act code of practice. We found that some staff had good knowledge around the Mental Health Act whereas; others had basic and limited understanding. However, all staff told us that they could speak to their colleagues and the consultant psychiatrists if they needed advice about the act.

During our inspection, we reviewed Mental Health Act documentation. We found that consent to treatment on Spencer and Shepherd ward was in line with legislation and guidance. Patients' medication records contained the correct legal documentation. We saw that nurses checked this documentation when nurses administered medication to patients.

There were arrangements to monitor the adherence of the Mental Health Act within the hospital however; these were not always effective at ensuring the Mental Health Act requirements were adhered to. We identified issues in relation to Mental Health Act documentation on child and adolescent mental health wards which had not being identified by the hospital. This was in relation to the valid consent and authorisation for treatment under the Mental Health Act and emergency treatment under section 62 of the Act. This meant that although Mental Health Act documentation was appropriate and up to date for Shepherd and Spencer wards the audit system in place may not identify issues should they occur in the future.

The hospital had a Mental Health Act team that were responsible for the auditing and reviewing of the application of the Act across the hospital. We saw the team carried out regular audits to check the correct Mental Health Act documentation was in place and up to date for the wards.

Patients had access to Independent Mental Health Advocacy services. Patients spoke positively about the advocacy service that they had access to.

Good practice in applying the Mental Capacity Act

The Mental Capacity Act enables people to make their own decisions wherever possible and provides a process and guidance for decision making where people are unable to make decisions for themselves. Training in the Mental Capacity Act was a mandatory training requirement for staff. Information sent to us by the provider showed that staff received Mental Capacity Act training as part of their induction to the hospital.

Requires improvement

Forensic inpatient/secure wards

The hospital had a Deprivation of Liberty protocol in place which was reviewed annually and provides staff with guidance on whether the treatment to be carried out would amount to a deprivation of liberty. In the six month period from 01 October 2015 to 31 March 2016 the service had not made any applications under the Deprivation of Liberty Safeguards.

On both wards we found that evidence that assessment of capacity was in accordance with legislation and guidance. Patients had assessments of capacity and there was evidence that patient capacity to consent was recorded in their files.

Staff knowledge was variable on the Mental Capacity Act and the code of practice. Staff told us they could seek advice around the act from their colleagues, managers and the consultant psychiatrists when needed.

Are forensic inpatient/secure wards caring?

Good

Kindness, dignity, respect and support

During our inspection, we saw interactions between staff and patients. Staff treated patients with kindness and respect. We observed that staff knew patients and their needs well and they spent time. They supported patients with completing tasks and provided positive support to manage behaviours that challenge. Staff encouraged patients positively throughout their engagement.

We received feedback from patients using two methods. We spoke to patients on the wards and we gained patient views using comment cards. We spoke with 10 patients across Spencer and Shepherd wards and reviewed seven comment cards that patients had completed. Patients we spoke with were positive about staff and how they were treated. Patients told us staff treated them well and gave them encouragement and support. The seven comments cards that we receive gave positive feedback. These comment cards praised ward staff and managers and described them as kind, compassionate and caring. Patients also reported that they felt safe and that staff treated them with respect.

The involvement of people in the care they receive

When patients arrived on the ward staff oriented them to their surroundings and provided information about the service.

We reviewed the care plans of 13 patients. Ten of the records we reviewed clearly showed that patients had been involved in the formulation of their care and that their views had been captured. Patients we spoke with told us they had a named nurse who compiled their care plans. They also told us that they had been involved with the completion of risk management plans. All care plans we reviewed had either been signed by the patient to say they had participated in the formulation of their care plan and agreed with its content, or were noted to say the patient refused to participate or sign the care record. Care plans were also noted to say either the patient had a copy or did not wish to have a copy of their care plan.

Patients said that they had time to speak to the pharmacist if they wanted to talk about medicines. Patients also reported that they have discussions with staff about treatments available and the potential side effects that could occur. Patients felt this enabled them to make informed decisions about their treatment.

Multidisciplinary meetings involved patients' relatives or carers with their consent. This enabled patients' relatives or carers to be included in decisions made about patients' future care and treatment.

Patient feedback and inclusion in service feedback was limited. At the time of our inspection the hospital had plans for patients to become included in clinical governance meetings. The hospital did not include patients in recruitment of staff. However, each ward had community meetings. Patients' could give their feedback on the service, raise concerns and discuss issues that were relevant to them.

Requires improvement

Forensic inpatient/secure wards

Are forensic inpatient/secure wards responsive to people's needs?
(for example, to feedback?)

Requires improvement

Over a six month period all wards had an occupancy rate of 85% or above. The average bed occupancy over the six month period between 01 October 2015 and 31 March 2016 was 100% on Shephard ward and 97% on Spencer ward.

The average length of stay for the these wards between 01 October 2015 and 31 March 2016 was:

- Low secure ward - Spencer – 22 months
- Long stay rehabilitation ward - Shepherd – 17 months

Patients on these wards had enduring mental health needs. Due to the length of care and treatment provided the availability of beds was reduced as patients stayed longer on the wards and wards had a high occupancy rate. All wards ensured that all patients had access to a bed on return from leave.

On low secure and long stay rehabilitation wards we did not see patients moved between wards. This was due to the difference in care provided. Staff told us that any decisions made around patients moving wards or discharge would be made at a multidisciplinary level and would involve other relevant external agencies. Where a patient required more intensive care, the hospital had procedures in place to organise this. The hospital did not have facilities to provide psychiatric intensive care to adult patients.

During the period between 01 January 2016 and 30 June 2016 the hospital reported one delayed discharge from low secure and long stay rehabilitation wards. The reason for this was reported as a delay in a community placement being available.

The facilities promote recovery, comfort, dignity and confidentiality

The hospital had a full range of rooms and equipment to support treatment and care. The hospital had a physical examination room on site. Staff told us that the examination room could be used when GPs visited patients. The GP could also see patients in their bedrooms. The hospital had rooms to complete individual and group therapy sessions. In addition, there were therapy kitchens and a multifaith room which patients could access.

Both wards had access to outdoor space. Patients could access refreshments could be accessed at all times of the day and night.

We looked at the rooms of some patients on both low secure and long stay rehabilitation wards and found they were clean and tidy. All bedrooms had en suite facilities. Patients were encouraged to personalise their rooms and we saw some patients had pictures on walls and their own personal bedding in their rooms, as well as other small personal items.

Patients had access to their own basic mobile phones which could make phone calls and receive text messages. In addition, phone booths were available for patients to make telephone calls on the wards.

In March 2016, the Food Standards Agency awarded the hospital food hygiene rating of five (very good). Patients gave positive feedback about the food provided. They told us that they had a choice at mealtimes and the provider catered for patients with special dietary requirements.

Wards had activity and therapeutic timetables. We did not see individualised patient therapy and activity plans. The hospital provided us with a copy of the ward activity timetables. These included a range of therapeutic, rehabilitation and recreational activities. Social outings also took place during the week and at weekends across the wards.

Staff had organised a monthly visit for small animals to visit the hospital. Patients from the wards could see the animals and listen to information about animal care. During our inspection, we saw that patients engaged with this session.

Meeting the needs of all people who use the service

The hospital was accessible for people with physical disabilities who required disabled access. The hospital had lifts so that access to the wards and areas of the hospital.

The hospital could access information leaflets for patients and their families and carers with alternative formats and languages when needed. Noticeboard displayed information about advocacy services and complaints.

Requires improvement

Forensic inpatient/secure wards

When needed the provider accessed interpreter services including British Sign Language interpreters. At the time of our inspection none of the patients at the hospital required the use of interpreter services.

Kitchen staff provided a variety of food options to cater to individual dietary needs. The hospital could access food to cater to religious, ethnic or personal needs and choices. A multi faith room was available to use. However, patients and staff reported that subject to leave from the ward that most chose to access local community facilities instead.

Listening to and learning from concerns and complaints

In the 12 month period from 01 March 2015 to 29 February 2016, the hospital received a total of 43 complaints. Thirteen of these complaints were in respect of Spencer and Shepherd wards. Seven complaints were received in relation to Spencer ward and six in relation to Shepherd ward.

Complaints made were in regard to the following themes:

- Satisfaction of the level of care and treatment provided
- Concerns about staff
- Visiting arrangements
- Maintenance
- Restraint

The hospital followed the complaint's policy and procedure. Staff investigated all complaints. Each complainant received a letter following the investigation. We saw that staff recorded discussions with the complainant. In response to some complaints meetings took place between the service's Chief Executive Officer and Director. Of the 13 complaints made four complaints were partially upheld. No complaints were referred to the ombudsman of the independent sector complaints and adjudication service.

Patients told us that they knew how to make a complaint. We saw that information was displayed on wards to explain the complaints procedure.

Are forensic inpatient/secure wards well-led?

Requires improvement

Vision and values

Cygnet Hospital Sheffield had organisational values. The values were:

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

Staff we spoke with had an awareness of the organisations values. During our inspection, we saw staff demonstrated these values during interactions with patients. We observed a number of interactions during our visit between staff and patients. We found that most of these clearly demonstrated the provider's values.

Staff we spoke with told us they knew who the senior managers were and said that they visited the wards.

Good governance

We reviewed information in order to look at the governance of Cygnet Sheffield Hospital. The hospital was acquired by Cygnet NW limited in August 2015. Prior to this the hospital was known as Alpha Hospital Sheffield and was provided by Alpha NW limited. The hospital was operating under a mixture of Cygnet and Alpha group policies. Staff told us that the hospital was gradually rolling out Cygnet policies to replace the previous provider's policies. There was a policy roll out schedule where a few Cygnet policies would be introduced each week and Alpha policies would be removed.

The provider had a governance structure in place. Governance meetings took place each month. We reviewed minutes of meetings that took place. We saw that meetings had standing agenda items, staff recorded minutes and minutes detailed actions to be completed with the staff responsible. Heads of wards and departments attended

these meetings. Regular agenda items included complaints, safeguarding, serious incidents, restraint and seclusion (including the use of prone restraint), service user and carer engagement and medicines management. Prior to our inspection, information sent by the provider stated that there was a plan for patient representatives to attend these meetings. At the time of our inspection this had not been implemented.

Systems to ensure that staff received current and appropriate training and support were not effective. We found that not all staff received up to date training in mandatory training courses.

Some staff did not receive regular supervision and appraisals. In the 12 months leading up to March 2016 staff turnover was high at 55%. At the time of our inspection, the provider had a retention plan in place to try to increase staff retention. This included a strategy of actions to be completed which included support from recruitment to ongoing career developments for staff.

The hospital had a system to try to ensure that wards had sufficient numbers of staff required. A resource assistant liaised with permanent staff, bank and agencies to acquire the numbers of staff required to safely staff the wards.

Representatives from the hospital participated in a 'regional recovery and outcomes' group. The group had representatives from the NHS and private sector. The aim of this was to work together and have a multiagency forum for discussion and cross working. Best practice was shared with providers throughout the sector within this group.

An electronic incident reporting system was in place. However, staff told us that when recording information about incidents this was not always accurate. This was in relation to recording of incidents and the restricted options on the system. Ward managers reviewed incident reports. The hospital completed investigations of incidents where appropriate. Staff received feedback from incidents including the outcome of safeguarding concerns and complaints.

Audits did not ensure that the Mental Health Act was adhered to across the hospital. The hospital had a Mental Health Act office. The aim of the office was to complete audits to ensure that Mental Health Act documentation was present and adhered to legislation and guidance. In relation to child and adolescent wards we found issues with Mental Health Act documentation which had not been identified through audits completed.

We reviewed seven personnel files for staff who worked at the hospital. All the files we reviewed contained evidence to show that the provider completed pre-employment checks of all staff. Staff files contained evidence of people's identity, qualifications, references, application forms and disclosure and barring service reference numbers. A disclosure and barring service check should be completed for all people who apply to work with adults at risk or children. The check informs the employer of any criminal convictions an employee has, or any list the employee may be named on, stating that the person poses a risk to children or adults at risk.

The hospital had a risk register in place. This had been recently reviewed at the time of out inspection. We saw that the risk register was discussed within governance meetings. Some of the issues that we identified during our inspection had not been identified by the hospital and so were not on the risk register.

All managers told us that they had sufficient authority and support to enable them to complete their role. Managers could escalate concerns to be considered to be put on the risk register.

Leadership, morale and staff engagement

Staff that we spoke with explained to us that they would report any concerns. Staff knew that the provider had a policy on whistleblowing and told us that they would follow this if needed. All staff said that they would be confident that any concern they raised would be addressed by the hospital. In the period between 01 April 2015 and 11 April 2016 there were no reported whistleblowing cases.

Staff spoke positively about their role and told us that they felt that they could make a difference in people's lives. Staff told us that they felt supported by their colleagues and managers.

The hospital had introduced a programme to support nursing assistants through nurse training. The provider had ten funded places for staff to apply to complete training to become qualified nurses.

Staff understood their responsibilities under the duty of candour. The policy on duty of candour in place was

written by the previous provider. Staff had a varied understanding however, all staff knew that when something went wrong that they had a responsibility to be open and honest and involve the patient.

Staff told us that they had seen a positive change in the hospital since it was acquired by the Cygnet group. Staff felt that they had the opportunity to contribute their feedback into the development of the service and that this was listened to by the hospital.

Commitment to quality improvement and innovation

We did not see examples of involvement in research or participation in national quality improvement of innovation initiatives.

Requires improvement

Child and adolescent mental health wards

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

Summary of findings

We rated safe as inadequate because:

- There was a disregard of safety policies and procedures in relation to infection control. The hospital did not follow their policy on infection control and eradication protocol, in response to three confirmed cases of on Haven child and adolescent ward. The hospital did not decontaminate reusable equipment which could contribute to further spread of infection. The hospital did not take all steps to ensure that the full prescribed treatment to eradicate the infection was in stock and available to a patient. Advice was not always sought when doses of medication were omitted. In addition we observed poor adherence to infection control measures including staff not using hand gel and not adhering to bare below the elbow rule by wearing jewellery on hands and false nails.
- Seclusion was used for longer periods of time than warranted and inappropriate language was used in seclusion records. We found that four seclusion records showed episodes of seclusion for periods of time where patient need did not warrant the continued use. Two seclusion records contained punitive language.
- Staff did not ensure medications were stored at the appropriate temperatures and the reason for that was that fridge and clinic rooms were excessively warm.
- Staff did not receive up to date training. We found that not all staff had completed the twenty one mandatory training courses identified by the provider across all wards. The level of training compliance was below the provider's target of 85% and some below 75%. This including training which was essential to the safe running of the service such as immediate life support.
- Across child and adolescent mental health wards blanket restrictions operated. All patients' mail was opened in the presence of staff members. There was no evidence that this had been considered as an individual risk for each patient.
- The child and adolescent wards had a search room which was not clean because it had a strong and unpleasant odour. This meant that it was not suitable for the purpose it was being used.
- Staff did not ensure that physical health monitoring and recording took place post rapid tranquilisation use. Four out of 12 records showed that physical health monitoring post the administration of rapid tranquilisation was not completed as frequently or for as long as the hospital policy stated.
- We found out of date equipment was found in the clinic room on Haven ward.
- There was a high vacancy rate for qualified nurses and nursing assistants. The hospital used agency staff to meet the minimum staffing requirements. Some shifts were not filled by bank or agency staff which meant that wards were understaffed.

Requires improvement

Child and adolescent mental health wards

- One patient told us and we received three comment cards from patients that stated that they had been restrained in their bedrooms and that they did not like this. We found a significant use of prone restraint on child and adolescent wards.

However:

- All staff knew what types of occurrences would be reportable incidents and how to report these using the electronic incident reporting system.
- All patients had up to date risk assessments and risk management plans.

We rated effective as requires improvement because:

- Staff failed to follow the Mental Health Act code of practice. They did not seek patients' consent to treatment under the Mental Health Act in line with legislation and guidance. One patient was treated without their consent or approval from a second opinion appointed doctor. Emergency treatment was given under section 62 without a valid certificate.
- Staff did not inform six detained patients of their rights as soon as practicable after their detention under section 132 of the Mental Health Act. In addition, two records showed that staff did not inform two patients of their rights under the Mental Health Act. This was not in line with the Mental Health Act code of practice.
- Audits completed did not identify incorrect and/or missing Mental Health Act documentation or out of date equipment in clinic rooms.
- Positive behavioural support plans did not provide information on prevention, de-escalation and diffusion strategies to manage actual or potential violence and aggression.
- The staff used electronic and paper records which were difficult to navigate and not all information was present in both files. A single contemporaneous record was not available.
- Not all staff received regular supervision. Only 77% of staff received regular supervision on Haven ward.
- The hospital did not audit or manage the use of the Mental Capacity Act and Deprivation of Liberty Safeguards.

However:

- All patients had up to date holistic recovery orientated care plans.

We rated caring as requires improvement because:

- Three patients told us and six comment cards that we received stated that staff did not treat them well. The hospital took appropriate action to investigate and respond to the concerns that we raised about this during our inspection.
- In the 12 months prior to the inspection the hospital received 30 complaints in respect of child and adolescent mental health wards. Of these complaints 13 related to complaints regarding care and treatment including patients felt they were treated by staff. Fourteen complaints were upheld, four were partially upheld and three were withdrawn by the complainant.

However:

- Staff knew patients and their needs well. Interactions between staff and patients observed showed that staff treated patients with respect and understanding.

We rated responsive as requires improvement because:

- Facilities did not protect the privacy and dignity of patients. Doors had been removed from the en suite bathrooms on child and adolescent wards. En suite bathrooms on Haven ward did not have shower curtains or other items to protect the dignity and privacy of patients.
- Medications were given through a hatch in a communal area. These could be seen by other patients, staff and visitors to the ward.
- Patients on the child and adolescent ward, Peak View, had limited restricted access to their mobile phones.

Requires improvement

Child and adolescent mental health wards

- The ward environment on Haven ward was in poor repair where patients had caused damage and the hospital had not made repairs.

However:

- Visiting facilities provided space off the ward for families and carers to visit patients. Small toys and outside space was available for young children who visited patients.

We rated well-led as requires improvement because:

- The governance systems in place were not effective in ensuring the service ran in safe way for patients.
- Systems did not ensure that all staff received up to date mandatory training, supervision and appraisal.
- Audits in place were not robust or comprehensive to assess, monitor and improve the quality of the service. Audits did not identify incorrect and missing Mental Health Act documentation and out of date equipment in the clinic room.
- The hospital operated using some of the previous provider's policies and procedures despite the current provider taking over in August 2015.

Are child and adolescent mental health wards safe?

Inadequate

Safe and clean environment

During our inspection, we visited the two child and adolescent wards at Cygnet Sheffield Hospital. Both wards had a lounge and a separate quiet room that all patients could access. In addition, each ward had a clinic room, a kitchen with a serving hatch and at least one nurses station. All bedrooms were en suite and wards had communal bathrooms and toilets. The child and adolescent psychiatric intensive care unit, Haven ward, had an additional lounge area, nurses station and clinic room. Throughout the hospital, a close circuit television system was in use in the communal areas. This enabled staff to view recordings to review observations and in the investigation of complaints and incidents.

The ward layouts did not allow staff to observe all ward areas. The layout of wards created blind spots where a clear line of sight was not always possible. This created a potential risk to patients. However, staff completed observations to ensure that they could see all areas of the wards at all times to mitigate this risk. During our inspection, we saw that wards allocated staff to support individual patients. Staff increased their observations of patients identified as higher risk, for example, where a patient had posed an increased risk of harm to themselves or others.

On Haven ward staff told us that they allocated the location of bedrooms to patients based on their individual needs. Patients with higher care needs had bedrooms closest to the main nursing station on the ward.

The hospital completed environmental risk assessments regularly and completed ligature audits of all areas of the hospital which were accessible to patients every six months. Ligature points are something that people can use to tie something to in order to be able to strangle themselves. The hospital had governance meetings where staff discussed ligature audits, and actions to take to reduce risk.

Ligature points were present on all wards, however risk had been minimised by observation. All wards had access to

ligature cutters, which are equipment used to release a ligature quickly to prevent strangling. Ligature cutters were stored in clinic rooms and at various places on the ward which were accessible to staff quickly in an emergency. Staff could access more than one set of ligature cutters at the same time when needed. For example, where more than one patient ligatured at the same time or if one pair of ligature cutters had broken or failed to work.

The seclusion facility was clean and fit for purpose. Prior to our inspection, four seclusion suites had been decommissioned and there was now only one seclusion suite in use at the hospital. The seclusion room was situated on Haven ward, and had recently been refurbished to ensure it was compliant with the Mental Health Act code of practice. We found that this was the case; the seclusion room had a separate bathroom area with a door that could be operated by staff from outside the room if necessary. It had an intercom which allowed staff and patients to communicate, a window with a blind operated by staff so that patients had access to light and fresh air, a clock which could be seen by the patient, appropriately safe pillows and blankets and mirrors in the bathroom and main seclusion area. Mirrors allowed staff to have a clear line of sight of patients. The provider had fitted equipment to ensure there were no blind spots in the seclusion room, to ensure staff could see patients at all times. There were appropriate temperature controls in place. However, one patient we spoke to told us that they had experienced the seclusion room to be cold.

The hospital had plans to refurbish the seclusion facilities on the child and adolescent acute ward, Peak View. The refurbishment plan was to change these into a visitors room and a de-escalation area. This refurbishment was due to start in December 2015 but this was rescheduled to February 2016. At the time of our inspection this work had not been started. The hospital did not use these seclusion facilities.

Bedrooms on child and adolescent mental health ward had en suite bathrooms. Haven and Peak View wards did not have female only day rooms. However, none of the patients that we spoke we raised concerns to use about not having access to female only day room facilities. Although this was not confirmed in writing in patient records.

Clinic rooms were present on all wards. The hospital also had a physical health clinic which was situated inside the main building of the hospital.

During our inspection, we looked at all clinic rooms. All clinic rooms had grab bags which contained emergency equipment. This meant the equipment was easily accessible when it was needed. Staff completed regular checks of these to ensure emergency equipment was in date, and in working order. Medicines were stored appropriately in locked cupboards. There was a process in place to ensure that medicines which were no longer needed could be returned to the pharmacy safely.

Staff checked temperatures of both the clinic rooms and the clinic fridges daily. We reviewed these temperatures over one month and found temperatures on Haven ward often exceeded the safe temperature levels for the storage of medicines. Over 28 days in June 2016, the temperature in one clinic room was over 25 degrees celsius on five days and in the other clinic room on three days. We also found that fridge temperatures exceeded eight degrees celsius on five days in one clinic room and one day in the other clinic room. We found that staff had used a fan in one clinic room to attempt to reduce the temperature. In the other clinic room an air conditioning unit was in place. We saw that this was not switched on at the time of the inspection. The actions taken by staff were ineffective in ensuring that temperatures remained within the recommended range. When medicines are not stored at the correct temperature, they may become less effective and this poses a risk to patients. On Haven ward, we also found injecting equipment which was out of date. During our inspection we raised these concerns and the registered manager ensured that out of date equipment was disposed of immediately.

Prior to our inspection we were notified by the provider that two patients on Haven ward had tested positive for methicillin-resistant staphylococcus aureus infections. This is a type of bacteria that is resistant to a number of widely used antibiotics. This is more commonly known as MRSA.

During our inspection, we were informed by the hospital manager that a member of staff from the same ward had also tested positive for methicillin-resistant staphylococcus aureus infection. This member of staff was removed from the hospital temporarily to prevent the further spread of infection. We spoke to the registered manager and they told us that the affected ward had been deep-cleaned and treatment was provided to the patients infected.

We spoke with the Clinical Commissioning Group responsible for Cygnet Hospital Sheffield and they advised

that two of the three cases had been found in open skin wounds and all three cases were the same strain. This meant it was likely to have been passed from one person to another. This suggested that the infection control procedures followed by staff were not effective in preventing the transmission of methicillin-resistant staphylococcus aureus infection.

Cygnet Sheffield Hospital had infection control policies and procedures in place which we reviewed during the inspection. The provider had an infection control manual, infection prevention and control policy and a methicillin-resistant staphylococcus aureus eradication protocol in place. The hospital provided information for staff about infectious diseases, minimising the spread of infections, and basic hygiene. This handbook also provided staff with instructions on how to manage methicillin-resistant staphylococcus aureus on wards, and covered standard infection control procedures, including the importance of good hand hygiene. The infection control manual also included a section relating to the decontamination of reusable medical equipment. However, when we asked the hospital manager about this we were informed that the ward had been deep cleaned but the medical equipment had not been decontaminated. This meant that there continued to be a risk that infection could spread. The Health and Social Care Act 2008 code of practice on the prevention and control of infections states that all providers should have policies and adhere to them in respect of the prevention and control of infections. The code also states that where people are at risk of or have developed infection they should receive appropriate and timely treatment to prevent further risk of transmitting the infection to other people. We found that the provider's policies and procedures outlined good infection control practices. However, this was not always followed by the hospital staff.

All clinic rooms had handwashing facilities and there was a good supply of hand sanitisers located throughout the hospital which were available for staff, patients and visitors to use. On Haven ward, we observed throughout our inspection that staff did not consistently wash their hands or use hand sanitisers that were available for use. This included when entering and leaving the ward area. This meant that patients were at risk from infection because staff were not following procedures. The registered manager told us that a bare below the elbows procedure was in place on the ward affected. This meant that anyone entering the ward must remove watches, jewellery, and clothing should be rolled up above the elbow to reduce the transfer of infection and cross contamination. However, during our inspection we saw hospital staff on the ward wearing jewellery, false nails and nail varnish.

At the time of our inspection, one of the patients infected with methicillin-resistant staphylococcus aureus had been discharged from the hospital and the staff member had been prevented from working until they were clear of the infection. The hospital had a methicillin-resistant staphylococcus aureus eradication protocol in place for one patient who remained on the ward. This gave information to staff on how to manage medication prescribed for the infection and how to reduce the risk of the infection spreading. However, this protocol was not being followed because the patient had been prescribed Chlorhexidine shampoo but this was never used as it was unavailable from the pharmacy and no alternative was given. This meant that the full treatment prescribed had not been completed so there was an increased risk that the methicillin-resistant staphylococcus aureus infection had not been effectively treated.

The child and adolescent wards were generally tidy. However, in one patient bedroom; there was a significant amount of dust and dirt on the floor. The hospital employed cleaning staff who cleaned these wards daily. We saw there was a cleaning rota in place. However, this was not detailed so it was difficult to see which areas were cleaned and how frequently. Furniture and furnishings throughout the two wards were well maintained and in generally good condition. However, we saw damage to areas on Haven ward, for example were patients had damaged walls and removed screws from electrical sockets. The registered manager told us that work would be carried out to repair damage and replace items however; the timescale was not clear because this was dependent on the ward being settled so that work could be completed. This meant that the environment appeared worn.

The wards had a room which was used by doctors and nursing staff to conduct personal searches with patients. We noticed there was a strong odour of urine in the room. We raised our concerns with the registered manager and they advised us that that the room had been converted previously from being a toilet washroom. The registered

manager was aware of the odour and had reported this to maintenance. At the time of our inspection this room was being used by the hospital. We felt that this room was not suitable for use due to the odour.

All staff carried mobile personal alarms whilst in the hospital grounds and on the wards to request assistance if needed. Throughout our inspection we saw that staff used these to request assistance from their colleagues and staff responded quickly to hearing the alarm sound.

Safe staffing

We reviewed information in relation to staffing across child and adolescent wards. Both wards had a full-time ward manager in post. Wards had minimum staffing levels for day shifts and night shifts. Ward managers calculated minimum staffing levels using a matrix which corresponded to the amount of patients on the ward and the levels of staffing required. At the time of our inspection the staffing levels were as follows:

Day shift staffing

- Peak View, an acute child and adolescent ward –– two qualified staff and five support staff
- Haven, a child and adolescent psychiatric intensive care unit –– three qualified staff and seven support staff

Night shift staffing

- Peak View, an acute child and adolescent ward Acute child and adolescent ward – two qualified staff and five support staff
- Haven, a child and adolescent psychiatric intensive care unit– two qualified staff and seven support staff.

The hospital had a high vacancy rate for qualified nurses across both child and adolescent wards. Information provided by Cygnet Hospital Sheffield showed that as of 31 March 2016 that there were 16 whole time equivalent vacancies, which was 68% of the qualified nurse establishment. There were 12 whole time equivalent nursing assistant vacancies, which was a vacancy rate of 34% for nursing assistants. The hospital also had a high staff turnover rate of 55% in the 12 months prior to 31 March 2016. Due to the high level of vacancies, we reviewed the ward rotas for June, July and August 2016 and found the wards adjusted staffing numbers when required, in order to meet the needs of the patients. For example, on 08 June 2016, Haven ward required up to 19 staff to meet the individual needs of patients that required one to one observation at night time.

When the hospital did not have not enough permanent staff to meet the needs of the wards, it brought in agency and bank staff to cover the shifts required. The hospital had a resource assistant that co-ordinated staff cover for all wards. Wherever possible the provider used regular agency staff. Information from the provider showed that bank and agency staff had filled 6819 shifts across all wards in the period from January 2016 to June 2016. Between 01 January 2016 and 31 March 2016, there were 38 shifts not filled by bank or agency staff. This meant that at these times, shifts were not fully staffed, increasing the risk of harm to patients and of their needs not being met.

Sickness rates were low. Information from the provider showed that in the 12 months leading up to our inspection the sickness rates were as follows: Haven 2% and Peak View 1%. The national average sickness rate is 5%.

Both wards had staff present in communal areas during our inspection. All patients told us who their named nurse was and could spend time with them. During our inspection, we observed that patients had section 17 leave from the ward escorted and unescorted leave depending on the individual patient risk. This is the leave offered to patients by their doctor when they are detained under the Mental Health Act. Between 20 January 2016 and 27 June 2016 there was one occasion where section 17 leave was cancelled. This related to Haven ward and the reason for cancelled leave was reported as suspended due to risk factors. There was enough staff to carry out physical interventions such as, restraint, when needed. Staff told us that when there were multiple incidents occurring at the same time that they could ask for additional support from the other child and adolescent ward. Staff told us that this was mainly in an emergency or urgent situation and was more likely that Haven ward required support from Peak View until additional staff could be in place.

There was adequate medical cover day and night. The Royal College of Psychiatrists' national service standards, as outlined in 'quality network for inpatient child and adolescent mental health services', states there should be a minimum of one consultant for every 12 patients. Peak View ward provided care and treatment for up to 15 patients. This slightly exceeded the recommended patient

to consultant ratio. The hospital had an on call doctor on evenings and weekends. In addition, a hospital manager was on call out of hours should staff need to seek advice or support.

The hospital had mandatory training requirements for all staff. The provider expected staff to complete refresher training for all mandatory training courses annually. We reviewed staff training records and found that the following mandatory training compliance was below the provider's target of 85%, and some areas of training were below 75%. These were:

- Haven ward: immediate life support 43%, child and adolescent mental health 52%, information governance 61%, security 70%, management of actual or potential aggression 74%
- Peak View ward: child and adolescent mental health 50%,immediate life support 56%, information governance 63%

Compliance rates for training in immediate life support showed this was not up to date on both child and adolescent wards. This caused risk to patients; because techniques such as restraint, seclusion and rapid tranquilisation were being used on the ward. The National Institute for Health and Care Excellence guideline NG10 Guidance on violence and aggression: short-term management in health and community settings outlines that health and social care providers must provide staff trained in immediate life support and a doctor trained in resuscitation equipment should be available immediately available to attend in an emergency if restrictive interventions might be used.

Assessing and managing risk to patients and staff

We reviewed information sent to us by the provider relating to the management of violence and aggression. This information related to six month period between 1 October 2015 and 31 March 2016. The amount of incidents of seclusion recorded were as follows:

- Child and adolescent psychiatric intensive care unit – Haven- eight
- Acute child and adolescent ward – Peak View - two

At the time of our inspection, Haven ward was the only ward that used the seclusion suite which was situated near to the ward. The seclusion facilities for Peak View had been decommissioned at the time of our inspection and was not in use. Episodes of seclusion for Peak View ward relate to when the seclusion suite was in use previously.

Information the provider shared with CQC reported that the number of long term segregation of patients was 22 across child and adolescent wards. There were two incidents of long term segregation reported on Haven Ward and 20 on Peak View ward. Long term segregation is where a patient is prevented from being able to mix freely with other patients on the ward. This was usually decided by a multidisciplinary team to minimise the risk from the patient segregated.

We reviewed information relating to the number of incidents of restraint being used. The amount of physical interventions involving restraint was highest on child and adolescent wards. Between the 01 January 2016 and 11 July 2016, the provider reported that on child and adolescent wards there were 306 incidents of restraint on Haven ward, of these 57 incidents were in the prone position. Prone restraint involves holding an individual chest down whether the individual places themselves in this position or not, resistive or not and whether face down or to the side. It includes being placed face down on a mattress whilst in holds; administration of depot whilst in holds prone, and being placed prone onto any surface. Guidance within the Mental Health Act code of practice 2015 states that there must be no planned or intentional restraint in the prone position unless there are cogent reasons for doing so. For the same period on Peak View child and adolescent ward there were 228 incidents of restraint and of these 44 were in the prone position. During our inspection, staff told us that they initially try to use de-escalation techniques to diffuse incidents before using physical techniques. Three patients told us that they did not like to be restrained in their bedrooms on the ward.

Staff told us that the information relating to the use of prone restraint was inaccurate. They said that this was because the electronic incident reporting system us did not allow for the accurate recording of some approved physical interventions. For example, staff told us that they could not record when a patient was laid on their side and therefore staff may have recorded these incidents as prone restraint. The Mental Health Act code of practice states that where physical restraint is used that staff should record details

about how the intervention was implemented and the patient's response. This meant that the system in place resulted in records not being compliant with the requirements of the Mental Health Act code of practice.

We reviewed 11 patient care and treatment records from child and adolescent wards. All patients had an up to date risk assessment and risk management plan. Staff reviewed these regularly. The provider used a recognised risk assessment tool. This was the Salford tool for assessment of risk. Staff involved all patients in the writing of their risk assessments and management plans. We saw that staff encouraged all patients to identify their own risks and worked with staff to formulate a management plan which was appropriate to their needs.

Both wards had blanket restrictions in place. A blanket restriction is defined by the Mental Health Act code of practice as a rule or policy which restricts a patient's liberty or rights which is applied to all patients routinely, or to classes of patients, or within a service without individual risk assessments to justify their application. On Haven ward, patients were not able to use mobile phones and if they wished to make a call they had to use one of the phones that belonged to the hospital. On Peak View ward, under staff supervision patients were allowed to use their own mobile for a designated amount of time. This was not individually risk assessed.

We also found that patients on both child and adolescent wards were required to open their post, both internal and external to the hospital, in front of members of staff. We asked staff what would happen if patients refused to do this, and were told the post would be withheld until a discussion with the multidisciplinary team could be held. We asked the provider for a copy of the policy which contained information relevant to communication. The provider sent us their policy named information for detained patients which had a section entitled 'correspondence'. The policy states that 'post sent to or by an informal patient cannot be withheld', the policy also states that 'post sent to a detained patient may not be read or withheld.' We were not provided with anything which explained or justified the reasoning behind post being opened in front of staff. We did not find any individual risk assessments in relation to patients' post.

None of the wards allowed potentially hazardous items including razors, glass and phone charges. Staff held these items on the ward. Patients had an individual risk assessment to identify the risk of self-harm. Patients could access restricted items under the supervision of staff.

Informal patients on child and adolescent wards could access a pass to leave the ward which opened doors to enable them to enter and exit the ward. We spoke to staff during our inspection and they told us that they discussed access to and from the ward for informal patients on an individual basis. We were informed that this was because some patients on the ward had been as young as 10 years old and did not know the local area. In this case, work was completed with patients' families and carers who had parental responsibility.

Training in breakaway techniques and the management of potential and actual aggression was a mandatory staff training requirement. This training is aimed at preparing staff with the knowledge and skills required to safely de-escalate and if needed complete physical interventions to manage actual and potential aggression to reduce risk to patients and staff. We found that breakaway training was not up to date on Haven was which was at 74%.

Staff did not always complete consistently the monitoring of physical health after rapid tranquilisation administration. We reviewed the use of rapid tranquilisation in line with best practice guidance. Rapid tranquillisation is the name given for when medicines that are given to quickly calm someone who is very agitated or displaying aggressive behaviour and reduce the risk of harm to self or others. The National Institute for Health and Care Excellence (NG10) Violence and aggression: short term management in mental health, health and community settings provides guidance on administration of rapid tranquilisation. It recommends that following administering rapid tranquilisation that physical health checks are completed to monitor patients until there are no concerns about physical health status.

We reviewed the records of patients who had been administered rapid tranquilisation. We found staff completed a rapid tranquilisation physical health recording sheet for each time it was used on a patient. Staff used this to record things like blood pressure, pulse, and respiration rate and oxygen saturation levels. The monitoring forms gave staff instructions on how long they should monitor the patient. We looked at 12 rapid tranquilisation monitoring

forms and found that in four of the records the physical health monitoring had not been completed as frequently or for as long as the hospital policy stated. We also found that records had not been fully completed or signed by nurses. On one record we found that the patient was recorded as alert, whilst the seclusion record for the same time showed the patient was asleep. This meant that patients were at risk of the signs of becoming deeply sedated and a loss of consciousness may not have been identified. In addition, staff training was not up to date for immediate life support. This meant that in the event of an emergency staff may not be able to perform actions needed to preserve life.

We also reviewed the use of rapid tranquilisation against the legal requirements outlined in the Mental Health Act code of practice. The Mental Health Act code of practice states that under section 62 of the act that treatment can be authorised to be given in an emergency where specific criteria are met. In this case the Mental Health Act code of practice states that a section 62 certificate should be issued and stored with the patient's notes and a copy with the patient's medication administration records. During our inspection we found that one patient had been administered one dose of medicine as rapid tranquilisation where we could not find evidence that this had been authorised under an emergency section 62 of the Mental Health Act. We reviewed this patient's care and treatment records and these indicated that a section 62 had been used to authorise the administration, however, we were not able to find the section 62 in the patient's file. We asked the hospital manager, ward staff and staff from the Mental Health Act office if they could produce this for us; however, we were told there was no section 62 in place. This practice did not follow the Mental Health Act and Mental Health Act code of practice.

Staff used seclusion when necessary. However, the use of seclusion was not always in line with best practice guidance. During our inspection we reviewed six seclusion records and spoke with four patients who had previously been secluded. Records showed that four episodes of seclusion had continued for longer than was necessary. For example, one record reviewed showed one patient who was placed in seclusion was recorded as being calm at 9.00pm but the episode of seclusion was not terminated until 2.15am. Another patient was kept in seclusion after being recorded as 'calm and communicating well', the seclusion record documented that the patient was kept in seclusion to allow the patient time to acknowledge behaviours and the impact on others. The same patient had a record following another period of seclusion, which stated, 'facilitating reflection on these incidents and helping develop extensive coping strategies'. The Mental Health Act code of practice states that: 'seclusion should immediately end when it is not warranted'. Holding patients in seclusion for longer than is warranted is against the principles of the Mental Health Act and code of practice and can infringe the human rights of patients. We saw that two seclusion records contained punitive language around the use of seclusion. This practice did not comply with the code of practice which states that seclusion should not be used as a punishment or a threat and should not be part of a treatment programme.

All staff received training in safeguarding as part of their mandatory training. Staff demonstrated that they had a good knowledge of safeguarding procedures to follow and showed a clear understanding of what would constitute a safeguarding concern. Staff knew how to report a safeguarding concern and records showed this was completed in a timely manner. The hospital had a social worker who was the safeguarding lead. Regular meetings took place to discuss safeguarding and the hospital manager attended these. Between the 12 April 2015 and 11 April 2016, there were 18 safeguarding concerns reported to CQC by the provider.

The hospital had a service level agreement in place with a pharmacy. This involved a pharmacist who attended the wards each week to carry out an audit of medicines held in stock and to ensure the stock held was correct. Any discrepancies or concerns were fed back to the hospital and ward managers.

Medication charts had photographs of patients to allow staff to make a clear identification prior to the administration of medication. Provision had been made on low secure wards to allow patients to self-medicate. This was discussed at multi-disciplinary team meetings and was based on individual needs and risk.

Staff administered prescribed medication to patients on Haven ward through a hatch. This meant that patients would not be able to speak privately with staff if they had questions about their medication. In addition, staff had a restricted view of patients through the hatch, meaning they could not be certain that medication had been taken by patients. During our inspection, we observed that on Haven ward, patients used the hatch to talk to staff in the clinic

room. We observed patients knocking on the hatch to gain staff attention and we observed staff discussing medical matters with patients through the hatch. This did not promote patient dignity.

Medicines were securely stored and nurses regularly checked the emergency medicines to ensure they were available, if needed. Discretionary medicines kept for treatment of minor ailments. The hospital had implemented a revised policy for the preparation and supply of leave medicines to help ensure that these could be safely and promptly provided.

Patients generally attended their ward rounds and medicines were discussed. However, pharmacist advice was not sought and documented when developing individualised pharmacological strategies for the short-term management of violence or aggression as advised by guidance from the National Institute of Health and Care Excellence (NG10) Violence and aggression: short-term management in mental health, health and community settings May 2015. When one patient had been administered rapid tranquilisation. We saw that post incident, the psychiatrist worked with the patient to identify what led to the incident and what could have been done differently. This followed best practice guidance issued by the National Institute for Health and Care Excellence.

Wards held an up to date children's version of the British National Formulary. The British National Formulary is a reference book on medication. We were told by staff that a representative from the pharmacy service the hospital used attended the hospital every week and carried out audits in relation to compliance with the Mental Health Act, administration errors, patient details, prescription writing and clinic room audit. The pharmacist reported back to ward and hospital managers on his findings. We saw evidence of these reports and also the quarterly reports sent from the pharmacist in relation to the findings.

The hospital facilitated patient visits for child and adolescent wards on the ward on Peak View and for patients on Haven ward a visiting room was used off the ward.

Track record on safety

Between 12 April 2015 and 11 April 2016, the hospital reported 84 incidents to the Care Quality Commission of these are as follows:

- Abuse or allegation - 13
- Serious injury - 44
- Police incident - 27

The recurrent themes reported by the provider were in relation to: self-harm, incidents with the police, hospitalisation and discharge of patients, and patient on patient alleged abuse.

Reporting incidents and learning from when things go wrong

The hospital had an electronic incident reporting system which all staff had access to. All staff told us how they identified incidents that required reporting and how they would access the electronic reporting system to do this.

Patients on child and adolescent wards shared with us mixed views about staff support following incidents. Most patients told us that staff acted appropriately and they felt supported them following incidents. These patients told us that staff completed debriefs following incidents which involved them and an understanding what happened leading up to the incident. Whereas, other patients reported that they did not feel that staff responded well to incidents involving self-harm.

Debriefs were not always possible immediately after incidents on child and adolescent wards. This was due to staff support being required on the ward. We also found an incident record which evidenced that following an incident, no debrief was held as there were not enough staff on shift to support this. However, each week a reflective practice session was led by a psychologist that supported staff in their roles and was an opportunity for staff to discuss incidents.

Staff discussed incidents at handover and professional meetings. Teams had a handover when the shift changed over to pass on information to the team starting their shift. Staff told us they could use this time to discuss any concerns they had following incidents.

Wards submitted monthly data in relation to seclusion, restraint and rapid tranquilisation. This information was analysed and used to determine if there were any trends or if intervention strategies were working effectively.

The hospital manager told us that there was a process in place which helped to review incidents. This involved the completion of a 24 hour report and 72 hour report into the

Requires improvement

Child and adolescent mental health wards

events leading up to the incident. The hospital also used root cause analysis investigations in order to learn from incidents and this was fed into either individual action plans or an overarching local action plan.

Staff that we spoke with gave us examples of incidents where changes to practice had been made as a result of incidents and lessons had been learned. An example, of this was where a patient had been involved in an incident. Following this there had been changes implemented to assessing risk at a multidisciplinary level and different factors were now being considered when planning leave. Examples given of this included: where the location of the section 17 leave will be, considering if there was a location that was safer and which staff are most appropriate to support escorted leave to minimise the risk of incidents occurring.

Staff reported that they felt supported by their managers and could access additional support after incidents if needed.

Are child and adolescent mental health wards effective?

(for example, treatment is effective)

Requires improvement

Assessment of needs and planning of care

We reviewed 11 patient care and treatment records. We found that all records had a comprehensive assessment of need. There was information in patient records, which had identified patients' physical and mental health conditions and diagnoses. Individual patient assessments identified patient support needs such as, any tasks that they required assistance to complete. Assessments contained information about patients' background and family and carers details.

Records showed that on admission to the hospital a physical health assessment was completed. Of the 11 records that we reviewed there was one patient that did not have information about physical health assessment on admission in their records.

Care records contained up to date and personalised and recovery-orientated care plans. We found that almost all care plans were up to date and had been regularly reviewed since admission. There were two records that had not been regularly reviewed since admission. Patients had numerous care plans which related to different aspect of their individual needs and what support patients required from staff. Most patients had care plans in place for mental health and physical health. For example we saw care plans in place for patients who had physical health conditions such as, asthma and diabetes. These care plans helped ensure that staff were aware of patients' conditions and how they may affect them.

All the care records we looked at contained positive behaviour support plans. Positive behavioural support plans are aimed at providing information to staff about techniques and ways to support an individual to de-escalate and diffuse situations before an incident occurs. We found that positive behaviour support plans only referenced how staff should respond to behaviour disturbances and not how to prevent and de-escalate situations.

The hospital used both electronic and paper based care records. An electronic patient records system was in place. However, patients also had paper files on the wards which also contained information relating to their care and treatment. We found that there were some discrepancies between paper and electronic notes, details of incidents were not always added to risk management plans and staff did not appear to have had sufficient training on the electronic system to allow them to use it effectively. We observed that ward staff could not easily find information on the patient electronic record system. There was not a clear contemporaneous record of patients' care and treatment that staff could easily refer to. Staff would need to look in both the patient's paper file and on the electronic patient record system to ensure that they were referring to the most recent up to date information. This would increase the risk to patients as staff not familiar with the ward would not be able to access important information about patients quickly, for example, agency staff.

Best practice in treatment and care

The hospital offered psychological therapies recognised by the National Institute for Health and Care Excellence which included dialectical behavioural therapy and cognitive behavioural therapy. During our inspection we saw that patients accessed individual one to one sessions with the psychologists.

Requires improvement

Child and adolescent mental health wards

Patients had access to education delivered by a teaching department. A full educational curriculum was available. We saw that teaching staff engaged with patients in a creative way to deliver education and promote patient engagement. Subjects taught included mathematics, science, English and art. At the time of our inspection, the hospital had completed an application to the Department of Education to be registered as an independent school.

The service had a dedicated physical health care team that carried out assessments of patients when they were admitted to the service and manged their physical health monitoring. The physical health team comprised of one qualified nurse and one physical health support worker. The previous physical health care nurse left the service in February 2016 and at the time of our inspection the new physical health nurse had recently started working at the hospital. Well-being groups had stopped when the previous nurse had left the hospital. However, staff told us that the hospital had plans to start these groups again.

A GP visited the hospital each week to look after patient's physical health needs. However, the results of physical health monitoring were not consistently inputted into patients review documentation. The medical director had spoken with the GP about this and was taking action to address this. A nurse had been recently appointed to lead physical health monitoring in the hospital.

The physical health care team carried out blood tests and electrocardiograms as part of the regular monitoring for some medications, carried out physical health assessments for new patients and were starting to provide smoking cessation help for patients. The team arranged GP appointments for patients and carried out blood testing in order to monitor the effects of medications like lithium and clozapine, as well as ensuring annual health checks were completed.

The hospital had a physical health policy that included the Lester tool. NHS England in partnership with NHS Improving Quality, Public Health England and the National Audit for Schizophrenia devised the Lester Tool to improve physical health monitoring for patients with serious mental illness. However, staff responsible for physical health care told us that they were unaware of the Lester tool and its use.

Staff told us that in the past kitchen staff and members of the physical health team met to discuss meals and healthy eating.

All wards used recognised scales to assess and record severity and outcomes. On child and adolescent wards the child and adolescent version of the Health of the Nation Outcome Scale was used to measure treatment effectiveness and outcomes for patients. The Health of the Nation Outcome scale is a measure to assess the health and social functioning of people with severe mental illnesses. The scale is usually completed to measure the progress of treatment and outcomes for people receiving mental health care and treatment. Staff at the hospital used rating scales to assess and record the severity of patient illness and to monitor patient outcomes through their treatment.

The hospital also used the Outcome Star to measure patient outcomes. The Outcome Star is a recognised outcome measure which was developed based on the principles of the Mental Health Recovery Star model. The Mental Health Recovery Star model considers mental health recovery to be holistic and related to all aspects of an individual's life.

We found that some clinical audits were completed. However, these did not always ensure that issues were identified or addressed. Staff completed audits of clinic room equipment and audits of Mental Health Act documentation. However, these did not always identify issues. During our inspection we found one occasion where a patient record did not contain valid consent or authorisation from a second opinion appointed doctor and one record where treatment had been given under section 62 of the Mental Health Act without a valid certificate. In one clinic room we found out of date injecting equipment. A physical health audit should have been carried out monthly however this had not been completed since January 2016 due to the absences within the physical health team. The hospital plans to re-introduce this audit now that a team is in place. The pharmacist who visited the wards also completed audits.

Skilled staff to deliver care

The hospital had a range of mental health disciplines and workers to provide input to the wards. The multidisciplinary team included: consultant psychiatrists, psychologists, occupational therapist lead, occupational

therapist assistants, social work lead, nurses and support workers. Each week a pharmacist visited the hospital and provided information, advice and audits. In addition, the hospital had an educational department with three teachers to provide education to children and young people.

Staff told us that they had received most training available to help them carry out their roles and felt that they had the knowledge and skills to assist patients. However, staff told us they had not received specific training in relation to eating disorders. We saw that some patients had displayed difficulties with the intake of balanced diets. Staff training in this area may have increased the effectiveness of care and treatment of these patients.

Not all staff received regular supervision. On Haven ward only 77% of staff received regular supervision. Staff we spoke with confirmed they did have supervisions and appraisals but the frequency reported varied between staff members and wards. The supervision policy which was in use was from the previous provider and stated that staff should receive supervision every two to three months.

All wards had regular team meetings. Staff had access to team meetings however, staff attendance was dependent on staff cover for the wards.

Multi-disciplinary and inter-agency team work

Regular and effective multiagency meetings took place at the hospital. The minutes of staff team meetings showed that there was representation of the full multidisciplinary team. We observed that all members of the multidisciplinary team contributed in discussions at meetings. Staff told us that they use meetings as an opportunity to seek help, advice and support from their colleagues. We were also informed that these meetings were used to share experiences and knowledge which included lessons learned and reflection of incidents.

The hospital provided regular reflective practice group sessions. These provided permanent staff with the opportunity to gain support and knowledge when they had experienced any challenging clinical situations. Staff we spoke gave use positive feedback about these sessions and told us they helped them to manage working in a challenging environment.

During our inspection we attended care programme approach meetings. We observed that multi-agencies attended meetings regarding patient care, treatment and discharge. We saw that representatives who attended meetings at the hospital included local authority social work teams, education, NHS England, community mental health services for children and adolescents, ward managers, psychologists, social workers, consultant psychiatrists and senior hospital managers.

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

During our inspection, we reviewed Mental Health Act documentation. Of the records that we reviewed we found that some records did not comply with the requirements of the Mental Health Act. The Mental Health Act sets out the requirements around consent to treatment. For patients detained under the Mental Health Act treatment can be given without consent for the first three months from the start date of medication treatment for mental disorder. After three months, medication treatment must only be given with the patient's consent or where the patient cannot or does not consent to treatment with the approval of a second opinion appointed doctor unless there is an emergency reason. Second opinion appointed doctors are appointed by the Care Quality Commission to ensure that patients' rights are upheld under the Mental Health Act and the treatment offered is clinically defensible and has balanced the rights and views of the patient. Consent to treatment certificates must be stored in patient files and with patients' medication records. A T2 certificate must be in place where a patient has given informed consent to their treatment and a T3 certificate must be in place where a patient is unable or has refused to consent to treatment.

We found that on Haven ward that one patient had been treated under the Mental Health Act without their consent or authorisation by a second opinion appointed doctor. We reviewed this patient's care and treatment records and found that it was recorded that the patient had told the responsible clinician that they did not consent to treatment on two separate occasions. One of these recordings was dated during March 2016. We saw consent to treatment form that said the patient did not consent to treatment was with their medication records. At the time of our inspection there had been no request for a second opinion appointed doctor. We raised this with the registered manager and the medical director and they was acted upon immediately.

In another patient record we found that the information contained on the consent to treatment form had been

completed by the previous responsible clinician. This should have been recompleted by the new responsible clinician. Whilst reviewing another patient record, we found that a consent to treatment form did not contain specific information relating to 'as and when required' medications and did not show any information relating to a discussion with the patient. In order for a patient to give informed consent to treatment there should be a record of the discussion that shows that the patient has consented to specified treatment and not any or all treatment that is offered by the hospital. Information should be provided to ensure that patients were aware of any potential side effects or risks of medication treatments when giving their consent. In this case, we could not see from the record how medication treatment had been discussed with the patient and of any specific treatment that the patient had given consent to. During our inspection we raised this with the medical director. This was removed from this patient's medication chart immediately.

Documentation relating to treatment administered in an urgent and emergency situation was not always present. We reviewed records relating to rapid tranquilisation and found that one record did not have a section 62 certificate present. The Mental Health Act outlines that treatment can be administered to patients under specific circumstances. In this case a section 62 certificate must be completed and kept within the patient's records. We found that on one occasion medication was administered to a patient in the form of rapid tranquilisation. We could not find a section 62 certificate in relation to this medication being administered. During our inspection, we asked hospital staff and they could not produce a section 62 certificate in relation to this medication that staff had administered. This was in relation to the patient where treatment had been given without valid approval from a second opinion appointed doctor or patient consent.

Detained patients did not always have their rights explained to them at as soon as practicable after their dention under the Mental Health Act. The Mental Health Act and Mental Health Act code of practice states that people that are subject to the Act should have their rights explained at as soon as practicable after their detention. We reviewed the records of eight patients detained under the Mental Health Act on the child and adolescent wards. We saw that there was a delay to patients' rights being explained for six patients. We saw no evidence of rights being explained to the other two patients. Not all patients would have been aware of their rights under the Mental Health Act and where patients' rights had been delayed this could have impacted negatively. For example, in understanding their rights to apply for a mental health tribunal or managers hearing and understanding their entitlement to legal representation as outlined in the Mental Health Act code of practice.

There were arrangements to monitor the adherence of the Mental Health Act within the hospital. However, these were not always effective at ensuring the Mental Health Act requirements were adhered to. The hospital had a Mental Health Act team that were responsible for the auditing and reviewing of the application of the Act across the hospital. We saw the team carried out regular audits to check the correct Mental Health Act documentation was in place and up to date for the wards. The team sent reminders to staff in the hospital when they had identified actions that needed to be taken. However, we found this system did not ensure that the Mental Health Act was adhered to. Staff told us that despite requesting documentation and information from doctors that they did not always receive this.

Mental Health Act training was a mandatory training course for all staff. Information provided by the provider stated that 86% had received training in the Mental Health Act. We spoke to staff members during our inspection and found that they had a variable understanding of the Mental Health Act and the Mental Health Act code of practice. We found that some staff had good knowledge around the Mental Health Act whereas; others had basic and limited understanding. However, all staff told us that they could speak to their colleagues and the consultant psychiatrists if they needed advice about the act.

Patients had access to Independent Mental Health Advocacy services. Staff and patients told us that patients could access Independent Mental Health Advocates. Some patients told us that advocates did not always visit the ward every week. There were two independent mental health advocacy services available to patients. One provided advocacy services to male patients and the other female patients. Advocates scheduled to visit the wards weekly. During our inspection we spoke with advocates and saw them interacting with patients Peak View child and adolescent ward.

Good practice in applying the Mental Capacity Act

Requires improvement

Child and adolescent mental health wards

The Mental Capacity Act enables people to make their own decisions wherever possible and provides a process and guidance for decision making where people are unable to make decisions for themselves. The Mental Capacity Act applies to individuals over the age of 16. Competency to make informed decisions for young people aged 16 and under is established under the rules of Gillick Competence. Training in the Mental Capacity Act was a mandatory training requirement for staff. Information sent to us by the provider showed that staff received Mental Capacity Act training as part of their induction to the hospital.

The hospital had a Deprivation of Liberty protocol in place which was reviewed annually and provides staff with guidance on whether the treatment to be carried out would amount to a deprivation of liberty. In the six month period from 01 October 2015 to 31 March 2016 the service had not made any applications under the Deprivation of Liberty Safeguards.

We reviewed the records of 11 patients and found mostly that where patients had been assessed for capacity or competency to make decisions depending on their age that there was an appropriate record of this assessment. We found that assessments related to ability to make specific decisions which is in line with the principles of Gillick competency, Mental Capacity Act and the associated code of practice.

Staff across both wards had variable knowledge about the Mental Capacity Act and the code of practice however, all staff could told us that they would speak to their colleagues, managers and consultant psychiatrists if they needed advice around the act. All staff had good knowledge around the definition of restraint and when this would be appropriate.

Are child and adolescent mental health wards caring?

Requires improvement

Kindness, dignity, respect and support

We observed staff and how they interacted with patients in the ward environments. On both wards we saw that staff treated patients with respect and kindness. We saw that that staff spent time with patients to respond to their individual needs and provided encouragement when completing tasks. Staff knew patients well and this enabled them to support patients who were displaying behaviours that challenge. During our inspection, on Haven ward, we observed an incident which required staff support and the use of physical interventions. Staff treated this patient with empathy and we saw that they spoke calmly to the patient and explained what they were doing and why to the patient. We saw that this provided reassurance to the young person involved.

We received feedback from patients using two methods. We spoke to patients on the wards and we also gained patient views on comment cards. We received mixed feedback from patients across both child and adolescent mental health wards.

We spoke with 13 patients on the child and adolescent wards and received 18 comment cards from these wards. Patients we spoke with gave us mixed feedback about staff and how they were treated. Patients told us that permanent hospital staff usually treated them well. However, three patients told us and six comment cards stated that patients did not like the way that they were treated by some agency staff who worked on the wards. Some of these patients disclosed to us that staff, provided by agencies, had made comments to them which they felt had been a threat about the use of seclusion and rapid tranquilisation. We raised these concerns with the registered manager and the hospital took immediate action to ensure the safety of patients on the ward, reported the information as a safeguarding concern and investigate the concerns raised.

Of the 18 comments cards we received eight gave positive feedback with praise for the staff and the changes that had been made to the service. This referred to patients reporting a reduction in restrictions on the wards. Ten comment cards gave negative feedback about the ward and staff. These were in relation to: perception of a poor staff response to self-harm, high use of agency staff, one comment card said that patients get no respect and another one said that the ward was 'horrible'.

Between 01 March 2015 and the 29 February 2016 the hospital received 30 complaints in relation to child and adolescent wards. Of these complaints, 13 complaints referred to staff attitudes, the way staff spoke to the patient, comments made by staff, treatment patients received from staff and the ward or staff reaction to

self-injurious incidents. The provider reported that 14 of these complaints were upheld, four of these complaints were partially upheld and three were withdrawn by the complainant.

The involvement of people in the care they receive

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Patients told us that when they were first admitted to the ward staff orientated them to their surroundings and they were provided with information about the service. Staff on child and adolescent wards told us that they wanted to produce some information for families and carers about the wards so that families and could see where the child or young person was staying whilst they were in the hospital.

We reviewed 11 care and treatment records. We found that nine out of 11 showed that patients had been involved in the development of their care plans and that their views had been captured. Patients told us they had a named nurse who had written their care plans. Patients also told us that they had been involved with the completion of risk management plans. Risk assessments and management plans were formulated in a way that allowed patients to take positive risks in order to maximise patient independence. Staff that we spoke with explained that when patients had asked to do an activity or a task they work with the patient and ask the patient to explain how it can be achieved in a safe way. This showed how staff involved patients in their care. We also observed that one patient on Haven ward had information printed about his mental health diagnosis and treatment. This had been provided by staff for the patient to read.

Patients told us that the pharmacist who visited the wards made time to speak with them about medicines. Patients also told us they were informed about possible treatment choices and potential side effects of these, so they were able to make an informed decision about their treatment. One patient that we spoke with said that their responsible clinician was very good and provided them with leaflets relating to their medication.

Multidisciplinary meetings involved patients and their families and carers. We saw that staff invited patients to ward rounds and care programme approach meetings. These meetings reviewed patient progress in care and treatment whilst in hospital and to discuss their future care. We observed four care programme approach meetings during our inspection.

In care programme approach meetings for patients, staff discussed the young person in a sensitive and age appropriate manner. This allowed time for the young person to speak about their feelings regarding the care they had received and how they would like to progress. We saw that prior to care programme approach meetings, professionals held a meeting where they were able to have a discussion regarding the young person's care and treatment. They also discussed what the next steps were for the patient before the patient and their family and carers joined the meeting. We saw there was documentation to support meetings including details of previous meetings.

We found care records contained signed authority from patients which allowed staff to share information regarding their care or treatment. For patients on child and adolescent wards this included the sharing of information with their parents or carers. If patients refused to have information shared this was documented to ensure staff were aware.

We spoke with the parents and carers of four patients using the service. All parents and carers spoke positively about their relationship with the hospital and the care provided. Parents and carers told us that they felt supported by staff and included in information about the patient's progress.

Patient feedback and inclusion in service feedback was limited. At the time our inspection, the hospital did not involve patients in the recruitment of staff. The hospital had plans to include patients in clinical governance meetings however, at the time of our inspection this had not started. Each ward had community meetings. Depending on which ward the level of patient participation varied according to patients' mental health needs. Patients' could give their feedback on the service, raise concerns and discuss issues that were relevant to them.

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

Requires improvement

Access and discharge

Requires improvement

Child and adolescent mental health wards

Over a six month period all wards had an occupancy rate of 85% or above. The average bed occupancy over the six month period between October 2015 and 31 March 2016 was Haven 92% and Peak View 85%.

Cygnet Sheffield Hospital provided an acute child and adolescent ward and a psychiatric intensive care unit. Admission to the hospital was determined by patient need. As a result of limited nationwide child and adolescent inpatient beds the hospital received referrals for admission for eligible children and young people who lived locally and out of the local area.

All wards across the hospital ensured that all patients had access to a bed on return from leave.

Ward managers reviewed all referrals for the child and adolescent wards. Information was provided to the ward manager and the ward manager or another member of staff would contact the referrer to obtain further information to help them with the decision making process. Ward managers had the authority to accept or reject referrals independently.

The hospital responded to referrals quickly. The hospital could admit patients the same day as referral when needed. Staff screened referrals and where it was felt that the referral was not appropriate this was communicate to the referrer promptly for an alternative to be found. Staff told us that Friday afternoon was time they received the most referrals for admission.

During our inspection we saw that patients were moved appropriately during an admission episode. Mostly a bed was available on a psychiatric intensive care unit for child and adolescent patients on the acute ward. However, the availability would depend on the occupancy level of the psychiatric intensive care unit. Where a child or adolescent patient required a bed on a psychiatric intensive care unit the hospital would try to ensure that they were able to provide this bed. The multidisciplinary team assessed when patients on the acute child and adolescent ward required more intensive care and similarly assessed when patients on the psychiatric intensive care unit no longer needed this level of care. Patients and their families and carers were involved in these decisions. Dependent on bed availability patient care could be stepped up or stepped down by moving patients between the two child and adolescent wards when needed. During our inspection, we saw that patients transferred between the wards in both ways. For example, we saw that one patient on the psychiatric intensive care ward, Haven, had a review with the multidisciplinary team and as a result were transferred to Peak View ward which was the acute child and adolescent ward.

There were delayed discharges from both Haven and Peak View wards. During the period between 01 January 2016 and 30 June 2016 the hospital reported that there had been five delayed discharges from Haven ward and three delayed discharges from Peak View ward. The hospital reported that the reasons for delayed discharges on child and adolescent wards was lack of appropriate alternative hospital beds, placements and supported accommodation.

The facilities promote recovery, comfort, dignity and confidentiality

The hospital had a full range of rooms and equipment to support treatment and care. The hospital had a physical examination room on site. Staff told us that the examination room could be used when GPs visited patients on site. The GP could also see patients in their bedrooms. A search room was in use which did not promote comfort or dignity because it contained no equipment, no examination couch and had a strong odour.

The hospital had rooms to complete individual and group therapy sessions. There was an occupational therapy kitchen, rooms which contained computer facilities and a full educational department for children and young people to access education during their stay. A multi-faith room was available for patients to use.

All patients had access to visitors' facilities at the hospital. The hospital had visitors rooms which were located off the wards. This was equipped with comfortable furniture and a secure garden area. The room had toys for patients who had young children visit them to play with. The visitors room had toilet facilities. Peak View ward also supported visits on the ward when appropriate.

We saw that there was outside space for patients to spend time. There were outdoor activities and Peak View child and adolescent ward had some small animals which staff supported patients to care for.

All wards provided refreshments to patients which were available anytime of the day and night.

All patient bedrooms had en suite facilities. On Haven ward, we found that the hospital had removed shower curtains

and their rails. En suite doors had also been removed on this ward. Patients that we spoke to told us that they had been removed due to safety. Staff told us that these had been removed to reduce the risk of patient's using these to ligature. Some patients told us that they did not like this as there was no alternative provided to protect their dignity whilst they were bathing. However, all patients had their own bedrooms and could close their bedroom door whilst bathing. On Peak View child and adolescent mental health ward, in bedrooms the doors to en suite bathrooms had been removed. The hospital had replaced these with a curtain.

Where patients required increased observations due to risk this did not always promote privacy and dignity. Staff completed patient observations through patient bedroom doors being slightly open. This meant that when patients including of the opposite sex walked through the ward they could see into patient bedrooms. This did not promote the privacy and dignity of patients.

Patients could personalise their rooms with their own belongings. We looked at the some of the rooms of patients on child and adolescent wards and found that most patient rooms were clean and tidy. There was one patient bedroom which had dust on surfaces. This was on Haven ward.

Patients had access to ward telephones to make phone calls. Patients on Peak View ward could have access to their own smart phones for a set amount of time in a specific place on the ward. Staff told us that this time was restricted to allow all patients to have equal access as a designated space was used on the ward. Patients on psychiatric intensive care unit for children and young people had access to a ward mobile phone which they could use. In addition, phone booths were available for patients to make telephone calls on the wards.

In March 2016 the Food Standards Agency awarded the hospital food hygiene rating of five (very good). Patients we spoke with were positive about the food provided. Patients were offered choices at meal times and the provider catered for patients with special dietary requirements.

Patients on Peak View ward had their own lockers where they were able to put drinks and snacks which they had bought or been given. Patients could hold the key for their locker if this had been assessed as safe.

Patients had access to education and therapy sessions. The hospital had submitted an application to the Department for Education to be registered as an independent school. There was a timetable in place for each ward. Patient activity timetables included education sessions. Education sessions accounted for 12.25 hours of the timetable for Haven ward and 12.75 hours of the timetable for Peak View. Staff and patients told us that attendance at education sessions was variable. Patients on the Haven ward attended less education sessions than patients on Peak View ward. However, staff made efforts to encourage patients to attend. Teachers attended the ward to encourage patient engagement in education. Staff we spoke with told us that acutely unwell and unsettled patients found engagement with education difficult. Teachers sent educational work to the wards when patients did not attend education sessions.

During our inspection we did not see individualised patient therapy and activity plans. Instead, ward activity plans were in place which patients could participate in activities, therapy and education. The hospital provided us with a copy of the ward activity timetables. These included activities like cooking and baking, bingo, karaoke, computer activities, and Friday social club as well as therapeutic sessions like dialectical behavioural therapy, recovery through activity and mindfulness. Therapeutic sessions and social outings also took place on weekends across all wards. Activities available included: movies, sports, games, cooking, relaxation and walking groups. Occupational therapists and assistants co-ordinated the activity programmes.

Hospital staff organised a monthly visit for small animals to visit the hospital. Patients from the wards could see the animals and listen to information about animal care. We saw that patients engaged with this session.

Meeting the needs of all people who use the service

The hospital was accessible for people with physical disabilities who required disabled access. The hospital had lifts so that access to the wards and areas of the hospital was accessible.

The hospital had information leaflets available for patients and their families and carers with alternative formats and languages available on request. Information relating to advocacy services was displayed across the hospital. We

saw that noticeboards displayed information about making complaints and other people and services they could contact for support with complaints, rights and other areas of concern.

Information was provided in an accessible format and age appropriate information was available for children and young people on child and adolescent wards. Patients and their families or carers were also provided with additional information regarding the hospital on admission to the wards.

Patients and their families and carers who did not speak English as a first language had access to interpreter services if required. At the time of our inspection none of the patients on the wards required an interpreter. In addition, the service was able to source a British Sign Language interpreter from the provider's interpreting service if needed.

Patients and staff told us the hospital was able to cater for individual dietary needs. This included meal options which met the requirements of religious and ethnic groups. Patients had access to spiritual support. A multi faith room was available for patients to use. Patients and staff told us that they often accessed community spiritual facilities when on leave from the hospital.

Listening to and learning from concerns and complaints

In the 12 month period from 01 March 2015 to 29 February 2016, the hospital received a total of 43 complaints. Thirty of these complaints were in respect of child and adolescent wards.

We found that the hospital investigated and responded to complaints in line with the provider's policy and procedure. None of these complaints were referred to the ombudsman or the independent sector complaints and adjudication service. However, of the 30 complaints received, 14 complaints were upheld and eight were partially upheld. We saw that in most cases the complainant received a letter following the complaint being investigated. We also saw evidence of direct interactions between staff and complainant. This included the service's Chief Executive Officer and Director conducting face-to-face meetings with a patients and families.

As part of our inspection we reviewed information submitted by the provider in relation to complaints. We saw that there were complaints submitted about the following aspects of care and treatment provided:

- The way staff spoke to patients
- Treatment received from staff
- Level of satisfaction of care received
- Allegations involving staff
- Staff reaction to incidents
- Issues experienced not specified
- Restraint
- Seclusion
- Medication
- Observations
- Information governance
- Communication
- Loss of property.

All patients told us that with knew how to make a complaint. Some of the patients we spoke with told us they had made a formal complaint and had received feedback in relation to this.

Are child and adolescent mental health wards well-led?

Requires improvement

Vision and values

Cygnet Hospital Sheffield had organisational values. The values were:

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

Staff we spoke with had an awareness of the organisations values. During our inspection, we saw staff demonstrated

these values during interactions with patients. We observed a number of interactions during our visit between staff and patients. We found that most of these clearly demonstrated the provider's values.

Staff we spoke with told us they knew who the senior managers were and said that they visited the wards.

Good governance

We reviewed information in order to look at the governance of Cygnet Sheffield Hospital. The hospital was acquired by Cygnet NW limited in August 2015. Prior to this the hospital was known as Alpha Hospital Sheffield and was provided by Alpha NW limited. The hospital was operating under a mixture of Cygnet and Alpha group policies. Staff told us that the hospital was gradually rolling out Cygnet policies to replace the previous provider's policies. There was a policy roll out schedule where a few Cygnet policies would be introduced each week and Alpha policies would be removed.

The provider had a governance structure in place. Governance meetings took place each month. We reviewed minutes of meetings that took place and meetings had standing agenda items, staff recorded minutes and actions to be completed with the staff responsible. Heads of wards and departments attended these meetings. Regular agenda items included complaints, safeguarding, serious incidents, restraint and seclusion (including the use of prone restraint), service user/carer engagement and medicines management. Prior to our inspection, information sent by the provider stated that there was a plan for patient representatives to attend ward meetings. At the time of our inspection this had not been implemented.

Systems to ensure that staff received current and appropriate training and support were not effective. We found that not all staff received up to date training in mandatory training courses.

Some staff did not receive regular supervision and appraisals. Staff turnover was high at 55% on the 12 months leading up to the 31 March 2016. At the time of our inspection, the provider had a retention plan in place to try to increase staff retention. This included a strategy of actions to be completed which included support from recruitment to ongoing career developments for staff.

The hospital had a system to ensure that wards had sufficient numbers of staff. A resource assistant liaised with permanent staff and agencies to acquire the numbers of staff required to safely staff the wards.

Representatives from the hospital were part of a 'regional recovery and outcomes' group. The group had representatives from the NHS and private sector. The aim of this was to work together and have a multiagency forum for discussion and cross working. Best practice was shared with providers throughout the sector within this group.

An electronic incident reporting system was in place. However, information about incidents was not always accurate. Staff told us that the system did not enable them to record incidents accurately and as a result information relating to restraint was not always accurately recorded. Ward managers reviewed incident records. The hospital completed investigations of incidents where appropriate. Staff received feedback from incidents including safeguarding and complaints.

Audits did not ensure that the Mental Health Act was adhered to. The hospital had a Mental Health Act office. The aim of this was to complete audits to ensure that Mental Health Act documentation was present and adhered to legislation and guidance. During our inspection we found that there was Mental Health Act documentation that was missing and incorrect. We found that there was one patient treated under the Mental Health Act without valid consent and authorisation; one record had a missing section 62 certificate for rapid tranquilisation administered to one patient. We also found that a consent to treatment form had not been replaced when the previous responsible clinician left the hospital. This certificate had not been replaced by the patient's current responsible clinician.

We reviewed seven personnel files for staff who worked at the hospital. All the files we reviewed had contained evidence to show that the provider completed pre-employment checks of all staff. Staff files contained evidence of people's identity, qualifications, references, application forms and disclosure and barring service reference numbers. A disclosure and barring service check was completed for all people who apply to work with vulnerable adults or children. The check informs the employer of any criminal convictions an employee has, or any list the employee may be named on, stating that the person poses a risk to children or vulnerable adults.

Requires improvement

Child and adolescent mental health wards

The hospital had a risk register in place. This was had been reviewed up to date at the time of out inspection. We saw that the risk register was discussed within governance meetings. However, the issues that we identified around Mental Health Act documentation being incorrect or missing, out of date equipment in the clinic room had not been identified by the hospital and so were not entered on the risk register.

All managers told us that they had sufficient authority and support to enable them to complete their role. Managers could escalate concerns to be considered for the risk register.

Leadership, morale and staff engagement

All staff told us their responsibilities in reporting concerns. Staff explained their understanding of the provider's whistleblowing policy and stated they felt confident in raising a concern and that this would be addressed. Between 01 April 2015 and 11 April 2016 there were no whistleblowing case reported.

Staff morale was good. All staff reported that they enjoyed their role and spoke positively about the difference they could make in people's lives. Staff told us that they felt supported by their colleagues and managers. However, staff who worked on child and adolescent mental health wards told us that their shifts could be difficult due to the complexities of the patients that they supported and their associated needs and behaviours. Staff reported that shifts could cause them to feel increased pressure if they worked with staff from agencies that were not familiar with the ward.

The hospital had introduced a programme to support unqualified staff through nurse training. The provider had ten funded places for staff to apply for training to become qualified nurses.

Staff understood their responsibilities under the duty of candour. The policy on duty of candour in place was written by the previous provider. Staff had a varied understanding however, all staff knew that when something went wrong that they had a responsibility to be open and honest and involve the patient.

Staff told us that they had seen a positive change in the hospital since it was acquired by the Cygnet group. Staff felt that they had the opportunity to contribute their feedback into the development of the service and that this was listened to by the hospital.

Commitment to quality improvement and innovation

At the time of our inspection the service did not take part in any national quality improvement or innovation initiatives. We did not see any examples of involvement in research.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must only provide treatment under the Mental Health Act with valid consent or authorisation as outlined by the Mental Health Act and the Mental Health Act code of practice.
- The provider must ensure that detained patients are informed of their rights as soon as practicable after their detention as per section 132 of the Mental Health Act.
- The provider must ensure that seclusion is in line with the Mental Health Act code of practice. Seclusion must only be used for the time that it is warranted and should not be used as a punishment or threat and it should not form part of a treatment programme.
- The provider must ensure that it reviews and amends restrictive practices. For example, staff should uphold patients' rights to open mail in privacy and mobile phone use should not be restricted without proper assessment of risk. The Mental Health Act code of practice states that rules that infringe rights should not apply to all patients and should be determined by individual patient need. This should be identified by an individual risk assessment.
- The provider must ensure that Mental Health Act audits are effective and identify missing or incorrect documentation and these issues are addressed promptly.
- The provider must review the use of restraint in patient bedrooms and review and reduce the use of prone restraint on child and adolescent wards.
- The provider must ensure that physical health monitoring and recording is undertaken after administration of rapid tranquilisation medication.
- The provider must ensure that patients' records in relation to the positive management of behaviour contain information about de-escalation, diffusion techniques and preventative strategies
- The provider must ensure that staff are trained in and adhere to infection control policies and procedures.
- The provider must ensure that equipment on Haven ward is decontaminated.
- The provider must ensure that if a search room is necessary, it is clean and odour free.
- The provider must ensure that prescribed medicines and treatments are given to patients.
- The provider must ensure that patients are given medication in a private space.
- The provider must ensure that the patient bedrooms and en suite bathrooms promote and uphold the privacy and dignity of patients' including whilst using the toilet and bathing facilities.
- The provider must ensure that staff undertake mandatory training which is necessary for the safe running of the service.
- The provider must ensure that all staff are appraised annually.
- The provider must ensure that they can provide a single contemporaneous record for each patient.
- The provider must ensure that an effective governance system is introduced to assess, monitor and improve the quality of the service via a robust audit system.
- The provider must complete regular checks of equipment. Out of date equipment must be disposed of appropriately.
- The provider must ensure that their organisations policies and procedures are operational in the service and remove all other policies and procedures from the previous provider.

Action the provider SHOULD take to improve

- The provider should ensure that records show consultation and agreement from patients about all patients having access to all communal areas of child and adolescent wards to comply with mixed sex accommodation guidance.
- The provider should ensure that clinic room temperatures do not exceed the recommended temperatures of 25 degrees celsius room temperature and eight degrees celsius fridge temperature. Where the temperature exceeds this the provider must ensure that staff take the necessary steps to report and reduce temperatures to within the recommended temperature.
- The provider should ensure that areas used by patients are clean and well maintained, and that repairs to the ward are carried out in a timely manner.

Outstanding practice and areas for improvement

- The provider should ensure that there is a robust workforce plan to reduce the amount of vacancies for qualified nurses and nursing assistants.
- The provider should ensure that appropriate advice is sought when a dose of medication has been omitted.
- The provider should review complaints thoroughly to ascertain a reason for the high number of complaints received by the hospital to reduce the frequency of these.
- The provider should audit the use of the Mental Capacity Act.
- The provider should ensure that staff initiatives are supported to improve practice.

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 Nursing care Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect How the regulation was not met: Patients on child and adolescent wards opened their post in the presence of staff. This did not allow patients to have privacy. Patients were not given their medication in a private space and were not appropriately monitored when taking medication. The hospital removed doors from the en suite bathrooms of patient bedrooms on child and adolescent psychiatric intensive care unit. Patients' privacy and dignity was not upheld as no alternative was offered. Patients on child and adolescent wards who required increased observations could be seen in their bedrooms from the corridor by staff and patients including of the opposite sex. This was a breach to regulation 10 (1)(2)(a)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Nursing care Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment How the regulation was not met: The provider did not ensure that staff followed policies and procedures around infection control to minimise the risk of infection spread.

This section is primarily information for the provider

Requirement notices

The provider did not ensure that equipment was decontaminated on Haven ward following three confirmed cases of MRSA.

The provider did not complete the full treatment programme prescribed to a patient infected with MRSA.

Four records showed that physical health monitoring and recording did not always take place after administration of rapid tranquilisation for the frequency or for as long as the provider's policy.

This was a breach of regulation 12(1)(2)(a) (b) (g) (h)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Nursing care Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment How the regulation was not met: Episodes of the seclusion of patients lasted for longer periods of time that required and outlined in the Mental Health Act code of practice. The clinical records indicated that patients were settled and the rational for not ending the seclusion included statements such as “to reflect on behaviour” these appeared punitive rather than for the shortest possible time. This was a breach of regulation 13 (4) (b)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Nursing care	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment

This section is primarily information for the provider

Requirement notices

Treatment of disease, disorder or injury	How the regulation was not met: The provider did not ensure that the search room was clean because it had an offensive and unpleasant odour. This meant that the room was also not suitable for the purpose it was being used. 15 (1) (a) (c)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Nursing care Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance How the regulation was not met: Systems in place to assess, monitor and improve the safety and quality of the service were not effective. Audits into Mental Health Act documentation did not identify all issues with missing or incomplete documentation. Where audits identified action required this was not fully completed by staff and missing and incomplete documentation continued. Equipment audits did not identify equipment that was passed its expiration date on Haven ward. The provider did not ensure they provided a single contemporaneous record for each patient. This was a breach of regulation 17(1)(2)(a) (b) (c)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983	Regulation 18 HSCA (RA) Regulations 2014 Staffing

This section is primarily information for the provider

Requirement notices

Nursing care

Treatment of disease, disorder or injury

How the regulation was not met:

Not all staff received regular appraisal and supervision.

A number of mandatory training courses were not up to date.

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