CareQuality
Commission

Cygnet Hospital Taunton

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

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

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

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

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

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

Summary of findings

Overall summary

We inspected the acute wards for adults of working age and psychiatric intensive care units on 2 – 3 October 2019, as when we completed the comprehensive inspection of the hospital in 26 March 2019 2019 these wards had just recently opened so were not inspected at that time.

We rated Acute wards for adults of working age and psychiatric intensive care units as requires improvement overall because:

- Staffing levels were not always safe. The wards had a high vacancy rate, particularly amongst registered nurses. Starling ward had a 38.9% vacancy rate and Sycamore ward had a 46.4% vacancy rate.
- Patients did not always receive the support they required from staff. They told us that night staff were difficult to engage with. Patients also said that it was difficult to get one to one time with their named nurse and that there were not enough activities to do on the ward. Patients had raised this with staff, but it had not been dealt with.
- Although there were convex mirrors to cover some blind spots in the corridors, staff did not have always have a direct line of sight throughout the ward. This meant staff were not always aware of the whereabouts of all patients.
- Managers did not have robust governance structures in place to support staff. Only 61% of staff on Sycamore had received management supervision in the month prior to our inspection and there were no mechanisms in place for staff to receive clinical supervision. Supervision records did not consistently highlight development needs for staff and their practice. We observed that managers did not use appropriate language when discussing skills deficits across the staff group.
- Ward areas were not clean. There was a lack of clarity of who was responsible for overseeing the housekeeping staff.
- Patient's care records did not always contain necessary, timely information. Not all discussions relating to patient's risks were adequately documented in care records. It was not always clear if patients had been offered copies of their care plans.
- Staff did not complete mental capacity assessments within an appropriate timescale.
- There was a lack of therapeutic space for multidisciplinary staff to see patients and complete therapy sessions.

However:

- The ward teams included, or had access to, the full range of specialists required to meet the needs of patients on the wards. The ward staff worked well together as a multidisciplinary team and with those outside the ward who would have a role in providing aftercare.
- Staff supported patients to engage in the wider community. There were opportunities to access sport facilities and to watch sport at local clubs. Patients were able to access support groups in the local community, such as drug and alcohol support groups. Friends and family were encouraged to facilitate community leave and overnight visits.
- Patients gave positive feedback about the day staff on both wards. They told us the day staff treated patients with compassion and kindness, respected their privacy and dignity, and understood the individual needs of patients. They actively involved patients and families and carers in care decisions.

Summary of findings

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Cygnet Hospital Taunton

Services we looked at

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

Summary of this inspection

Background to Cygnet Hospital Taunton

Cygnet Hospital Taunton is an independent mental health hospital near Taunton in Somerset, providing a range of specialist mental health services. This can include people detained under the Mental Health Act and those with challenging behaviour, as well as patients with long-term mental illness and additional physical health conditions.

At the time of the inspection there was no registered manager in place, although an application had been made. The hospital is registered to provide two regulated activities; treatment of disease, disorder or injury and assessment or medical treatment of persons detained under the Mental Health Act 1983.

There were five separate wards within the hospital at the time of inspection. Starling ward and Sycamore ward are male acute inpatient wards, with nine and 17 beds respectively. Redwood Ward is a seven-bedded locked ward for men with a mild to moderate learning disability and who may also have an Autistic spectrum disorder. Mulberry and Swift wards support older people with mental health difficulties. Mulberry has eight beds and Swift has nine beds.

The hospital was last inspected in March 2019 and was awarded a rating of good. The acute wards were not inspected at this time as they had only recently opened. Only the acute inpatient wards, Starling and Sycamore, were inspected on this occasion.

Our inspection team

The team that inspected the service comprised three CQC inspectors and a specialist advisor with experience in working in acute inpatient mental health services.

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?

During the inspection visit, the inspection team:

- visited both wards at the hospital, looked at the quality of the ward environment and observed how staff were caring for patients
- spoke with five patients who were using the service and three carers of patients who were using the service
- spoke with the senior management team and managers for each of the wards
- spoke with 10 other staff members; including doctors, nurses, occupational therapist, psychologist and social worker
- attended and observed a patient meeting and a multi-disciplinary team meeting
- looked at 12 care and treatment records of patients
- carried out a specific check of the medication management on the wards and

- looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the service say

Patients were positive about the support they received from staff during the day. They told us that staff were able to recognise when they required support and offered time on an individual basis to talk. However, patients felt that the night staff were not as supportive as during the day. We were also told that it was difficult to get one to one time with their named nurse due to their workload.

Patients told us there was a lack of activities on the ward to keep them occupied. They were positive about the physical activity provided but would like more indoor activities. Patients had raised this with staff but felt it had not changed.

Carers told us they were involved in the care and treatment of their loved ones. They felt able to contribute to decision making and that their contributions were valued. Carers said the staff were very approachable and flexible when it came to facilitating visits and leave.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Requires improvement ●

We rated safe as requires improvement because:

- The wards were not clean, particularly in communal areas. When we raised this with ward managers they were unsure who had responsibility for the housekeeping staff.
- The layout of the ward did not allow staff to easily observe patients, despite some areas having convex mirrors to mitigate blind spots. The corridors did not have direct line of sight and we observed patients who appeared agitated walking the corridors without staff support.
- There was a high vacancy rate on both wards. Bank and agency staff were used to manage the vacancies but shifts regularly went unfilled, leaving the wards short staffed. This had an impact on the patients.
- Although discussions of patient risk were taking place during ward reviews, these were not adequately documented in patient care records. If ward staff were not present in ward reviews, they would not have access to the discussions that took place.

However:

- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse.
- The wards had a good track record on safety. The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.
- There was a program in place to reduce restrictive interventions. Ward managers reviewed restrictions with staff and patients. There was a blanket restrictions audit every six months to monitor progress.

Are services effective?

Requires improvement ●

We rated effective as requires improvement because:

- Patients did not always receive mental capacity assessments in a timely manner after admission. This could result in a delay to referrals for advocacy if required or patients without capacity consenting to informal admissions.

- Managers did not regularly complete management supervision. Ward staff were not receiving clinical supervision because there was no system in place for staff to access clinical supervision internally or externally from the organisation.
- Care and crisis planning were inconsistent across both wards. It was not always clear if patients had been offered copies of their care plans.
- There were no posters on display by the exits which explained that informal patients could leave the ward.

However:

- Staff provided a range of care and treatment interventions suitable for the patient group which were consistent with national guidance on best practice. They ensured that patients had good access to physical healthcare and supported patients to live healthier lives.
- Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care. The ward teams had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation.
- Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice and discharged these well. Managers made sure that staff could explain patients' rights to them. The Mental Health Act administrators ensured the patients received their rights when they were due.
- Staff assessed the physical and mental health of all patients on admission. Patient's care and treatment was reviewed regularly through multidisciplinary discussion throughout admission and updated as needed.

Are services caring?

Good ●

We rated caring as good because:

- We observed staff treating patients with compassion and kindness. They respected patients' privacy and dignity.
- Staff understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition.
- Staff informed and involved families and carers appropriately.

However:

- Patients gave mixed feedback on the care provided. They said that the night staff were more difficult to engage with. Patients also told us that it was hard to get one to one time with their named nurse.

Are services responsive?

Good ●

We rated responsive as good because:

- Staff assessed referrals for suitability to ensure the hospital could meet their needs prior to accepting referrals. Staff managed admissions based on the acuity of the ward to ensure the safety of all patients.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team and the wider service.
- Staff supported patients to engage in the wider community. There were opportunities to access sport facilities and to watch sport at local clubs. Patients were able to access support groups in the local community, such as drug and alcohol support groups. Friends and family were encouraged to facilitate community leave and overnight visits.
- The food was of good quality and the patients told us there was a choice of food on the menu. Specific dietary requirements could be catered for.

Are services well-led?

Requires improvement ●

We rated well-led as requires improvement because:

- Managers were not supporting staff to develop their skills. Managers had not provided new staff with a comprehensive induction; they did not have support or action plans in place to support staff with identified performance concerns.
- There were no mechanisms for oversight from the senior management team of the progress of staff induction or provisions in place to support new staff in the development of the required skills. We raised this at the time of the inspection and the senior management team acknowledged this was an area for improvement.
- Managers were not offering staff clinical supervision in line with policy or ensuring robust governance oversight of support and supervision for staff.
- There were incidents of managers using discriminatory language when discussing staff. Inspectors heard managers negatively refer to the age and maturity of the staff teams.

However:

- Staff knew and understood the provider’s vision and values and how they were applied in the work of their team. There were values ambassadors across the hospital to support the delivery of organisational values.
- Managers maintained a risk register for identified risks and action plans for their management. There was also an overarching local action plan that contained risk areas identified but did not reach threshold for the risk register.
- Managers encouraged research and innovative practice. There were innovations in providing physical activity to clients and the psychology department were undertaking research to ascertain the effectiveness of a proposed model of care for the acute wards.

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.

Staff explained patients their rights under the Mental Health Act in a way they could understand and repeated it as required.

There was one dedicated Mental Health Act administrator for the hospital who prompted ward staff when patients were due to have their rights explained.

Staff on the ward had mandatory awareness training on the Mental Health Act. Staff were confident that they had a good understanding of the Mental Health Act, the Code of Practice and the guiding principles.

Patients had easy access to information about independent mental health advocacy. We saw information about independent mental health act advocacy displayed on both wards for patients and saw evidence that staff had supported patient's access to an advocate.

Staff explained to informal patients on admission that they could leave the ward freely. However, there were no displayed posters to tell them this.

Mental Capacity Act and Deprivation of Liberty Safeguards

Staff on the ward had access to mandatory electronic training on the Mental Capacity Act.

Staff did not always assess capacity to consent to treatment or admission at the point admission. When we reviewed patient records, there was frequently a delay from admission to capacity assessment. This could result in a delay in referring a patient for an advocate.

There was one deprivation of liberty safeguards application (used to agree admission when a patient lacks capacity to make the decision) made in the previous six months. This application was unsuccessful.

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

Requires improvement ●

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

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

Requires improvement ●

Safe and clean environment

The ward environments were not clean. Communal areas were dirty. We saw tobacco in window frames and food behind dustbins, drink stains on the wall and there were areas that were malodorous. When we raised this with the ward managers, they were unclear who was responsible for the housekeeping staff.

The ward layout did not allow staff to observe all parts of the ward. There were mirrors in blind spots to allow staff observation. However, the corridors were long with several turns. We observed agitated patients pacing in corridors a long way from the nursing office without staff support. The clinic room on Starling ward was a long way from the nursing office, which placed the staff administering medication in a vulnerable position. However, we were told that patients could not go into the clinic room on Starling ward and they used the clinic room on Sycamore ward which was in a more central location.

Staff had access to personal alarms for use in emergency. Patients had access to nurse call alarms and were shown how to use them at the point of admission.

There was CCTV in the communal areas of the wards. Managers used this to review incidents and staff could monitor the communal areas from the nurse’s offices on both wards. There were appropriate policies and procedures in place for the use of CCTV.

Managers completed environmental risk assessments, including ligature anchor point risk assessments. A ligature anchor point is anything which could be used to attach a cord, rope, or other material for hanging or strangulation. There were mitigation plans in place for identified ligature anchor points.

Clinic rooms were fully equipped. Staff checked, maintained, and cleaned equipment. Accessible resuscitation equipment and emergency drugs were held in the nursing office that staff checked regularly.

Safe staffing

The wards had a high vacancy rate. Starling ward had a 38.9% vacancy rate and Sycamore ward had a 46.4% vacancy rate. Ward managers told us that they managed this with contracted agency staff. However, on Sycamore ward shifts regularly went unfilled. This was as high as 22 shifts in four weeks on one occasion. The majority were registered nurse shifts. The wards managed by sharing nursing staff across the two wards when this occurred.

Ward managers had sufficient autonomy to increase staffing numbers depending on the acuity of the ward. However, it was not always possible to fill the shifts with bank and agency staff.

Managers monitored sickness levels of staff. Although there were processes in place to monitor and reduce the sickness rates of staff, the human resources manager told us this had previously not been the case and was working closely with current ward managers around this. The sickness rate on Starling was 9.6% and on Sycamore ward was 7.8%.

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

Requires improvement ●

The wards had sufficient medical cover. Each ward had a consultant psychiatrist and a ward doctor. There were two dedicated GP clinics each week for patients from either ward. Out of hours there was a ward doctor and a consultant psychiatrist available on call.

Patients rarely had their escorted leave or activities cancelled, even when the service was short staffed.

Staff were up to date with mandatory training. This was a mixture of face to face and online training. Compliance rates were all above 75% for ward staff. Ward managers monitored training rates of staff. The human resources manager had implemented new systems to improve attendance of staff on face to face training, which had a positive impact on the ward staff. 84.7% of staff across the two wards were now up to date with proactive management of violence and aggression, which had previously been lower. 100% of required staff had completed intermediate life support.

Assessing and managing risk to patients and staff

Staff screened patients risks prior to admission to assess whether the ward could meet their needs. Staff completed risk assessments when patients arrived on the ward, which were updated as required throughout admission. All patient care records we reviewed had a current risk assessment. Risks were discussed on a daily basis in risk assessment meetings. We observed that risks were reviewed in ward round meetings on a weekly basis. However, there was no documentation that evidenced these discussions about client's risk.

Although staff knew about any risks to each patient, we saw that staff did not always act to prevent or reduce risks. There were times on the ward where members of the CQC inspection team were subject to potentially risky behaviour from patients, but staff did not intervene and support patients to manage these situations. The layout of the wards made this more challenging for staff. There were no direct lines of sight across the wards which meant that patients could be a long way from staff without support. There was CCTV in communal areas of the ward which allowed staff in the nursing office to monitor other areas of the ward. However, if staff were in other areas of the ward they would be unaware of agitated or distressed patients.

Staff followed National Institute for Health and Care Excellence guidance when using rapid tranquilisation. In the six months prior to our inspection, there was one incident of rapid tranquilisation on Starling ward and three on Sycamore ward. Staff completed incident forms following incidents requiring rapid tranquilisation. Incident forms prompted staff to complete the necessary physical health monitoring. Staff completed physical health monitoring following oral medication as well as intramuscular injections.

Staff followed the hospital's policies and procedures when they needed to search patients or their bedrooms to keep them safe from harm. Staff were clear on the actions they would take if an informal patient required searching.

Managers told us the levels of restrictive interventions were reducing. The ward managers were aware of issues surrounding blanket restrictions and had begun a program of challenging and reducing existing blanket restrictions. There was an audit of blanket restrictions every six months to ensure levels of restrictions were reducing. For example, allowing patients to have access to mobile telephones and charger cables following individual risk assessment instead of a blanket ban across the wards.

Crisis planning was inconsistent. In the care records we reviewed, patients had a crisis management plan as part of the mental health care plan. Although some were detailed, others did not contain sufficient information for staff to support patients in a crisis. This was highlighted at the time of this inspection we were told that this depended on the patient's mental state and that not all patients required a crisis plan.

Safeguarding

Staff received training on how to recognise and report abuse, appropriate for their role. Staff kept up-to-date with their safeguarding training, with 89% of staff across the two wards up to date with mandatory safeguarding training. Staff knew how to recognise adults and children at risk of or suffering harm and worked with other agencies to protect them. Staff knew how to make a safeguarding referral and who to inform if they had concerns.

Staff followed clear procedures to keep visiting children safe. There was a family room on site for patients to have visits with their children, but children were not allowed on the ward.

There was a safeguarding lead based at the hospital who maintained oversight of all safeguarding referrals made and supported ward staff with safeguarding referrals.

Staff access to essential information

Staff had access to electronic and paper patient records. These were securely stored. However, multidisciplinary staff members told us triangulation of data was a lengthy process as they were required to scan in paper notes and upload to electronic files as well as store them in the paper patient files.

Medicines management

Staff followed systems and processes when safely prescribing, administering, recording and storing medicines. Staff stored and managed medicines and prescribing documents in line with the provider's policy.

Staff followed current national practice to check patients had the correct medicines. Medicines reconciliation took place when patients were clerked in by doctors on admission.

Staff reviewed patients' medicines regularly and provided specific advice to patients and carers about their medicines. Staff reviewed the effects of each patient's medication on their physical health according to National Institute for Health and Care Excellence guidance. Decision making processes were in place to ensure people's behaviour was not controlled by excessive and inappropriate use of medicines. There were no patients on high dose antipsychotics at the time of this inspection.

An external pharmacist undertook regular audits of medication charts, medicines and clinic rooms. We saw evidence of improvements as a result of issues highlighted in these audits.

Track record on safety

The wards had a good track record on safety.

In the six months prior to our inspection, Sycamore ward reported two serious incidents and Starling ward reported three serious incidents. This included patient self-harm and AWOL (absence without leave) of detained patients. Review of these incidents showed that staff had responded appropriately.

Reporting incidents and learning from when things go wrong

The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team, the wider service and across the organisation through lessons learned emails and lessons learned forums. For example, following serious incidents at another Cygnet hospital, managers now review CCTV after incidents have occurred to ensure they are managed safely by staff.

The team made changes as a result of feedback from incidents. We were given an example of a serious incident where one patient had absconded over a fence and a second patient had attempted to abscond the same way. Staff altered their observation of outdoor areas whilst awaiting a new, more suitable fence.

Staff were debriefed and received support after a serious incident.

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

(for example, treatment is effective)

Requires improvement ●

Assessment of needs and planning of care

Staff assessed the physical and mental health of all patients on admission. All the patient records we reviewed on Sycamore and Starling wards contained care plans. They developed individual care plans which were reviewed regularly through multidisciplinary discussion and updated as needed. Care plans reflected patients' assessed needs and were recovery-oriented.

Staff captured the patient's voice throughout their care plans. However, in five of the 12 care records we looked at the patient's signature was missing and there was no other supporting documentation to evidence that a copy of the care plan had been given or offered to the patient.

Best practice in treatment and care

Staff provided a range of treatment and care for patients based on national guidance and best practice. The interventions were those recommended by, and were delivered in line with, guidance from the National Institute for Health and Care Excellence (NICE). This included access to psychological therapies. The psychology team delivered individual and group interventions to patients. This included psychoeducational groups, individual cognitive behaviour therapy and compassion focused therapy.

Staff supported patients to have healthier lives. There was an active life lead who supported patients with physical activity and diet. We saw evidence that there were plans in place to train active life champions on each ward to increase the levels of activity available to all patients.

Staff used recognised rating scales to assess and record severity and outcomes, including the Health of the Nation Outcome Scales (HoNOS).

Staff participated in clinical audits, benchmarking and quality improvement initiatives. For example, staff completed audits of medicines management and blanket restrictions. Managers undertook quality walk rounds, where they would visit other wards on the hospital to assess and rate the quality of the care provided.

Skilled staff to deliver care

Managers did not ensure that all staff had the right skills or training to meet the needs of the patients in their care. Recently employed staff had not received a comprehensive induction or been offered further training where managers had identified a deficit in skills. Training to new staff had primarily promised of shadowing existing members of staff. We saw induction checklists that had not been fully completed and supervision records did not contain individualised development plans. However, the new senior management team had plans in place to address the issues with the induction process. A new induction is due to be implemented which includes comprehensive face to face training and skills development for new starters.

The service had access to a full range of specialists to meet the needs of the patients on the ward, including psychology, occupational therapy and a social worker.

Agency and bank staff were given an induction at the start of their shift to ensure they were familiar with the ward. When possible, the hospital used agency staff on longer contracts or who had experience of working at the hospital.

Managers ensured that healthcare assistants had access to regular team meetings, which registered nurses were invited to attend.

Ward managers were responsible for delivering management supervision to ward staff. We reviewed six staff files and 12 supervision records. There were no records of discussions or plans in place to support staff to develop the required skills for their roles. We reviewed files for new staff who had completed their induction program. There was evidence that probation goals had been reviewed but there was no evidence of discussions with staff about how they could improve their scores. On Sycamore ward, only 61% of staff had received management supervision in the month prior to our inspection, although on Starling ward 100% of staff had received management supervision.

There were no systems in place for staff to access clinical supervision.

Multi-disciplinary and inter-agency team work

Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care. There was a daily multidisciplinary handover where the multidisciplinary team received information about patients on the ward. We saw examples of where referrals had been made to members of the multidisciplinary team which had been acted on promptly.

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

Staff on the ward had mandatory awareness training on the Mental Health Act. This had been completed by 86.4% of clinical staff across the hospital. Staff were confident that they had a good understanding of the Mental Health Act, the Code of Practice and the guiding principles.

Patients had easy access to information about independent mental health advocacy. We saw information about independent mental health act advocacy displayed on both wards for patients and saw evidence that staff had supported patient's access to an advocate. However, when we reviewed patient records, there was frequently a delay from admission to capacity assessment. This could result in a delay in referring a patient for an advocate.

Staff explained to informal patients on admission that they could leave the ward freely. However, there were no displayed posters to tell them this.

Staff knew who their Mental Health Act administrators were and when to ask them for support. There was one dedicated Mental Health Act administrator for the hospital.

Staff explained patients their rights under the Mental Health Act in a way they could understand, repeated it as required and recorded that they had done this. The Mental Health Act administrator prompted ward staff when patients were due to have their rights explained.

Staff ensured that patients were able to take Section 17 leave (permission for patients to leave hospital) when this had been granted, although patients told us that leave often had to be planned in advance. Staff requested an opinion from a second opinion appointed doctor (SOAD) when necessary.

Staff stored copies of patients' detention papers and associated records (such as Section 17 leave forms) correctly and so that they were available to all staff that needed to access them. The master files were kept in the Mental Health Act administrator's office, with copies of the paperwork stored on the ward.

Good practice in applying the Mental Capacity Act

Staff on the ward had access to mandatory electronic training on the Mental Capacity Act. This had been completed by 83.3% of clinical staff across the hospital.

Staff did not assess capacity to consent to treatment or admission at the point of admission. There was frequently a delay of several days before the assessment took place. In half of the records we reviewed, there was a delay between one and 16 days from admission to capacity assessment. This could result in patients without capacity being allowed to consent to an informal admission.

There was one Deprivation of Liberty Safeguards application (used to agree admission when a patient lacks capacity to make the decision) made in the previous six months. This application was unsuccessful.

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

Good ●

Kindness, privacy, dignity, respect, compassion and support

We observed staff delivering care that was discreet, respectful and responsive. We also saw examples where staff treated patients with compassion and kindness. However, feedback from patients was mixed. Some of the patients were positive about the care they received and the way they were treated by staff. We were told that there were some staff on night shifts that were unapproachable and difficult to communicate with.

Patients told us that the nursing staff were particularly busy and one to one time with their named nurse needed to be scheduled in advance. However, patients were positive about the support they received on a day to day basis and were able to access emotional support and advice from healthcare assistants.

Staff told us they could raise concerns about disrespectful, discriminatory or abusive behaviour towards patients without fear of the consequences. Staff also told us all members of the senior management team were approachable and were able to raise concerns without fear of repercussions.

Staff followed policy to keep patient information confidential.

Involvement in care

Staff introduced patients to the ward and the services as part of their admission. Staff told us patients were provided with a welcome pack on admission. We saw a copy of one displayed on the wall.

Staff made sure patients understood their care and treatment. Patients told us they felt involved in their care but were not always provided copies with their care plans unless they asked for them. Patients were invited into multidisciplinary team meetings to discuss their care.

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

Requires improvement ●

Carers told us they felt involved in care. They said they could contribute to decision making and felt listened to by staff. Carers were invited to attend review meetings and there were no set visiting hours to accommodate families who travelled long distances.

Although patients were given the opportunity to provide feedback through community meetings, they provided examples of where concerns raised had not been acted on. For example, boredom was a prevalent concern amongst the patients which they felt had been consistently raised with staff.

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

(for example, to feedback?)

Good ●

Access and discharge

The wards admitted patients primarily from local NHS trusts. One local NHS trust had block purchased the majority of the beds on Sycamore ward. If a bed was available patients could be admitted the same day. Nurses and managers discussed referrals and agreed admissions on a risk basis. The ward did not have a seclusion room and would not admit patients who were high risk. The ward had refused or delayed admissions due to the high level of acuity on the ward if they felt that a person's needs could not be safely met at that time.

The average length of stay on Sycamore ward was 52.6 days and on Starling ward it was 23.8 days. Managers reported that discharges were routinely delayed. However, there was now a dedicated care co-ordinator based at the hospital for all patients from a local NHS trust to support and facilitate discharges. Managers reported they hope this will improve patient flow and reduce length of stay.

There was always a bed available when patients returned from leave. When patients were moved or discharged, this happened at an appropriate time of day.

Staff planned for patients' discharge, including good liaison with care coordinators and family where appropriate. This process started from the point of admission.

Staff supported patients during referrals and transfers between services, for example, if they required treatment in an acute hospital or transfer to a psychiatric intensive care unit.

The facilities promote recovery, comfort, dignity and confidentiality

Each patient had their own bedroom, which they could personalise. Patients had a secure place to store personal possessions. Staff risk assessed patients for keys to their bedrooms. There were shared communal lounges on each ward.

Staff told us that there was a lack of space on the wards. This impacted on their ability to offer activities and therapies to the patients and required staff to plan their timetables and appointments around each other.

The service offered a variety of good quality food. Patients told us the food was nice and there were options on the menu. Patients could make hot drinks at any time. However, snacks were not always available between meals.

Each ward had a dining room but on Sycamore it did not contain enough space for all patients to eat together at the same time. However, the patients did not raise this as an area of concern.

Patients could use their own devices to access the internet on the ward. We were told there was also a laptop available for patients to access however no patients we spoke with were aware of this. Patients told us they would like access to a computer on the ward.

Patients had access to outside space. Access to the garden was supervised due to a low perimeter fence, which was due to be changed. There were garden access times displayed on the wards. Staff told us this was the minimum and guaranteed access to the garden. However, patients told us that these times were sometimes missed.

Staff risk assessed patient's access to their mobile telephones and chargers. Patients could be provided with access to a cordless phone to use privately in their bedroom.

Patients' engagement with the wider community

Staff supported patients to access gym facilities in the community. Patients were able to attend football matches at the local football club for free.

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

Requires improvement ●

Patients could access community drug and alcohol support meetings in the local area.

Staff supported patients to maintain contact with their families and carers. Staff also encouraged patients to develop and maintain relationships with people that mattered to them, both within the services and the wider community.

Patients spent time out of the hospital in the community as part of the discharge preparation process. We saw examples of patients being encouraged to take overnight leave early into admission. However, patients on escorted leave told us there is not always enough staff to go outside.

Meeting the needs of all people who use the service

The service could support and make adjustments for people with mobility difficulties. There was access to the ward via a lift and there was an assisted bathroom on Starling ward. Equipment for supporting patients with mobility difficulties, such as hoists, could be accessed from other wards at the hospital. However, there were no bedrooms on either ward adapted or with increased space for use of such equipment.

Managers made sure staff and patients could get help from interpreters or signers when needed. Leaflets in other languages were not routinely available. However, managers told us they can use the interpreting service to translate leaflets and letters when required.

The service provided a variety of food to meet the dietary and cultural needs of individual patients.

Staff made sure patients could access information on treatment, local services, their rights and how to complain. There was information on display on the wards and information on how to complain was included in the patient welcome packs.

Listening to and learning from concerns and complaints

The service investigated formal complaints, learned lessons from the results and shared these with the whole team and wider service.

In the 12 months prior to the inspection, Sycamore received three complaints and Starling received one. Two of the complaints received about Sycamore ward are ongoing and the third was upheld. We saw evidence of action as a result of the complaint. We saw evidence that the complaint on Starling Ward had been verbally resolved with the patient. There were no trends identified relating to complaints.

Staff understood the policy on complaints and knew how to handle them. They were aware of their duty of candour. Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint.

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

Requires improvement ●

Leadership

The senior leadership team were all new to the hospital and had only been in place a few months at the point of inspection. Staff told us there had been a positive change in culture since the arrival of the new management team. The leadership team had identified issues across the hospital and were implementing a program of change in order of priority.

Leaders were visible in the service and approachable for patients and staff. Senior leaders carried out regular walk rounds on the ward and were well known to staff.

Ward managers had a good understanding of the wards they managed. They did one shift on the ward per week as nurse in charge to ensure they understood the challenges faced by ward staff.

The senior management team were new to the hospital. However, they were working to identify the issues, priorities and challenges the service faced. They were developing action plans in response to areas of concern.

Vision and strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. They were aligned to local plans and the wider health economy. Managers made sure staff understood and knew how to apply them.

Staff knew and understood the provider's vision and values and how they were applied in the work of their team. The provider's senior leadership team had successfully communicated the provider's vision and values to the frontline staff in the service. There were values ambassadors across the hospital to support the delivery of organisational values.

Culture

Managers used discriminatory language when discussing staff. We heard managers reference the age and maturity of the staff teams. When we challenged this, the problems managers discussed were to do with skills and inexperience. When this was raised with the senior management team, there was no plan in place to address this use of language.

Staff felt able to raise concerns without fear of repercussion. Staff were aware of policies and procedures and knew how to use the whistle-blowing process.

Staff told us they felt supported by their ward managers. Staff also spoke positively of the culture within the team.

The provider recognised staff success within the service, for example there were acts of random kindness awards where staff could be nominated for the kind things they did for patients and each other.

Governance

Governance systems in place were not adequately robust or effective to ensure oversight at ward level of the quality of supervision and induction processes. Ward managers reported management supervision rates but there were no systems in place to monitor the quality. There was no monitoring of the completion of induction programs or the quality of support received during the induction process. There were no systems in place for the ward staff to receive clinical supervision.

There were monthly governance meetings between the senior management team, ward managers and heads of department. Previous issues raised were discussed to ensure actions had been completed.

There were weekly operations meetings with the ward managers where the quality of work was scrutinised. There was a thematic quality review of the wards and managers were working to an action plan produced following this review.

There were key performance indicators that the ward reported on which included safeguarding, injuries, restraints and medication errors. The senior management team reviewed these weekly and asked ward managers for narrative if required.

Ward managers uploaded incidents onto an online reporting system. However, they were not aware of a system to recognise trends in incidents and believed it was up to them to spot patterns. We saw no evidence of trend analysis however following the inspection we were informed trend analysis occurs during clinical governance meetings.

Staff undertook or participated in local clinical audits. Audits included care plans, Mental Health Act and physical health. We saw evidence of changes made as a result of issues highlighted during audits.

Management of risk, issues and performance

Leaders managed performance using systems to identify, understand, monitor, and reduce or eliminate risks. They ensured risks were dealt with at the appropriate level. Clinical staff contributed to decision-making on service changes and supported managers to deliver change on the wards.

The senior management team maintained a risk register for the site. Ward managers told us they could escalate concerns to the risk register. The senior management team held responsibility for the risks and their resolution once on the risk register.

The senior managers maintained the overarching local action plan. This was for risk issues and their action plans that did not reach threshold for the risk register. The senior management team maintained this at hospital level but contained risk items at ward level.

Information management

The service collected reliable information and analysed it to understand performance and to enable staff to make decisions and improvements. The information systems were integrated and secure.

Information governance systems included confidentiality of patient records.

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

Staff made notifications to external bodies such as the local authority and the CQC as needed.

Engagement

Staff, patients and carers had up to date information about the ward and the services provided. This information was disseminated through the intranet, newsletters and team meetings.

Patients and carers had opportunities to give feedback on the service. This could be done directly to staff members or anonymously through email and comment cards. Patients could attend weekly community meetings where they could recommend improvements to the wards. However, these had only been in place for two weeks and there was no evidence of changes implemented as a result.

Learning, continuous improvement and innovation

Leaders encouraged innovation and participation in research. For example, the head of psychology was undertaking a piece of research to establish the impact of training ward staff in cognitive behavioural therapy on the patient journey and the active life lead was being supported to implement innovative ways to encourage physical activity amongst the patients.

The ward did not participate in any accreditation schemes at the time of the inspection.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that the ward areas are clean. (Regulation 12)
- The provider must ensure sufficient staffing to ensure safe and quality care. (Regulation 18)
- The provider must ensure staff receive appropriate induction, support, training, professional development and supervision to enable them to carry out the duties they are employed to perform (Regulation 18)
- The provider must ensure that there are effective governance systems in place to monitor and support the development of staff and receive feedback on the service from all staff. (Regulation 17)
- The provider must ensure that patients are observed and supported by staff in all areas of the ward (Regulation 12)
- The provider must ensure that all discussions about patient's risks are clearly documented in their care records (Regulation 12)
- The provider must ensure that capacity assessments are undertaken in a timely manner (Regulation 11)

Action the provider SHOULD take to improve

- The provider should ensure that there are posters on exits to the ward to inform informal patients they can freely leave the ward.
- The provider should ensure that patient concerns are acted on when they raise them to staff.
- The provider should ensure that client’s involvement in their care plans is evidenced and clients receive copies of their care plans.
- The senior management team should ensure they use professional language when discussing the development of staff within the diversity of the staff group.
- The provider should ensure that patients have sufficient access to therapy environments and computers for education and vocational recovery.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent Staff did not assess capacity to consent to treatment or admission at the point of admission. There was frequently a delay of several days before the assessment took place. In half of the records we reviewed, there was a delay between one and 16 days from admission to capacity assessment. This could result in patients without capacity being allowed to consent to an informal admission. This was a breach of Regulation 11(1)(3)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The layout of the ward did not allow staff to easily observe patients. The corridors did not have direct line of sight and we observed patients who appeared agitated walking the corridors without staff support. Patient's care records did not always contain necessary, timely information. Discussions relating to patient's risks were not adequately documented in care records. This was a breach of Regulation 12(2)(a)(d)

Regulated activity	Regulation

This section is primarily information for the provider

Requirement notices

Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment The ward environments were not clean. Communal areas were particularly dirty. We saw tobacco in window jams, food behind dustbins and there were areas that were malodorous. When we raised this with the ward managers, they were unclear who was responsible for having oversight of the housekeeping staff. This was a breach of Regulation 15(1)(a)(2)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance There were not adequate governance systems in place to support the development of staff. Where performance concerns had been identified in staff, this had not been raised in management supervision and there were no development plans in place. Management supervision was not routinely being completed. There were no systems in place for ward staff to receive clinical supervision. There were no systems in place for registered nurses to meet on a regular basis to discuss issues and concerns. This was a breach of Regulation 17 (1)(2)(a)(d)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing The wards had a high vacancy rate. Starling ward had a 38.9% vacancy rate and Sycamore ward had a 46.4% vacancy rate. On Sycamore ward shifts regularly went unfilled. This was as high as 22 shifts in four weeks on one occasion.

Requirement notices

Staff did not receive clinical supervision. Management supervision was not consistently delivered across the wards and did not always identify the development needs of staff.

This was a breach of Regulation 18 (1)(2)(a)