Cygnet (OE) Limited

Cygnet Hospital Hexham

Inspection report

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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

Overall rating for this location	Good
Are services safe?	Requires Improvement
Are services effective?	Good
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Good

Summary of findings

Overall summary

Our rating of this service improved. We rated it as good because:

- The ward environments were safe and clean and where possible improvements to the environment had been made as identified at the last inspection. Staff assessed and managed risk well. They minimised the use of restrictive practices, managed medicines safely and followed good practice with respect to safeguarding.
- Staff developed holistic, recovery-oriented care plans informed by a comprehensive assessment. They provided a range of treatments suitable to the needs of the patients and in line with national guidance about best practice. Staff engaged in clinical audit to evaluate the quality of care they provided.
- The ward teams included or had access to the full range of specialists required to meet the needs of patients on the wards. Managers ensured that these staff received training, supervision and appraisal. The ward staff worked well together as a multidisciplinary team and with those outside the ward who would have a role in providing aftercare.
- Staff understood and discharged their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005.
- 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.
- The service managed admissions well with multi-disciplinary discussions occurring between the providers central admission team and hospital managers.
- The service was well led, and the governance processes ensured that ward procedures ran smoothly.

However:

- The service continued to use high numbers of agency staff to cover shifts in response to increased observation levels. Agency staff did not always follow risk management plans effectively to keep patients safe.
- The service had recently employed a psychologist and so not all patients had a formulation plan in place for use by support staff when managing patient's needs.
- The service had two patients on the psychiatric intensive care unit who had been there for longer than 12-week pathway. However, staff were trying to address this.
- The service had not adjusted the bright lighting on the ward on an evening after recommendations in a recent Mental Health Act visit.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Acute wards for adults of working age and psychiatric intensive care units	Good 	

Summary of findings

Contents

Summary of this inspection

Background to Cygnet Hospital Hexham

Cygnet Hospital Hexham is a 27-bed mental health facility for women with complex mental health needs. Cygnet Hospital Hexham is an independent mental health hospital based on the outskirts of Hexham. The service has two wards, Fisher ward (17 bed acute ward), and Franklin ward (10 bed psychiatric intensive care unit) for females of 18 years and over.

Cygnet Hospital Hexham is registered with the Care Quality Commission to provide the following regulated activities;

- Assessment or medical treatment for persons detained under the Mental Health Act 1983
- Treatment of disease, disorder or injury

The hospital had a registered manager in place at the time of the inspection.

We conducted a focused responsive inspection in April 2021 in response to whistleblowing concerns in relation to patient safety. We did not review all domains; we conducted a focused review of practice relating to these concerns within the safe and well led domains. We did not re-rate Cygnet Hospital Hexham following this focused inspection.

During this inspection we found that the ward did not have enough space for patients to provide a safe and therapeutic environment. The dining and lounge areas were small and would not accommodate all patients at the same time if required to do so. Patients could not access the dining area without support from staff as it was accessed via a locked corridor. The seclusion room was small and provided patients with very limited space to move around when the mattress was on the floor. It was in a corridor that was the main thoroughfare for patients and staff to access the staff room, patient dining room, treatment room and laundry.

Following an inspection in May 2019, when the service provided wards for adults with a learning disability and/or autism (named Cygnet Chesterholme) enforcement action was taken and the service was rated inadequate and placed in special measures. The hospital closed in September 2019 and re-opened in October 2020 providing acute admission and psychiatric intensive care wards.

What people who use the service say

We spoke to four patients while on inspection, reviewed six discharge questionnaires and reviewed the feedback giving during the last Mental Health Act monitoring visits. Patients said they felt safe on the wards and that staff were supportive in meeting their needs. One patient said that she hadn't had leave which we checked out with staff. Staff had been supporting the patient to go on leave. One patient was concerned about the cleanliness of the communal beverage bay and this was being addressed by nursing staff. Five out of the six discharged patients felt that the hospital had helped them and would recommend the hospital to family or friends.

During the most recent Mental Health Act monitoring visit in August 2021 most of the patients we spoke with told us they felt safe and were treated with respect. Patient feedback about staff was nearly all positive and included that staff listened to them. Comments from patients included; "exceptionally good", "staff are good, they help you and you can talk to them" and "staff are wonderful". However, one patient felt staff talked down to them and two others felt they were not always treated fairly when it came to planning outings.

Summary of this inspection

Three patients commented that the ward was “aesthetically pleasing” and had good facilities. One family member told us staff were friendly and helpful.

How we carried out this inspection

We conducted a comprehensive inspection of Cygnet Hospital Hexham

The team that inspected the service comprised of two CQC inspectors and one specialist advisor.

During the inspection visit, the inspection team:

- visited both wards at the hospital, looked at the quality of the ward environments and observed how staff were caring for patients
- interviewed the hospital manager, clinical manager and both ward managers
- interviewed 17 other members of staff including nurses, support workers, advanced nurse practitioner and the consultant psychiatrist
- spoke with four patients who were using the service
- observed two morning meetings
- reviewed six care and treatment patient records
- reviewed three incident records and all observations sheets.

You can find information about how we carry out our inspections on our website: https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection

Areas for improvement

Action the service MUST take to improve:

- The provider must ensure that there are enough numbers of suitably qualified, competent, skilled and experienced staff working at the hospital.

Action the service SHOULD take to improve:

- The provider should ensure that the lights at night are adjusted to allow patients to sleep undisturbed.
- The provider should ensure that the overflow medications are safely and neatly stored so that staff can access and check dates.
- The provider should continue to ensure that all patients have a formulation completed with input from the psychologist which is communicated and understood by all staff.
- The provider should ensure that staff understand the hospital risk register.
- The provider should continue to review and support discharge plans for those patients who have been in the psychiatric intensive care unit for longer than 12-week pathway.

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Acute wards for adults of working age and psychiatric intensive care units	Requires Improvement	Good	Good	Good	Good	Good
Overall	Requires Improvement	Good	Good	Good	Good	Good

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

Good

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

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

Requires Improvement

Safe and clean care environments

All wards were safe, clean well equipped, well furnished, well maintained and fit for purpose.

Safety of the ward layout

Staff completed and regularly updated thorough risk assessments of all wards areas and removed or reduced any risks they identified.

Staff could observe patients in all parts of the wards. Managers had responded to the April 2021 responsive inspection and had removed the door to the psychiatric intensive care unit ward staff room. This meant that there was more communal space for patients on the ward. Work on the dining room was due to start later this year to remove the servery and ensure a more efficient process of serving food.

The psychiatric intensive care unit was located on the ground floor and had a separate entrance

for new admissions which was through a locked gate. The entrance led to a corridor, where there was a seclusion room, extra care room, treatment room, laundry and a dining room which contained a beverage area. The acute ward was located upstairs, and patients could freely access the garden downstairs. Any blind spots were mitigated with mirrors.

Each ward had a communal lounge, kitchen area and smaller rooms for one to one session. Both wards had access to well-maintained garden areas.

There were ligature audits in place for both wards and any potential ligatures were mitigated by observation. Both wards were fitted with anti-ligature facilities and a quality assessment had been carried out across the hospital.

Staff had easy access to alarms and patients had easy access to nurse call systems. The inspection team were provided with alarms throughout the inspection while in patient areas.

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

Good

Maintenance, cleanliness and infection control

Ward areas were clean, well maintained, well-furnished and fit for purpose. We observed cleaning staff at the hospital during the inspection. The hospital had been refurbished had part of the reconfiguration of the service.

Staff made sure cleaning records were up-to-date and the premises were clean.

Staff followed infection control policy, including handwashing. Reception staff checked COVID-19 status of visitors on arrival. Visitors were prompted to wear appropriate personal protective equipment and use hand sanitiser before entering premises. Posters were displayed around buildings to advise staff and patients of good hand hygiene and masks were being worn inside the premises.

Seclusion room

The seclusion room allowed clear observation and two-way communication. It had a toilet and a clock. The seclusion room was small, and patients had very limited space to move around the room when the mattress was on the floor. When the room was not in use, staff placed the mattress against a wall in the room to provide more space. The corridor where the seclusion room was located was the main route for patients to access the dining area, treatment room and laundry. This was also the route for new patients being admitted into the hospital. This meant that there was a lot of people moving through the corridor, which was noisy and could disturb the patient when the seclusion room was in use.

Clinic room and equipment

Clinic rooms were fully equipped, with accessible resuscitation equipment and emergency drugs that staff checked regularly. Each ward had its own clinic room and we found that each room had a small cupboard which was used to store overflow medications. The cupboards were cluttered, and this had been identified on the prescribing audit. Managers had ordered a large cupboard for the larger clinic room upstairs to store the medications for both wards.

Staff checked, maintained, and cleaned equipment.

Safe staffing

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

Nursing staff

The service had enough nursing and support staff to keep patients safe. Overall, the hospital had 93 staff who worked a mix of days and nights on a rota basis. Managers ensured that staff were not always working with the same group of people. The wards were meeting the minimum staffing levels in place for each shift with two qualified nurses and four support workers during the day and three support workers at night. Managers increased support staff if patient observation levels increased.

The service had no vacancies at the time of the inspection. The last of the vacant posts had been filled in the previous month.

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

Good

The service was using a high number of agency staff to cover support workers shifts when acuity was high. In the last 12 months 3194 shifts had been covered by agency staff. The number of shifts covered fluctuated each month depending on the observation levels of patients. Shifts covered by agency staff ranged from the highest of 391 in February 2022 to the lowest of 151 in July 2021.

The number of shifts covered by agency nurses had reduced in the last six months with four shifts being filled by agency staff. This was a significant reduction from the 108 shifts covered in the six months from April 2021 to September 2021. Managers tried to request staff familiar with the service and where possible tried to use regular agency staff. Managers encouraged agency staff to apply for permanent posts and encouraged regular staff to give feedback to managers if they thought someone was not suitable.

Managers made sure agency staff had a full induction and understood the service before starting their shift. An induction had been introduced in response to recent incidents and all agency staff shadowed a permanent member of staff before they worked independently on the ward.

The service had reducing turnover rates. Since the hospital had opened a significant number of staff had left the hospital. Managers reported that turnover had reduced to 13% in the last 12 months. Staff had left the hospital for several reasons including finding the hospital challenging or wanting to move onto other specialist areas. Managers had reviewed the interview process to allow permanent support workers to talk through some scenarios of day to day work at the hospital to ensure potential employees could make an informed decision.

Managers supported staff who needed time off for ill health. Sickness levels at the time of the inspection was 5%.

Managers accurately calculated and reviewed the number and grade of nurses, and healthcare assistants for each shift. Each shift had minimum staffing numbers, and this was increased depending on acuity and observation levels.

Patients had regular one to one session with their named nurse.

Patients rarely had their escorted leave or activities cancelled, even when the service was short staffed. We observed several staff on the acute ward out on leave during the two-day inspection.

The service had enough staff on each shift to carry out any physical interventions safely.

Staff shared key information to keep patients safe when handing over their care to others. Handovers took place after each shift and were documented in paper format.

Medical staff

The service had enough daytime and night-time medical cover and a doctor available to go to the ward quickly in an emergency. The consultant psychiatrist working across both wards was the medical director and was supported by a second consultant psychiatrist. There were two specialist registrar doctors working at the hospital. The doctors were visible on the wards and available to staff when needed. The doctors led daily meetings and weekly ward rounds.

Mandatory training

Staff had completed and kept up to date with their mandatory training. Training compliance for the Fisher ward was 78% and Franklin ward was 87%. The staff who were not compliant with training had been off work so had not been able to complete training.

The mandatory training programme was comprehensive and met the needs of patients and staff.

Managers monitored mandatory training and alerted staff when they needed to update their training.

Assessing and managing risk to patients and staff

Staff assessed and managed risks to patients and themselves well and followed best practice in anticipating, de-escalating and managing challenging behaviour. Staff used restraint and seclusion only after attempts at de-escalation had failed. The ward staff participated in the provider's restrictive interventions reduction programme.

Assessment of patient risk

Staff completed risk assessments for each patient on admission, using a recognised tool, and reviewed this regularly, including after any incident. We reviewed six records and saw that risks were recorded and updated.

Staff used a recognised risk assessment tool.

Management of patient risk

Regular staff knew about any risks to each patient and acted to prevent or reduce risks. Patient risks were displayed on patient boards in the staff office and on the observation record. Risks were regularly discussed and communicated to staff.

There had been incidents where agency staff had not followed risk management plans. Where this had been identified managers had tried to address the concerns with the staff. All risks were detailed on staff boards and observation sheets. Agency staff were encouraged to review patient records and attend handovers and where possible agency staff would not be put onto one to one observation with patients until they were familiar with the risks. However, acuity meant that shifts were reliant on agency staff.

Staff identified and responded to any changes in risks to, or posed by, patients. Handovers took place after each shift where any changes were passed over to the next shift. Any changes to observation levels were communicated to staff by the nurse in charge and changed on the white board. If observation levels changed then a new observation sheet was put in place.

Staff could observe patients in all areas of the wards and support staff could explain where patients were likely to be. We found some patients were in their bedrooms while others were in community areas. We observed support workers carrying out observation checks and either entering bedrooms or looking through bedroom panels if the person was asleep.

Staff followed the hospital policies and procedures when they needed to search patients or their bedrooms to keep them safe from harm.

Use of restrictive interventions

Levels of restrictive interventions had increased on Franklin ward in the last three months. Most incidents related to two patients who had been on the ward for nine months. Between December 2021 and February 2022 there had been a total of 447 incidents of which 167 were restraints and 76 were incidents of rapid tranquilisation of which 65 related to one patient. The patient had an advanced statement in place to direct staff in less restrictive interventions. We saw evidence that staff attempted to follow this but that the patient did not always engage. We reviewed the last three months records and found that physical observations were being carried out in line with guidance.

We reviewed the care plan for this patient and found that an advanced statement had been put in place. However, notes showed that the patient would often refuse the interventions in the plan. There was evidence of regular discussions at ward and hospital level. The patient had been ready for discharge but become unwell while staff were securing a move on placement. Managers had requested external support to review the patient and this was in progress with no date in place at the time of the inspection.

The incidents on Fisher ward had decreased over the same period. There had been a total of 165 incidents, of which 41 were restraints and 14 rapid tranquilisations.

Staff participated in the provider's restrictive interventions reduction programme, which met best practice standards.

Staff made every attempt to avoid using restraint by using de-escalation techniques and restrained patients only when these failed and when necessary to keep the patient or others safe. Managers acknowledged that physical interventions increased as the number of agency staff increased. This was due to agency staff not always being aware and familiar with the patients. Regular staff could give examples of how language was important when speaking to patients and knew the words that should not be used with certain patients. This level of understanding was not always shared with agency staff who were less familiar with the wards and the patients. Regular staff supported agency staff with this.

Staff understood the Mental Capacity Act definition of restraint and worked within it.

Staff followed NICE guidance when using rapid tranquilisation.

There had been two incidents of seclusion in the last three months. Both incidents were in January 2022 and an internal review of each incident was completed. The review identified that both seclusions were potentially avoidable due to least restrictive interventions not being utilised. Managers responded by holding focused supervisions with staff involved including a review and reflection session using the CCTV recording. A flow chart was now visible in the nurse's station to prompt staff around the use of seclusion.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Staff received training on how to recognise and report abuse, appropriate for their role. The compliance of staff trained was 95%. Staff had made 71 safeguarding referrals in the last three months. The local safeguarding team had attended the hospital to review the safeguarding procedures and agree a threshold for referral to the local authority.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act.

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

Good

Staff knew how to recognise adults and children at risk of or suffering harm and worked with other agencies to protect them. We saw evidence of discussions taking place with home teams to ensure patients had safe homes to return to.

Staff followed clear procedures to keep children visiting the ward safe. A family room was situated off the main ward areas and leave was facilitated when family visited.

Staff knew how to make a safeguarding referral and who to inform if they had concerns.

Staff access to essential information

Staff had easy access to clinical information, and it was easy for them to maintain high quality clinical records.

Patient notes were comprehensive, and all staff could access them easily.

When patients transferred to a new team, there were no delays in staff accessing their records.

Records were stored securely.

Medicines management

The service used systems and processes to safely prescribe, administer, record and store medicines. Staff regularly reviewed the effects of medications on each patient's mental and physical health.

Staff followed systems and processes to prescribe and administer medicines safely. The consultant psychiatrist had a good understanding of the patients on the wards and worked closely with the nursing staff.

Staff reviewed each patient's medicines regularly and provided advice to patients and carers about their medicines. We observed discussions taking place around medications and how patients were responding.

Staff completed medicines records accurately and kept them up to date.

Staff stored and managed all medicines and prescribing documents safely.

Staff followed national practice to check patients had the correct medicines when they were admitted, or they moved between services.

Staff learned from safety alerts and incidents to improve practice.

The service ensured people's behaviour was not controlled by excessive and inappropriate use of medicines.

Staff reviewed the effects of each patient's medicines on their physical health according to NICE guidance.

Track record on safety

The service had a good track record on safety.

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

Good

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 and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

Staff knew what incidents to report and how to report them. Managers had identified that there were inconsistences with how staff graded incidents and the clinical manger was delivering sessions with staff to increase awareness of the process and the importance of ensuring that the full incident details were recorded.

Staff raised concerns and reported incidents and near misses in line with provider policy.

Staff reported serious incidents clearly and in line with provider policy.

Some staff required prompting on their understanding of the term duty of candour. However, they did understand the need to be open and transparent and gave patients and families a full explanation when things went wrong. We reviewed a duty of candour letter in relation in a medication incident.

Managers debriefed and supported staff after any serious incident. The number of debriefs being offered had improved following informal training and supervision. Managers had reinforced the importance and purpose of carrying out a debrief to staff and patients.

Managers investigated incidents thoroughly. This had improved after a whistleblowing which highlighted an inappropriate restraint which had not been fully investigated. As a result, the hospital had adopted a new protocol which meant that all incidents categorised as medium or above were reviewed by the clinical manager. The manager reviewed the CCTV and cross referenced this with the information detailed in the incident report. Managers had identified a further incident where staff had used non approved techniques during a restraint. Managers had taken appropriate action. Where appropriate patients and their families were involved in investigations.

Staff received feedback from investigation of incidents, both internal and external to the service.

Staff met to discuss the feedback and look at improvements to patient care.

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

Good

Assessment of needs and planning of care

Staff assessed the physical and mental health of all patients on admission. They developed individual care plans which were reviewed regularly through multidisciplinary discussion and updated as needed. Care plans reflected patients' assessed needs, and were personalised, holistic and recovery oriented.

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

Good

Staff completed a comprehensive mental health assessment of each patient either on admission or soon after. Psychology staff were now completing formulation on each patient and this was assisting staff in the daily management of patients. This was a new process due to recent recruitment and so not all patients had this in place at the time of the inspection.

Patients had their physical health assessed soon after admission and regularly reviewed during their time on the ward. A physical health nurse had been in post for two months and worked between the wards. There had been an incident where physical health checks had not been carried out for one patient. Managers had introduced further checks to ensure this did not happen again.

Staff developed a comprehensive care plan for each patient that met their mental and physical health needs. We reviewed six patient records and found that all patients had a care plan in place which covered the areas identified in the assessment. Formulation plans were in place for some patients and these were contained within the observation sheet for staff.

Staff regularly reviewed and updated care plans when patients' needs changed.

Care plans were personalised, holistic and recovery orientated.

Best practice in treatment and care

Staff provided a range of treatment and care for patients based on national guidance and best practice. They ensured that patients had good access to physical healthcare and supported them to live healthier lives. Staff used recognised rating scales to assess and record severity and outcomes. They also participated in clinical audit, benchmarking and quality improvement initiatives.

Staff provided a range of care and treatment suitable for the patients in the service.

Staff delivered care in line with best practice and national guidance. (from relevant bodies e.g. NICE)

Staff identified patients' physical health needs and recorded them in their care plans. Patients were being supported to access dentist and opticians and for hospital appointments when required. The service was unable to get patients access with local GPs as most were out of area. In response to this a physical health nurse had been employed.

Staff met patients' dietary needs and assessed those needing specialist care for nutrition and hydration. We saw evidence of food and fluid charts being used and discussions taking place in morning meetings.

Staff helped patients live healthier lives by supporting them to take part in programmes or giving advice. Staff were preparing for becoming a non-smoking site in October 2022 and were working closely with smoking cessation.

Staff used recognised rating scales to assess and record the severity of patients' conditions and care and treatment outcomes.

Staff used technology to support patients. Most patients had access to mobile phones and staff supported patients to use technology to keep in touch with relatives who often lived several miles away.

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

Good

Staff took part in clinical audits, benchmarking and quality improvement initiatives. This included monthly medications, Mental Health Act, individual and health files, observation engagement and CCTV, a six-monthly audit of blanket restrictions and hand hygiene and quarterly infection control audits.

Managers used results from audits to make improvements.

Skilled staff to deliver care

The ward teams included or had access to the full range of specialists required to meet the needs of patients on the ward(s). Managers made sure they had staff with the range of skills needed to provide high quality care. They supported staff with appraisals, supervision and opportunities to update and further develop their skills. Managers provided an induction programme for new staff.

The service had access to a full range of specialists to meet the needs of the patients on the ward. The hospital had two consultant psychiatrists, two speciality registrars, psychologists and two assistant psychologists, two occupational therapists and a range of nurses and support workers. The psychology team were relatively new to the hospital although the assistant psychologists had worked as support workers before qualifying. Both occupational therapists were due to leave, and these posts had been recruited to.

Managers ensured staff had the right skills, qualifications and experience to meet the needs of the patients in their care, including bank and agency staff. Managers were committed to ensuring that the hospital attracted staff with the skills to work in a challenging environment.

Managers gave each new member of staff a full induction to the service before they started work. An induction was given to agency staff who were supported to understand the patients' needs before working.

Managers supported staff through regular, constructive appraisals of their work and 93% of staff had an appraisal.

The medical director was based at the hospital and supported permanent medical staff to develop through yearly, constructive appraisals of their work. Medical staff were supported through regular, constructive clinical supervision of their work

Managers supported non-medical staff through regular, constructive clinical supervision of their work and 96% of staff were receiving managerial supervision. The psychologist was also supporting nursing and support staff with group support.

Managers made sure staff attended regular team meetings or gave information from those they could not attend.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge.

Managers made sure staff received any specialist training for their role. Staff had received training on personality disorder and a psychiatric intensive care unit masterclass.

Managers recognised poor performance, could identify the reasons and dealt with these. We saw evidence of where staff contracts had not been extended past the probation periods.

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

Good

Multi-disciplinary and interagency teamwork

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 team(s) had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation.

Staff held regular multidisciplinary meetings to discuss patients and improve their care. Meetings were held daily for each ward and were attended by all members of the team. Patients had regular ward rounds each week.

Staff made sure they shared clear information about patients and any changes in their care, including during handover meetings. We reviewed handover documentation and saw that these took place and were documented. Information from daily meetings was shared with staff by the nurse in charge. A clinical administrator took minutes at the meetings and shared these with staff.

Ward teams had effective working relationships with other teams in the organisation and external teams. The hospital was a standalone service with patients being referred from other areas. Staff reported some frustrations at the continuity of care once patients were discharged back to home. Staff worked hard to develop good links with home teams and services local to the patient to prepare for discharge.

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

Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice and discharged these well. Managers made sure that staff could explain patients' rights to them.

Staff received and kept up to date with training on the Mental Health Act and the Mental Health Act Code of Practice and could describe the Code of Practice guiding principles.

Staff had access to support and advice on implementing the Mental Health Act and its Code of Practice.

The Mental Health Act administrators were based at the hospital and were available to staff for support.

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

Patients had easy access to information about independent mental health advocacy and patients who lacked capacity were automatically referred to the service. A new advocate had recently been appointed and was working into the hospital. There had been a short gap in the advocacy service due to sickness.

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

Staff made sure patients could take section 17 leave (permission to leave the hospital) when this was agreed with the Responsible Clinician and/or with the Ministry of Justice. We observed that several patients from the acute ward were out on leave and we spoke to patients who said that they were able to visit the local area. We saw that one patient was being encouraged to take leave as this was something they had not accepted since their admission.

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

Good

Staff requested an opinion from a Second Opinion Appointed Doctor (SOAD) when they needed to.

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

Informal patients knew that they could leave the ward freely and the service displayed posters to tell them this.

Care plans included information about after-care services available for those patients who qualified for it under section 117 of the Mental Health Act.

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

Good practice in applying the Mental Capacity Act

Staff supported patients to make decisions on their care for themselves. They understood the provider policy on the Mental Capacity Act 2005 and assessed and recorded capacity clearly for patients who might have impaired mental capacity.

Staff received and kept up to date with training in the Mental Capacity Act and had a good understanding of at least the five principles.

There was a clear policy on Mental Capacity Act and deprivation of liberty safeguards, which staff could describe and knew how to access.

Staff knew where to get accurate advice on the Mental Capacity Act and deprivation of liberty safeguards.

Staff gave patients all possible support to make specific decisions for themselves before deciding a patient did not have the capacity to do so. We observed patients being encouraged to access leave and attend activities.

Staff assessed and recorded capacity to consent clearly each time a patient needed to make an important decision.

When staff assessed patients as not having capacity, they made decisions in the best interest of patients and considered the patient's wishes, feelings, culture and history.

Staff made applications for a Deprivation of Liberty Safeguards order only when necessary and monitored the progress of these applications.

The service monitored how well it followed the Mental Capacity Act and acted when they needed to make changes to improve.

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

Good

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

Good

Kindness, privacy, dignity, respect, compassion and support

Staff treated patients with compassion and kindness. They respected patients' privacy and dignity. They understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition.

Staff were discreet, respectful, and responsive when caring for patients. We observed staff responding to patients' requests and spoke briefly to four patients who said staff met their needs.

Staff gave patients help, emotional support and advice when they needed it. We observed staff helping a patient who was in distress after a serious of negative events during that day. Patients were directed into the garden area or to quieter spaces if needed. The use of seclusion had reduced, and staff described being more confident in using the de-escalation room. We spoke to one patient who said staff had supported her to move to a quieter bedroom on the ward.

Staff supported patients to understand and manage their own care treatment or condition. Patients were encouraged to attend ward rounds and we saw that advance statements were used.

Staff directed patients to other services and supported them to access those services if they needed help. We observed patients being supported to attend appointments for physical healthcare and using the local facilities.

Patients said staff treated them well and behaved kindly.

Staff understood and respected the individual needs of each patient.

Staff felt that they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards patients. This included raising concern with managers about agency staff who were not suitable to work at the hospital.

Staff followed policy to keep patient information confidential.

Involvement in care

Staff involved patients in care planning and risk assessment and actively sought their feedback on the quality of care provided. They ensured that patients had easy access to independent advocates.

Involvement of patients

Staff introduced patients to the ward and the services as part of their admission.

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

Good

Staff involved patients and gave them access to their care planning and risk assessments. We observed this in-patient record and saw examples of patients being involved in developing advance statements to direct staff in periods of distress. A snack and chat group had been introduced each evening to give patients the chance to discuss any concerns or complaints.

Staff made sure patients understood their care and treatment (and found ways to communicate with patients who had communication difficulties).

Staff involved patients in decisions about the service, when appropriate.

Patients could give feedback on the service and their treatment and staff supported them to do this. We reviewed six patient discharge questionnaires which were positive about feeling safe on the ward and felt that the hospital had helped them.

Staff made sure patients could access advocacy services. The post had been vacant for some time due to sickness, but a new advocate was in post at the time of our inspection.

Involvement of families and carers

Staff informed and involved families and carers appropriately.

Staff supported, informed and involved families or carers. We saw evidence of this in care records and discussion at the morning meetings.

Staff helped families to give feedback on the service.

Staff gave carers information on how to find the carer's assessment.

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

Good

Access and discharge

Staff managed beds well. A bed was available when a patient needed one. Patients were not moved between wards except for their benefit. Patients did not have to stay in hospital when they were well enough to leave.

Bed management

Managers made sure bed occupancy did not go above 85%. Managers ensured that the wards did not admit more than three patients requiring enhanced observations at any one time. They also the limited the number of patients with similar high risk profiles' as not to discriminate.

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

Good

Managers regularly reviewed length of stay for patients and regularly discussed the two patients on the psychiatric intensive care unit who had been in the hospital for nine months. The service pathway was that patients should stay between eight and 12-weeks. There had been difficulty securing move on placements and incidents had increased as the patients were ready for discharge. Staff described frustration at not being able to secure discharge at the appropriate time.

All patients at the hospital were out-of-area placements. The acute ward had an arrangement with an out of area trust for 13 of the beds on this ward.

Managers and staff worked to make sure they did not discharge patients before they were ready.

When patients went on leave there was always a bed available when they returned.

Patients did not move between wards due to the commissioning arrangements. However, if there was a clear clinical reason or it was in the best interest of the patient then they could be moved to the psychiatric intensive care unit.

Staff did not move or discharge patients at night or very early in the morning.

The psychiatric intensive care unit was not to full capacity and there had been incidents where patients had been moved from the acute ward.

Discharge and transfers of care

Managers monitored the number of patients whose discharge was delayed and discussed this in local and regional governance meetings and with the providers pathway manager. There was regular discussion with home teams about the patients who stays had exceeded the pathway. An external review was due to take place on one of the patients.

Patients did not have to stay in hospital when they were well enough to leave.

Staff carefully planned patients' discharge and worked with care managers and coordinators to make sure this went well.

Staff supported patients when they were referred or transferred between services.

The service followed national standards for transfer.

Facilities that promote comfort, dignity and privacy

The design, layout, and furnishings of the ward supported patients' treatment, privacy and dignity. Each patient had their own bedroom with an en-suite bathroom and could keep their personal belongings safe. There were quiet areas for privacy. The food was of good quality and patients could make hot drinks and snacks at any time.

Each patient had their own bedroom, which they could personalise. We viewed two bedrooms and found these homely and comfortable. Patients had personalised their rooms and had somewhere to store their clothes and belongings. Patients had raised an issue with the lighting at night which remained bright and could disturb them. Managers had escalated this to estates and dimmer lights had been ordered. The order was still outstanding at time of our inspection due to a problem with identifying suitable lights.

Patients had a secure place to store personal possessions. Patients on the acute ward had access to their own bedroom key.

Staff used a full range of rooms and equipment to support treatment and care.

The service had quiet areas and a room where patients could meet with visitors in private. The family room was off the main ward next to the reception. Patients were encouraged to visit the local area with family if they had leave.

Patients could make phone calls in private and most had access to their own mobile phones.

The service had an outside space that patients could access easily. Each ward had its own garden which was spacious and well maintained. Patients could freely access the garden area.

Patients could make their own hot drinks and snacks and were not dependent on staff. We saw patients making their own drinks. Patients on the psychiatric intensive care unit had to be given access to the beverage area. Staff were available to facilitate this.

The service offered a variety of good quality food. Some patients had raised issues about the quality of food during a Mental Health Act monitoring visit in August 2021 and managers had responded. The kitchen was now fully staffed and set mealtimes had been introduced for both wards. Staff ensured that vegetables, salad and fruit were readily available. Dietary preference forms were contained within patient records and copies were giving to kitchen staff. Patients were able to give feedback in evening snack and chat groups and some continued to raise issues with variety of the food.

Patients' engagement with the wider community

Staff supported patients with activities outside the service, such as work, education and family relationships.

Staff made sure patients had access to opportunities for education and work, and supported patients. Staff reported that it was sometimes difficult to engage patients in the local community as patients would eventually be moving back to home areas. Patients were supported to access the local leisure centre and shops in the local town centre throughout their admission.

Staff helped patients to stay in contact with families and carers. We saw evidence in the records that families visited patients and were involved in care and treatment if appropriate. Families were encouraged to attend ward rounds. We spoke to a patient whose partner had recently visited with the family dogs. Patients were encouraged to visit the local area with family members who had travelled long distances to visit.

Staff encouraged patients to develop and maintain relationships both in the service and the wider community.

Meeting the needs of all people who use the service

The service met the needs of all patients – including those with a protected characteristic. Staff helped patients with communication, advocacy and cultural and spiritual support.

The service could support and make adjustments for disabled people and those with communication needs or other specific needs.

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

Good

Staff made sure patients could access information on treatment, local service, their rights and how to complain. A patient booklet was available, and this was discussed during ward rounds.

The service had information leaflets available in languages spoken by the patients and local community.

Managers made sure staff and patients could get help from interpreters or signers when needed.

The service provided a variety of food to meet the dietary and cultural needs of individual patients. Some patients had raised that there was no halal or vegetarian meals available which the hospital manager had dealt with.

Patients had access to spiritual, religious and cultural support.

Listening to and learning from concerns and complaints

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team and wider service.

Patients, relatives and carers knew how to complain or raise concerns. Complaints were reviewed at the local clinical governance meeting. Complaints related to the noise on the ward and poor choice of meals. The hospital manager dealt with all complaints and responded appropriately.

The service clearly displayed information about how to raise a concern in patient areas.

Staff understood the policy on complaints and knew how to handle them. All complaints were directed to the hospital manager who investigated and identified themes.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint.

Staff protected patients who raised concerns or complaints from discrimination and harassment.

Patients received feedback from managers after the investigation into their complaint.

Managers shared feedback from complaints with staff and learning was used to improve the service.

The service used compliments to learn, celebrate success and improve the quality of care. We saw thank you cards displayed in office areas.

Are Acute wards for adults of working age and psychiatric intensive care units well-led?

Good

Leadership

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

Good

Leaders had the skills, knowledge and experience to perform their roles. They had a good understanding of the services they managed and were visible in the service and approachable for patients and staff.

Leaders had the skills, knowledge and experience to perform their roles. Leaders included a hospital manager, clinical lead and two ward managers. All leaders had worked at the hospital since it had opened. Both ward managers had been promoted from other roles. They had a good understanding of the service and were committed and passionate to the running and improvement of the hospital.

Leaders had a good understanding of the services they managed. They could explain clearly how the teams were working to provide high quality care and were open and transparent about issues. Managers were aware that the high use of agency staff impacted the ward and could result in increased incidents. This was regularly discussed, and staffing was an ongoing priority.

Leaders were visible in the service and approachable for patients and staff. Leaders were based off the ward but were visible throughout the day on the wards and attended daily meetings. All staff said that the managers were approachable and supportive.

Leadership development opportunities were available, including opportunities for staff below team manager level. Staff were supported to apply for senior support roles and staff including the ward managers had progressed to management positions.

Vision and strategy

Staff knew and understood the provider's vision and values and how they (were) applied to the work of their team.

Staff knew and understood the provider's vision and values and how they were applied in the work of their team. This was displayed throughout the hospital and on the intranet.

The provider's senior leadership team had successfully communicated the provider's vision and values to the frontline staff in this service.

Staff had the opportunity to contribute to discussions about the strategy for their service, especially where the service was changing. Staff had giving feedback on the running of the hospital and managers had been able to give feedback on the environment which had

Staff could explain how they were working to deliver high quality care within the budgets available. The hospital was run by an independent provider. Finance was closely monitored and reported on including reporting any enhanced observation requirements back to home teams. Managers had good oversight over the hospital spending and were able to demonstrate that they were routinely within the hospital budget.

Culture

Staff felt respected, supported and valued. They said the provider promoted equality and diversity in daily work and provided opportunities for development and career progression. They could raise any concerns without fear.

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

Good

A staff survey was carried out between 5th March and 9th April 2021 with an overall 80% response rate. Staff reported feeling respected, supported and valued with 69% reporting that the enjoyed working for the provider, 74% reported a good team spirit and 67% able to contribute to running of service. Just over half at 54% felt comfortable with workload which was down 18% from March 2020 and 78% felt supported and valued by line managers.

Managers had responded to the 46% of staff who said that they didn't feel there was enough staff. An action plan was put in place following the staff survey and the hospital was now fully staffed.

Staff felt able to raise concerns without fear of retribution. Staff knew how to use the whistle-blowing process and about the role of the speak up guardian. Three national leads were visiting the hospital at the time of the inspection. They included a staff relations group lead, expert by experience lead and the national freedom to speak up guardian. They were part of a national steering group and responsible for comparing feedback, capture themes, lessons learned and best practice across the organisation.

Managers dealt with poor staff performance when needed. We saw examples of where staff had not stayed past the probation period. Managers were open and honest about the need to have the right staff working at the hospital.

Teams worked well together and where there were difficulties managers dealt with them appropriately.

Staff appraisals included conversations about career development and how this could be supported.

Staff reported that the provider promoted equality and diversity in its day to day work and in providing opportunities for career progression. This was reflected in the staff survey and we saw examples of where staff had been promoted. The two newly appointed assistant psychologists had been support workers at the hospital. Support workers were encouraged to complete nurse training, and this was financially supported by the provider.

Staff had access to support for their own physical and emotional health needs through an occupational health service as well as a range of other wellbeing support schemes. Staff debriefs took place at the end of each shift during handover to give staff a chance to off load before ending their shift.

The provider recognised staff success within the service – for example, through staff awards.

Governance

Our findings from the other key questions demonstrated that governance processes operated effectively at team level and that performance and risk were managed well.

Our findings from the other key questions demonstrated that governance processes operated effectively at team level and that performance and risk were managed well. We saw evidence of effective audit processes in place which had identified issues which managers had then acted upon. Managers had introduced a new system to review all incidents categorised as medium or above. The clinical manager took overall responsibility for reviewing and sharing reports with the wider team. The hospital manager had good oversight of staffing, and closely monitored the high use of agency staff, staff training and supervision and effective processed were in place to manage referrals. Learning from incidents was shared across the whole staff team through bulletins, team meetings and in staff handovers. Managers had implemented a robust programme of audit and ensured that any issues identified were appropriately addressed.

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

Good

There was a clear framework of what must be discussed at a local level in team meetings to ensure that essential information, such as learning from incidents and complaints, was shared and discussed.

Staff had implemented recommendations from reviews of deaths, incidents, complaints and safeguarding alerts at the service level.

Staff undertook or participated in local clinical audits. The audits were enough to provide assurance and staff acted on the results when needed.

Staff understood the arrangements for working with other teams, both within the provider and external, to meet the needs of the patients.

Management of risk, issues and performance

Teams had access to the information they needed to provide safe and effective care and used that information to good effect.

Staff maintained and had access to the risk register at hospital level. However, some staff were not aware of the hospital risk register although they felt able to escalate concerns when required.

Staff concerns matched those on the risk register.

The service had plans for emergencies – for example, adverse weather or a flu outbreak.

Information management

Staff collected analysed data about outcomes and performance and engaged actively in local and national quality improvement activities.

The service used systems to collect data from both wards that were not over-burdensome for frontline staff. The information systems were easy to navigate, and information could be taken direct from the systems. The hospital manager had an overall hospital plan which they could navigate easily.

Staff had access to the equipment and information technology needed to do their work. More laptops had been ordered in response to the staff survey. The information technology infrastructure, including the telephone system, worked well and helped to improve the quality of care. Staff reported that the internet sometimes ran slowly outside of patient areas.

Information governance systems included confidentiality of patient records.

Team managers had access to information to support them with their management role. This included information on the performance of the service, staffing and patient care. The provider had a central team who could support managers to access information around mandatory training, supervision and appraisals.

Information was in an accessible format, and was timely, accurate and identified areas for improvement.

Staff made notifications to external bodies as needed such as CQC notifications and safeguarding referrals.

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

Good

Engagement

Managers engaged actively other local health and social care providers to ensure that an integrated health and care system was commissioned and provided to meet the needs of the local population. Managers from the service participated actively in the work of the local transforming care partnership.

Staff, patients and carers had access to up-to-date information about the work of the provider and the services they used – for example, through the intranet, bulletins, newsletters and so on.

Patients and carers had opportunities to give feedback on the service they received in a manner that reflected their individual needs. Patients were able to give feedback during daily meetings which were attended by the ward managers and other staff as required.

Managers and staff had access to the feedback from patients, carers and staff and used it to make improvements.

Patients and carers were involved in decision-making about changes to the service.

Patients and staff could meet with members of the provider's senior leadership team to give feedback. Staff described being closer in terms of engagement with senior managers and felt more able to speak openly. Senior managers visited the hospital and were available to address concerns.

The hospital manager engaged well with external stakeholders and had an open and honest relationship with the regulator, local authority safeguarding teams and commissioners. The local host commissioner had visited the hospital.

Learning, continuous improvement and innovation

Staff were given the time and support to consider opportunities for improvements and innovation and this led to changes. The hospital had been open for 15 months and in this time managers and staff had developed. There had been challenges since opening which had been addressed and managers were committed to improving the service.

Staff used quality improvement methods and knew how to apply them.

Staff participated in national audits relevant to the service and learned from them.

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 18 HSCA (RA) Regulations 2014 Staffing The service was using a high number of agency staff to cover support workers shifts when acuity was high. In the last 12 months 3194 shifts had been covered by agency staff.