Cygnet Hospital Blackheath

Quality Report

80 – 82 Blackheath Hill
London
SE10 8AD
Tel: 020 8694 2111
Website: www.cygnethealth.co.uk

Date of inspection visit: 24-26 April 2018
Date of publication: 10/07/2018

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

Ratings

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

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

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

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

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

Summary of findings

Overall summary

We rated Cygnet Hospital Blackheath as requires improvement because:

- Ward staff did not have opportunities to learn from incidents and improve the safety of the care provided to patients. On Tyler Ward, there were no discussions in team meetings about the frequent incidents involving actual assault, attempted assault, verbal threats and disruptive or aggressive behaviour.
- Supervision sessions did not support staff to discuss the care they provided for individual patients in order to reflect on and develop, their professional practice. Records of supervision sessions were very brief.
- There were a high number of medication errors on Tyler Ward, particularly errors relating to compliance with the Mental Health Act 1983. These errors had resulted in doctors prescribing medication unlawfully.
- High use of agency staff on Tyler Ward was potentially impacting on the consistency and quality of care as these staff did not have access to team meetings or supervision to support them with meeting the challenges of patients with complex needs.
- A majority of patients we spoke with on Tyler Ward said they did not feel safe on the ward or that they had experienced aggression from other patients.
- Staff on Meridian Ward did not receive specialist training in relation to the complex needs of many patients such as learning disability, autistic spectrum disorders or epilepsy.
- Staff morale was poor. Whilst staff felt well supported by managers within the hospital, they did not feel that senior managers in the organisation listened to and responded to their concerns. Staff were unhappy about changes to their terms and conditions linked to changes in the organisation.

However,

- Senior staff within the hospital had a good understanding of the wards. This team met every morning for a daily planning meeting. During this meeting they discussed staffing, incidents, safeguarding admissions and discharges.
- Managers had clear information that enabled them to compare their performance with other similar wards within Cygnet Health Care.
- Most of the 15 patients we spoke with said that staff were kind, caring and respectful.
- Carers spoke very positively about the improvements that the people they cared for had made whilst on Meridian Ward and the level of stability they had achieved.

Summary of findings

Contents

Requires improvement

Cygnet Hospital Blackheath

Services we looked at:
Acute wards for adults of working age and psychiatric intensive care units and Forensic inpatient/secure wards;

Summary of this inspection

Background to Cygnet Hospital Blackheath

Cygnet Hospital Blackheath has two wards. Tyler ward is a psychiatric intensive care ward for up to 15 male patients. Meridian ward is a low-secure rehabilitation ward for up to 17 male patients. Both wards provide services to patients over the age of 18.

Cygnet Hospital Blackheath has been inspected nine times since 2009. At the most recent inspection in October 2015, we rated the service as being good in all domains, covering safe, effective, caring, responsive and well-led.

Cygnet Hospital, Blackheath is registered for the following regulated activities:

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

The service has not had a registered manager since July 2017. The hospital manager had been in post for five months and intended to register as the manager when they completed their probationary period.

Our inspection team

The team that inspected the service comprised two CQC inspectors, an inspection manager, an assistant inspector, a specialist advisor and an expert by experience. The specialist advisor had a professional background in mental health nursing. The expert by experience had personal experience of using mental health services.

Why we carried out this inspection

We inspected this service as part of our ongoing comprehensive mental health inspection programme. This was an announced inspection.

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 15 patients who were using the service;
- spoke with the hospital manager, medical director, clinical services manager and managers or acting managers for each of the wards;
- spoke with 18 other staff members; including doctors, nurses, healthcare assistants, occupational therapists, a clinical psychologist and a social worker;
- attended and observed two daily management meetings;
- reviewed 10 care and treatment records of patients;
- reviewed records of incidents, restraint and rapid tranquilisation on both wards
- carried out a specific check of the medication management on both wards;
- looked at a range of policies, procedures and other documents relating to the running of the service.

Summary of this inspection

What people who use the service say

We spoke with eight patients on Tyler Ward. All patients said that staff were caring and respectful. Patients said that the food was good. Patients also said that the clinical psychology sessions and occupational therapy were very good. Some patients said they found their medication helpful. However, five of these patients said they did not feel safe on the ward or that they had experienced aggression from other patients. One patient said they could not relax because an incident could start at any time. All patients were detained under the Mental Health Act and many said they were frustrated by not being able to go out when they wanted to. Two patients said they had asked to see a priest or a spiritual leader but this had not happened.

We spoke with seven patients on Meridian Ward. Most patients said that staff were caring and respectful, although some patients said that staff ignored patients when they were busy. Patients were pleased with the recent refurbishments. Patients also said the occupational therapy was good. As with Tyler Ward, all patients were detained under the Mental Health Act and many said they were frustrated by not being able to go out when they wanted to. One patient said they wanted to see a priest but had not been able to. Another patient said they had been waiting a long time to be allowed to go to the local place of worship each week.

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:

- Although managers and senior clinical staff reviewed incidents at monthly meetings, ward staff did not discuss patients, risks or incidents in team meetings.
- Staffing could become stretched on both wards. When an incident required the involvement of a number of staff there were few staff left to support other patients. Due to the high number of incidents on Tyler Ward, this was more likely to happen there.
- Staff on Tyler Ward did not carry out checks of emergency equipment and fridge temperatures consistently. There were gaps of up to six weeks between checks.
- Staff on Tyler Ward did not always update risk assessments after patients were involved in incidents.
- On Tyler Ward, there was a high use of agency staff. These staff did not receive supervision or ongoing training. This could impact on the consistency and quality of the care delivered.
- A report of an investigation into a serious incident on Tyler Ward had not been produced in the time scale required by national guidance on investigating serious incidents.
- Five out of eight patients on Tyler Ward said they did not feel safe on the ward or that they had experienced aggression from other patients.
- Whilst staff were open and transparent and understood their duty of candour, staff on Tyler Ward had not informed patients of medication errors that had occurred in relation to the Mental Health Act.

However,

- Both wards were clean and well maintained.
- Although there was a vacancy rate of 56% for nurses on Tyler Ward, the ward always ensured that all shifts were filled.
- Staff had undertaken over 90% of the mandatory training programme on both wards.
- Staff on both wards carried out a comprehensive risk assessment using a standard risk assessment tool on the day that patients were admitted.
- Each patient had a specific care plan with details of how their risk should be managed.

Summary of this inspection

- Staff on both wards used correct techniques for restraining patients and kept detailed records of each incident of restraint in accordance with national guidance.
- Staff on both wards followed national guidance when using rapid tranquilisation. This included recording comprehensive details of physical health observations carried out after they administered the medicine.
- Staff on both wards regularly monitored the physical health of patients receiving high doses of anti-psychotic medication. This included the use of electrocardiograms.
- Staff on both wards were encouraged to report incidents, errors and near misses.

Are services effective?

Requires improvement

We rated effective as requires improvement because:

- There had been 18 errors in relation to administering medication under the Mental Health Act on Tyler Ward between October 2017 and March 2018. These errors had resulted in doctors prescribing medication unlawfully.
- Staff supervision records showed no evidence of staff discussing patients or their professional practice. Supervision sessions did not provide the opportunity for staff to reflect on their work and develop professionally.
- Staff on Meridian Ward did not receive specialist training in relation to the complex needs of many patients such as learning disability, autistic spectrum disorders or epilepsy.

However,

- Doctors completed a comprehensive physical health examination of every patient on the day of admission.
- The service provided a range of care and treatment interventions suitable for the patient group and recommended by National Institute for Health and Care Excellence (NICE). This included medicines, clinical psychology, and individual occupational therapy.
- Senior staff met each morning to discuss planned new admissions, new referrals, incidents, scheduled events, and patient appointments. This meant that managers had a good understanding of what was happening at the hospital.

Are services caring?

Good

We rated caring as good because:

Summary of this inspection

- Patients said staff treated them well and behaved appropriately towards them. We spoke with 15 patients across both the wards. Almost all these patients said that staff were kind, caring and respectful.
- Staff responded to patients who became agitated in a calm and caring manner.
- Staff read through care plans and risk assessments with patients to check their understanding of these documents.
- Four out of five patients on Meridian Ward said they had been given choices about their care and treatment and had been involved in decision making.
- The service had appointed a former patient as an expert by experience to support patients to give feedback to senior staff. The service also held regular community meetings and a monthly user council meeting.
- On Meridian Ward, some patients acted as a buddy for new patients to help them settle in.
- Two carers of patients on Meridian Ward were very positive about the service. They said the patients they cared for had made a lot of progress and achieved a level of stability that had not been possible at other hospitals.

However,

- Staff recorded patients' views in their care plan, although often this was limited to very brief comments. Patients often refused to sign their care plan.

Are services responsive?

Good

We rated responsive as good because:

- Discharges were not delayed, other than for clinical reasons.
- Patients had their own bedrooms with secure facilities to keep their belongings safe.
- The occupational therapy department had been accredited by the Unit Award Scheme to formally recognise patients' learning through awarding certificates issued by the Assessment Qualification Alliance (AQA).
- Staff knew how to handle complaints appropriately. Complaint records showed the manager completed thorough investigations and responded in a timely manner.

However,

- There was limited room on the ward for activities. For example, the room where gym equipment was kept was also used for meetings, thus limited patients' access to the equipment.

Summary of this inspection

- Staff did not always ensure that patients had access to appropriate spiritual support. Two patients on each ward said they had asked for spiritual support but staff had not responded to their requests.

Are services well-led?

Good

We rated well-led as good because:

- The service was generally well-managed with good systems and policies in place. There were clear structures for meetings and decision making.
- Leaders had a good understanding of the services they managed. Managers met every day to discuss what was happening on the wards.
- Staff had confidence in the hospital manager.
- Staff were proud of their work and spoke positively about their colleagues at the hospital.
- Staff had access to support for their own physical and emotional health needs through an occupational health service.
- The service responded to the findings of audits.
- The service maintained a risk register and business continuity plan.
- The service made changes in response to suggestions from patients.

However,

- Staff said they had not been adequately consulted about changes that had taken place. Staff were unhappy about recent changes to their terms and conditions and this had a negative impact on their morale. They did not feel that senior staff in the organisation would listen to and respond to their concerns.
- On Tyler Ward, staff turnover was 36% and staff sickness was 7.7%.

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.

All patients at the hospital were detained under the Mental Health Act 1983 (MHA). On the day of the inspection, 22 patients had been admitted for treatment and one had been admitted for assessment. Three patients were subject to hospital orders with restrictions.

Eighty-nine per cent of staff had had training in the Mental Health Act. The provider had relevant policies and procedures that reflected the most recent guidance.

Patients had easy access to information about independent mental health advocacy. An independent mental health advocate visited the wards once a week. Staff explained to patients their rights under the Mental Health Act in a way that they could understand, repeated it as required and recorded that they had done it.

Staff requested an opinion from a second opinion appointed doctor when necessary.

However, an audit showed there had been 18 errors in relation to administering medication under the Mental Health Act on Tyler Ward between October 2017 and March 2018, including eight errors in March 2018. These errors had resulted in doctors prescribing medication unlawfully. The medical director was aware of these errors and had introduced an action plan to address this. This plan included the responsible clinician checking prescription charts each week and ensuring that staff attached statutory documents relating to medication to prescription charts.

Mental Capacity Act and Deprivation of Liberty Safeguards

Ninety-three per cent of staff had completed training in the Mental Capacity Act.

Staff had a good understanding of the Mental Capacity Act, in particular the five statutory principles.

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

The provider had a policy on the Mental Capacity Act, including Deprivation of Liberty Safeguards. Staff were aware of the policy and had access to it. Staff said that they would talk to their team leader or the ward manager if they needed advice about a patient's capacity.

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	Requires improvement	Good	Good	Good	Requires improvement
Forensic inpatient/ secure wards	Good	Requires improvement	Good	Good	Good	Good
Overall	Requires improvement	Requires improvement	Good	Good	Good	Requires improvement

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	Good

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

Requires improvement

Safe and clean environment

Safety of the ward layout

- Staff did regular risk assessments of the care environment. The ward staff had completed a ligature risk assessment on 17 May 2017 and reviewed this on 20 April 2018. Staff carried out environmental checks twice a day. These checks included a focus on high-risk areas such as the balcony and laundry room.
- The ward layout allowed staff to observe all parts of the ward. The ward comprised of two corridors in the form of a T-shape. Closed circuit television (CCTV) was used to record activity in communal areas.
- Staff mitigated the risk of potential ligature anchor points on the ward though its ligature risk assessment. The ligature risk assessment identified patients' bedrooms and ensuite facilities as presenting a high risk due to potential ligature anchor points on door hinges and washbasin taps. Staff mitigated these risks through observation and engagement with patients, risk assessments of each patient and environmental checks. There were three ligature cutters on the ward. Staff kept these in the nursing office, clinic room and emergency bag. At the time of the inspection, seven patient bedrooms had been fitted with new bathroom suites, incorporating anti-ligature features. The other eight bedrooms were due to have these facilities installed as part of the refurbishment programme.
- Staff had easy access to alarms. Staff collected personal alarms at the start of each shift. The hospital tested these alarms each day.

Maintenance, cleanliness and infection control

- All ward areas were clean, had good furnishings and were well maintained. Corridors and communal areas were clean and well lit. The service had repainted the ward to optimise the light. The ward had recently installed new art work. Furniture was well designed and comfortable. A member of the facilities staff carried out routine maintenance. A subcontractor carried out any extensive repairs. The hospital manager met with the facilities staff each morning to review the repairs they needed to do and assess the urgency of these repairs. Facilities staff received weekly supervision. There were no outstanding repairs or maintenance issues at the time of the inspection.
- The ward kept cleaning records that were up to date and demonstrated that ward areas were cleaned regularly. During our inspection, domestic staff were cleaning the wards.
- Staff adhered to infection control principles, including handwashing. Each ward completed an infection control audit. The service displayed handwashing instructions in all toilets.

Clinic room and equipment

- The clinic room was being refurbished during the inspection. A small room was being used as a temporary clinic room. This room was clean and well organised. Resuscitation equipment and emergency drugs were available. Staff had recorded seven checks of equipment in the 11 weeks prior to the inspection. However, staff did not complete these checks at regular intervals.

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

Requires improvement

There was a gap of six weeks between the check on 11 February 2018 and the check on 22 March 2018. Similarly, staff did not always check the temperature of the clinic room and fridges every day. In March 2018, there were eight gaps in the daily temperature record, in February there were 11 gaps and in January there were eight missing entries.

- Staff maintained equipment well and kept it clean. At the previous inspection in 2015, the clinic room on the ward had some clutter on the floor. At this inspection, this was not an issue.

Safe staffing

- The service calculated the number of staff needed on each shift according to the number of patients. At the time of the inspection, there were 13 patients on the ward. For this number of patients there were three registered nurses (RMN) during the day and two RMNs at night. There were three healthcare assistants (HCA) during the day and one HCA during the night. There were the correct number of nurses and healthcare assistants on all shifts.
- There were five vacancies for qualified nurses, amounting to 56% of the ward's establishment levels. There were four vacancies for healthcare assistants, amounting to 19% of the ward's establishment level.
- Permanent staff covered the ward rota and bank and agency staff were used when patients needed higher levels of observation. From April 2017 to March 2018, the ward had used agency staff to cover 4063 shifts providing enhanced observations. This meant that, on average, half the staff on the ward were agency staff. Bank and agency staff received an induction but agency staff did not have ongoing supervision, training and access to team meetings. This meant that these staff may not be sufficiently supported and the service may not have an adequate understanding of their competency which could impact on the consistency and quality of care.
- Some staff were working for long hours. Permanent staff worked additional hours to provide cover when needed. The service allowed staff to work up to 55 hours per week. This resulted in six staff working over 220 hours in a month. Only one member of staff had worked more than the maximum number of hours. None of the staff had worked more than five consecutive days.
- The staff sickness rate from April 2017 to March 2018 was 7.7%. Staff turnover rate in this period was 36.3%.
- Managers could increase the number of nurses and healthcare assistants required depending on the acuity level of patients. If the service had more than one patient who required enhanced observations, the ward brought in additional staff members.
- When necessary, the ward manager could access agency and bank nursing staff to maintain safe staffing levels. If bank staff were not available, the service brought in agency staff from a pool of experienced agency staff who were familiar with the ward. Agency staff were available at short notice, and could attend the ward within an hour of the ward manager making the request. A qualified nurse was present in communal areas of the ward at all times. The nurse in charge allocated nurses to this role at the start of each shift.
- Staffing levels allowed patients to have regular one-to-one time with their named nurse. Patients said that nurses were always available.
- Staff rarely cancelled escorted leave or ward activities. Sometimes patients' escorted leave and their activities were delayed, but they were rarely cancelled.
- There were usually enough staff to carry out physical interventions safely. However, incidents of violence and aggression could put pressure on staff. For example, a full restraint of a patient involved six members of staff. This meant there were no staff available to care for the other patients on the ward at the time. Four members of staff said that on such occasions there were not enough staff on the ward to support patients.

Medical staff

- There was adequate medical cover day and night and a doctor could attend the ward quickly in an emergency. During office hours, there were two associate specialist doctors working at the hospital. The hospital had a rota of seven doctors who worked on-call outside office hours. These doctors lived locally and could attend the ward promptly in an emergency. The medical director checked the appraisals and revalidation for all the doctors working at the hospital.

Mandatory training

- Staff had received and were up to date with appropriate mandatory training. The ward rated compliance as green or amber in all categories of training.

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

Requires improvement

- Overall, staff in this service had undertaken 91% of the various elements of training that the service had set as mandatory. This included equality, diversity and disability, fire awareness and emergency first aid.

Assessing and managing risk to patients and staff

Assessment of patient risk

- We reviewed five patient records in full. We reviewed a further four risk assessments of patients who had been involved in incidents in the weeks before the inspection. Most records showed that staff completed risk assessments on admission, but some records were not updated after incidents.
- Staff usually did a risk assessment of every patient on admission and updated it regularly, including after any incident. Of the nine records we reviewed, staff had completed a comprehensive risk assessment of eight patients on the day of their admission or the day after. We reviewed the records of four patients who had been involved in incidents in the four weeks before the inspection. On each record, we found that staff had regularly updated risk assessments. However, the dates on which staff updated risk assessments did not coincide with the incidents. For example, one patient had been verbally abusive and tried to assault staff on 6 April 2018, and physically assaulted another patient on 9 April. Staff had not updated the patient's risk assessment between 27 March and 19 April.
- Staff used a recognised risk assessment tool. This form evaluated a patient's risk across seven domains including violence to others, self-harm and substance misuse.

Management of patient risk

- Staff were aware of and dealt with any specific risk issues. Staff included details of the specific risks the patient presented in the risk assessments. For example, some patients presented specific risks in relation to absconding, violence and substance misuse.
- Staff identified and responded to changing risks to, or posed by, patients. Each patient had a care plan entitled "My Safety Planning". Staff used these care plans to record details of situations in which the patient's risks may increase and how staff should respond to these risks. Staff reviewed patients' risks in handover meetings at the start of each shift. Staff assigned patients a risk rating of red, amber or green.
- Staff followed good policies and procedures for use of observation (including to minimise risk from potential ligature points) and for searching patients or their bedrooms. On the day of the inspection, two patients were on one-to-one observations and one patient was on two-to-one observations. The observation policy allowed for the nurse in charge to increase the observation level for any patient. The policy stated that the multidisciplinary team should review this increase in the observation level as soon as possible. The policy on searches stated that staff should increase the level of observations of a patient, and inform the responsible clinician, if the patient refused a personal search.
- Staff applied blanket restrictions on patients' freedom. These restrictions were usually justified by the need to manage risks. For example, the service had a long list of items prohibited from the wards such as alcohol, glass bottles and sharp objects. This practice was reasonable and consistent with the level of security needed in a psychiatric intensive care unit.
- Staff adhered to best practice in implementing a smoke-free policy. The hospital did not permit smoking anywhere on the hospital site. The service offered nicotine replacement therapy to patients who requested it.

Use of restrictive interventions

- In the 12 months before the inspection there had been 97 incident involving restraint, 17 of which had involved restraint in the prone position. There had been 57 incidents requiring the use of rapid tranquilisation. Of these, 22 incidents involved the use of intramuscular injections and 35 involved oral medication. There had been no incidents of seclusion or long-term segregation.
- The ward participated in the provider's restrictive interventions reduction programme. The clinical services manager led the restrictive interventions programme and produced a monthly audit of restrictive interventions, including analysis of restraints.
- There had been some reduction on the use of restraint since our last inspection. At the last inspection in 2015, there had been 74 incidents of restraint on 33 different patients in the previous six months; 13 of which had been in the prone position. Eleven of these restraints in

the prone position had resulted in rapid tranquillisation. At this inspection, seven of the restraints were in the prone position, all of which had resulted in rapid tranquilisation.

- Staff only used restraint after de-escalation had failed and they recorded the use of correct restraint techniques. However, staff only recorded the use of de-escalation on two of the five restraint records we reviewed. These records showed that staff used correct restraint techniques including precautionary standing, forearm holds and thumb/wrist holds. Staff recorded the names of each member of staff involved in the restraints and which limb the member of staff was responsible for holding. When staff used prone or supine restraint, they recorded the length of time this restraint lasted.
- Staff understood and, where appropriate, worked within the Mental Capacity Act definition of restraint. Restraint records showed that staff were aware of this definition, as they recorded when they restricted a patient's movement or used force to ensure a patient did something that they were resisting. For example, staff used force to prevent patients from harming themselves or other people or to gain control of a dangerous situation.
- Staff followed NICE guidance when using rapid tranquilisation. We reviewed six records of rapid tranquilisation. Staff completed each record on a standard form. Staff recorded the medicine, the dose and the route of administration. Staff monitored the patient's pulse, blood pressure, respiration and level of consciousness at least every hour until there were no concerns about the patient's physical health. When patients refused these observations, staff recorded the patient's level of consciousness and offered further observations every 15 minutes. When a patient fell asleep after rapid tranquilisation, staff monitored their physical health by ensuring the patient remained on enhanced observations.
- At the last inspection in 2015, we were unable to locate documented evidence that the ward had completed the procedure for seclusion according to the Mental Health Act Code of Practice. At this inspection, we found that no episodes of seclusion had occurred within the last 12 months.

Safeguarding

- Staff were trained in safeguarding, knew how to make a safeguarding alert, and did so when appropriate. Eighty-nine-percent of staff had completed safeguarding adults training, and 86% of staff had completed safeguarding children training. Staff said that they would speak to their manager or the social worker if they had safeguarding concerns about a patient at risk of abuse. At the weekend, staff telephoned the local authority directly to make a safeguarding referral.
- Staff could give examples of how to identify patients at risk of harm, such as financial abuse due to patients asking more vulnerable patients for money.
- Staff followed safe procedures for children visiting the ward. There was a family room off the ward where children could visit patients.

Staff access to essential information

- Staff recorded information on paper records and electronic records.
- Staff recorded daily progress notes on an electronic record. Staff recorded key documents, such as care plans and risk assessments on paper. Statutory documents relating to the Mental Health Act were kept in the Mental Health Act office.
- All information needed to deliver patient care was available to all relevant staff when they needed it and was in an accessible form. Information was easily accessible through the electronic patient record. Staff kept paper documents in the nurses' office.

Medicines management

- Staff followed good practice in some aspects of medicines management in line with national guidance. A specialist pharmacy service provided medicines management for the hospital. This included ensuring that appropriate arrangements were in place for the transport, disposal and medicines reconciliation for the hospital. The pharmacy service also provided a monthly audit of medicines charts to highlight any prescribing or administrative errors. This audit showed that in the six months from October 2017 to March 2018 there had been 169 errors including 76 prescribing errors, 20 administrative errors and 18 errors in relation to the Mental Health Act. The number of errors was three times higher than the 56 errors recorded on the neighbouring ward. The medical director was aware of these errors and had introduced an action plan to address this.

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

Requires improvement

- Staff reviewed the effects of medication on patients' physical health regularly and in line with National Institute for Health and Care Excellence (NICE) guidance, especially when they prescribed patients with a high dose of antipsychotic medication. At the time of the inspection, two patients were receiving high dose antipsychotic medication. Staff regularly monitored the physical health of these patients, including the use of electrocardiograms.

Track record on safety

- At the last inspection in 2015, the service recorded 21 serious incidents in the previous 12 months. At this inspection, there had been 20 incidents in the first four months of 2018.
- These incidents included two unprovoked attacks by a patient on another patient, a patient being taken to hospital after falling to the floor and being unresponsive and a patient failing to return from unescorted leave.

Reporting incidents and learning from when things go wrong

- All staff knew what incidents to report and how to report them. All staff we interviewed gave examples of incidents they have reported, including situations that may have resulted in harm but did not. In the staff survey in 2018, 98% of staff said they were encouraged to report errors, near misses and incidents
- Staff reported all incidents that they should report. During the month before the inspection, staff had reported 32 incidents. There had been eight incidents of actual assault, four incidents of attempted assault, four incidents of verbal threats and six incidents of disruptive or aggressive behaviour.
- Staff understood their duty of candour. They were open and transparent, and usually gave patients and families a full explanation if and when things went wrong. Responses to complaints included acknowledgements of when staff had not followed procedures correctly. Staff spoke to us in an open and transparent manner about mistakes they had made and how they were working to improve this. However, the hospital had not informed patients of medication errors in relation to the Mental Health Act.
- Some staff received feedback from investigations of incidents, both internal and external to the service. The provider held an integrated governance meeting (IGM) each month. All the managers at the hospital attended these meetings. At these meetings, managers discussed incidents and shared learning. Managers then shared learning from incidents in monthly incident learning meetings, attended by senior clinical staff. Managers told us that staff then received this learning through monthly staff meetings and supervision. However, when we reviewed the staff meeting and supervision records, there were no mention of incidents and the learning from them.
- There was evidence that the ward had made changes as a result of feedback. For example, after a serious incident involving a death of a patient, staff carried out more stringent physical health assessments when patients were admitted to the service. Staff also audited physical health assessments.
- The service had taken steps to improve safety. For example, the hospital had trained all staff in the prevention and management of violence and aggression. The service had also introduced systems for more detailed monitoring of prescription charts. In January 2018, the associate specialist doctor had completed an audit of the use of intramuscular medication on the ward. The report of this audit included recommendations for involving patients more in planning for situations when they may need this medication. The service had also introduced complex case conferences held every week where the multidisciplinary team could discuss patients who they found difficult to support. Doctors and the clinical psychologist attended these meetings to discuss different ways to meet patients' needs. The staff who attended the meetings found this helpful. However, staff did not record these meetings so it was difficult to share any learning with colleagues who were unable to attend.
- The ward provided debriefing and support to staff involved in an incident. At the IGM, managers assured themselves that staff and patients received debriefing after all incidents. However, only one of the five records of restraint we reviewed stated that de-briefing had taken place.

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

(for example, treatment is effective)

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

Requires improvement

Requires improvement

Assessment of needs and planning of care

- The inspection team examined five care records. Some care plans demonstrated good practice in being comprehensive and person centred. Other care plans tended to be quite generic.
- Staff completed a comprehensive mental health assessment of the patient in a timely manner at, or soon after, admission. Staff had recorded details of these assessments on each patient record. Initial assessments contained detailed notes covering the reason for the referral, psychiatric and medical history, and a comprehensive mental state examination.
- Staff assessed patients' physical health needs in a timely manner after admission. All the records we reviewed showed that a doctor had completed a physical health examination on the day of admission. Physical health examinations covered the patient's weight, blood tests, urinary drug screening, electrocardiogram, blood tests, blood pressure, heart rate and respiration.
- Staff developed some care plans that met the needs identified during assessment. Patients had different care plans for their mental health, management of risk and physical health. Some care plans addressed specific matters identified in the initial assessment, such as one care plan that focused on helping the patient to manage the voices they heard. The risk assessment for one patient identified specific risks relating to non-compliance with medication. The care plan for this patient specifically addressed these risks. However, some care plans were quite generic. For example, in one care plan, the objectives were simply to reduce the symptoms of the patient's illness without any details of what these symptoms were.
- Staff updated care plans when necessary. On all the records we reviewed, staff had updated care plans each week.

Best practice in treatment and care

- The inspection team examined five care records. Most care records demonstrated good practice in treatment and care.
- Staff provided a range of care and treatment interventions suitable for the patient group. The interventions were those recommended by, and were delivered in line with, guidance from the National Institute for Health and Care Excellence (NICE). These included medication and psychological therapies. Patients were experiencing psychosis or schizophrenia. The service primarily used antipsychotic medication to treat patients' symptoms. Doctors reviewed each patient's medication on admission. Doctors carried out a full physical examination prior to starting medication, including offering an electrocardiogram. The ward provided a weekly psychology group, a music group, art group and individual occupational therapy.
- Staff ensured that patients had good access to physical healthcare, including access to specialists when needed. One patient had a specific care plan to address their needs in relation to obesity.
- Staff supported patients to live healthier lives, for example, through participation in smoking cessation schemes, healthy eating advice, managing cardiovascular risks, screening for cancer, and dealing with issues relating to substance misuse. The ward ran a health and fitness group each morning. The ward also ran a life skills and smoking cessation workshop once a week.
- Staff used recognised rating scales to assess and record severity and outcomes. The service used a version of the health of the nation outcome scales that was adapted for use in secure mental health settings. Staff carried out assessments of most patients using this scale every two weeks.
- Staff participated in clinical audit, benchmarking and quality improvement initiatives. For example, staff audited patient care records, risk assessments, incident reporting and physical health assessments. Following these audits, managers gave feedback to staff members who needed support to improve their record keeping.

Skilled staff to deliver care

- The team included, or had access to, the full range of specialists required to meet the needs of patients on the ward. As well as doctors and nurses, the service employed occupational therapists, clinical psychologists, social workers, pharmacists, and peer support workers. The service brought in dieticians and speech and language therapists from the community when required.

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

Requires improvement

- Staff were experienced and qualified, and had the right skills and knowledge to meet the needs of the patient group. Some of the staff had worked at the service for more than six years. The service employed a nurse who was qualified in learning disability and autism to assist patients who required this extra support.
- Managers provided new staff with an appropriate induction developed by the provider. New staff received supervision from their manager each week. They were required to complete their mandatory training within three months.
- Managers provided permanent staff with monthly supervision. The supervisor had the same professional background as the supervisee and, therefore, sessions could include both managerial and clinical supervision. However, the supervision records indicated that these sessions did not meet the objective, set out in the supervision policy, of providing the opportunity to reflect and develop professionally in an effort to achieve best practice. We reviewed 18 staff supervision records over four months. Many of these sessions were recorded in a single sentence. There were no records showing that staff discussed safeguarding, patients' abuse towards staff, managing challenging behaviour, complaints or learning from these incidents. There was almost no documentation of the learning needs of staff or support for professional development. In four of the 18 supervision records, there was no mention of patients. This meant there was a significant risk that staff did not receive the necessary support to learn from incidents, develop their professional practice and, more broadly, improve the care and support that patients received.
- Managers ensured that staff had access to team meetings. We reviewed the minutes for the last five staff meetings. Whilst these meetings usually took place each month, there had been no meetings for three months between December 2017 and February 2018. Staff recorded the meetings in detail. However, the staff meetings tended to focus on administrative matters. There was no mention of learning from incidents, safeguarding referrals, or complaints. This meant that staff did not have the opportunity to reflect together on incidents and improve practice to make the ward safer.
- The percentage of staff that had had an appraisal in the last 12 months was 96%.
- The percentage of staff that received regular supervision was 94% for the past year, although we were concerned that these sessions did not adequately support staff to carry out their role.
- Records of supervision sessions included no evidence that managers identified the learning needs of staff and provided them with opportunities to develop their skills and knowledge.
- Managers ensured that, on some occasions, staff received the necessary specialist training for their roles. All staff said they had received training in basic life support. Some staff said they had received specialist training in phlebotomy and using electrocardiograms.
- Manager addressed poor staff performance by providing extra support to staff members. Between April 2017 and March 2018, one member of staff had been suspended following concerns about their right to work in the United Kingdom.

Multi-disciplinary and inter-agency team work

- Staff held multidisciplinary meetings, led by the consultant psychiatrist, twice a week. The frequency of these meetings meant that the multidisciplinary team could usually see any new patients within 72 hours. At the meetings, the multidisciplinary team developed a care plan for each patient.
- Staff shared information about patients at effective handover meetings within the team in the morning and evening during shift change. There was also a handover meeting between staff members and the clinical team, such as the clinical psychologist and doctors, at 9am Monday to Friday. There was a morning briefing meeting for ward managers, senior staff and doctors. At this meeting, the team discussed planned new admissions, new referrals, incidents, scheduled events, and patient appointments. This ensured that managers and senior staff understood what had happened in the previous 24 hours and knew what colleagues would be doing that day.
- The ward team had effective working relationships with teams outside the organisation. Staff said that they had regular contact with patients' care coordinators and local mental health trusts. Staff supported patients to visit a GP when required.

Adherence to the MHA and the MHA Code of Practice

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

Requires improvement

- All patients on Tyler Ward were detained under the Mental Health Act 1983 (MHA). On the day of the inspection, the ward had 11 patients admitted for treatment, one for assessment and one who was subject to a hospital order with restrictions.
- Eighty-nine per cent of staff had had training in the Mental Health Act. Staff had a good understanding of the Mental Health Act, the Code of Practice and the guiding principles.
- Staff had easy access to administrative support and legal advice on implementation of the Mental Health Act and its Code of Practice. The MHA administrator provided initial advice. If the matter was complicated, the MHA administrator could consult the MHA lead for Cygnet Health Care. The MHA administrator was based at the hospital and was well known to ward staff.
- The provider had relevant policies and procedures that reflected the most recent guidance. For example, the hospital had policies on each aspect of the MHA such as a policy on restricted patients, recording mental capacity and holding powers. The provider reviewed these policies every three years.
- Staff had easy access to local Mental Health Act policies and procedures and to the Code of Practice. Staff could access policies and the Code of Practice through the staff intranet.
- Patients had easy access to information about independent mental health advocacy. An independent mental health advocate visited the wards once a week.
- Staff explained to patients their rights under the Mental Health Act in a way that they could understand, repeated it as required and recorded that they had done it.
- Staff ensured that patients were able to take Section 17 leave (permission for patients to leave hospital) when this had been granted.
- Staff requested an opinion from a second opinion appointed doctor when necessary.
- A specialist pharmacy service provided weekly checks of prescribing, including checks of compliance with the MHA. This audit showed there had been 18 errors in relation to administering medication under the Mental Health Act between October 2017 and March 2018, including eight errors in March 2018. These errors had resulted in doctors prescribing medication unlawfully. For example, on eight occasions doctors prescribed medicines that were not included in certificates confirming that the patient had given consent or that a second opinion appointed doctor had authorised the use of the medicine. The medical director was aware of these errors and had introduced an action plan to address this. This plan included the responsible clinician checking prescription charts each week and ensuring that staff attached statutory documents relating to medication to prescription charts. However, during the inspection, we found a further error involving the responsible clinician authorising non-urgent treatment under the provisions for urgent treatment.
- Staff stored copies of patients' detention papers and associated records (for example, Section 17 leave forms) correctly and so that they were available to all staff that needed access to them.
- Some care plans referred to identified Section 117 aftercare services to be provided for those who had been subject to section 3 or equivalent Part 3 powers authorising admission to hospital for treatment.
- Staff did regular audits to ensure that the Mental Health Act was being applied correctly. There was evidence of learning from those audits. For example, an action plan had been created to address the concerns about prescribing medication in accordance with the MHA.

Good practice in applying the MCA

- Ninety-three per cent of staff had completed training in the Mental Capacity Act.
- Staff had a good understanding of the Mental Capacity Act, in particular the five statutory principles. At the last inspection in 2015, some staff did not have an understanding of the MCA. At this inspection, we found that all staff could explain the principles of the MCA and told us that some patients' capacity could fluctuate. Staff said that they would raise concerns about a patient's capacity to make a decision at daily handovers and weekly ward rounds. The responsible consultant would assess a patient's capacity to make a decision, if necessary.
- There were no deprivation of liberty safeguards applications made in the last 12 months.
- The provider had a policy on the Mental Capacity Act, including deprivation of liberty safeguards. Staff were aware of the policy and had access to it. Staff said that they would talk to their team leader or the ward manager if they needed advice about a patient's capacity.

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

Requires improvement

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

Good

CARING

Kindness, privacy, dignity, respect, compassion and support

- Staff attitudes and behaviours when interacting with patients showed that they were discreet, respectful and responsive, providing patients with help, emotional support and advice at the time they needed it. For example, we observed staff responding promptly to patients' requests for help or information. Staff responded to patients who became agitated in a calm and caring manner. However, five out of eight patients said they did not feel safe on the ward or that they had experienced aggression from other patients.
- Staff supported patients to understand and manage their care, treatment or condition if possible. However, the nature and degree of patients' illnesses often presented difficulties for patients in managing their own care. All patients were detained under the Mental Health Act. The consultant psychiatrist made decisions about the amount of leave each patient could have from the ward.
- Staff directed patients to other services when appropriate and, if required, supported them to access those services, when this was possible. However, most patients at the hospital were a long way from their homes, making it difficult to access services that could help them after discharge.
- Patients said staff treated them well and behaved appropriately towards them. We spoke with eight patients. All these patients said that staff were kind, caring and respectful. Patients said that staff always knocked on their door before entering. One patient said that staff went out of their way to help. Another patient said that staff were always there for patients. Only one patient gave a negative comment. They said that some night staff occasionally spoke in an aggressive tone.
- Staff did not always understand the individual needs of patients, including their personal, cultural, social and religious needs. Three patients said they had specific cultural needs. Two patients said they had asked to speak to someone from their religious community but this had not happened.
- Staff said they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards patients without fear of the consequences. Staff we spoke with all said they could talk to a manager about any concerns they had.
- Staff maintained the confidentiality of information about patients. Staff kept all records in the nurses' office. Staff only discussed patients in private meetings or in the nurses' office. Information about patients that staff displayed in the nurse's office could not be seen from the corridors.

Involvement in care

Involvement of patients

- Staff used the admission process to inform and orient patients to the ward and to the service. Staff had produced an information pack for patients. However, only two patients said they had received information on admission. Five patients said staff had shown them around the ward. One patient explained that they had been unwell on admission and that staff had only recently inducted them to the ward.
- Staff involved patients in care planning and risk assessment when this was possible. Staff invited patients to attend multidisciplinary team meetings to discuss their care and treatment. Staff recorded patients' views in their care plan, although often this was limited to very brief comments. Staff gave a copy of the care plan to the patient. On three of the five care plans we reviewed, the patient had refused to sign.
- Staff communicated with patients so that they understood their care and treatment. Staff read through care plans and risk assessment with patients to check their understanding of these documents.
- Staff had made efforts to involve patients when appropriate in decisions about the service. The service had appointed a former patient as an expert by experience to support patients to give feedback to senior staff. The service also held a monthly user council in conjunction with another local Cygnet hospital. Patients appointed a representative to attend these meetings to discuss any plans for the service.

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

Requires improvement

- Staff enabled patients to give feedback on the service they received. The ward held a community meeting every month. At the meeting in April 2018, patients gave positive feedback about the housekeeping staff and the food. In February and March 2018, patients expressed concerns about incidents of assaults on the ward. The ward requested feedback from patients using a user satisfaction survey. Only three patients had completed this survey between October 2017 and March 2018. All three responses were positive.
- Staff did not enable patients to make advance decisions (to refuse treatment, sometimes called a living will) when appropriate.
- Staff ensured that patients could access advocacy. An advocate visited the ward every Thursday.

Involvement of families and carers

- Staff informed and involved families and carers appropriately and provided them with support when needed when this was possible. Two patients said that their families were involved in their care and treatment. Three patients said their families had some involvement in the care and treatment but that this was difficult as they lived so far away.
- Staff enabled families and carers to give feedback. The service produced a newsletter for families and carers every quarter. The most recent newsletter included details of how families and carers could provide feedback on the service. The hospital had held a coffee morning for families and carers in December 2017.

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

(for example, to feedback?)

Good

Bed management

- The service received referrals from other intensive care units, community settings, health based places of safety, locked rehabilitation wards and acute wards.
- There was always a bed available when patients returned from leave. Patients did not go on overnight leave unless it was part of a transition to another service.
- Staff did not generally move patients between wards during an admission episode unless it was justified on clinical grounds and was in the interests of the patient. For example, staff could move a patient temporarily to the neighbouring ward if they had been involved in a serious incident with another patient.
- When patients were moved or discharged, this happened at an appropriate time of day. At the last inspection in 2015, staff sometimes transferred patients across long distances out of working hours. At this inspection, we found that the ward often admitted patients in an emergency and this could take place at any time of the day or night. The authorities funding the patient's care could recall the patient to their home area at any time. Sometimes, patients were recalled at short notice and this could involve long journeys at night. However, the funding authority made this decision, not the hospital.

Discharge and transfers of care

- In the last 12 months, there was one delayed discharge from the ward.
- When patients were ready for transfer to an acute ward, staff usually had time to prepare them for the transition. Staff contacted services in the patient's local area, and liaised with their care coordinator, to ensure a smooth transition. However, sometimes the hospital in the patient's local area demanded that patients move to another intensive care unit without transition planning. Staff said that in these cases, they moved patients within the same day as the request, and they did not have time to ensure that patients had a person-centred transition. However, this was outside the control of the service.
- Discharge was very rarely delayed, other than for clinical reasons. At the last inspection in 2015, discharge from the ward was sometimes delayed for non-clinical reasons. At this inspection, we found only one patient had their discharge delayed because of difficulties in finding a service which would meet their needs.

Facilities that promote comfort, dignity and privacy

- Patients had their own bedrooms and were not expected to sleep in bed bays or dormitories. Most bedrooms had ensuite facilities.
- Patients could personalise bedrooms although few patients chose to do so.

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

Requires improvement

- Patients had somewhere secure to store their possessions. Patients could store their possessions in a safe. Patients could also lock their bedroom doors.
- There was very limited room on the ward to carry out the activities. The occupational therapy room on the ward was also the room used for weekly ward rounds, for tribunals, Mental Health Act assessments and care programme approach meetings. This meant that activities for patients were sometimes cancelled due to meetings taking place.
- There were quiet areas on the ward and a room where patients could meet visitors.
- Patients could make phone calls in private using their own phones. However, the staff only permitted patients to have telephones that did not have an integrated camera. If a patient did not have a telephone, they could use a telephone in one of the offices.
- Patients had access to outside space. Patients had unrestricted access to a small balcony. Patients had restricted access to a small garden. Patients could only use this garden with authorisation from their responsible clinician.
- The food was of a good quality. Four of the patients we spoke with specifically said that the food was very good.
- At the time of the inspection, patients could not make hot drinks or snacks at any time. However, as part of the refurbishment programme, the service was installing a drinks station in the patients' lounge. This was due to be completed in May 2018.

Patients' engagement with the wider community

- When appropriate, staff ensured that patients had access to education and work opportunities. The occupational therapy department had been accredited by the Unit Award Scheme to formally recognise patients' learning through awarding certificates issued by the Assessment Qualification Alliance (AQA). The ward also operated a scheme to employ patients to assist in maintaining the kitchen used in occupational therapy sessions and to participate in the service user council.
- Staff supported patients to maintain contact with their families and carers. However, three patients said this was difficult as their families lived a long way away.
- Staff encouraged patients to develop and maintain relationships with people that mattered to them, both within the services and the wider community when this was possible. However, patients' access to the wider community was limited due to risks and their detention under the Mental Health Act.

Meeting the needs of all people who use the service

- The service made adjustments for disabled patients. The service had installed a lift to ensure that people with physical disabilities could access the ward.
- Staff ensured that patients could obtain information on treatments, local services, patients' rights, and how to complain. Staff displayed this information on notice boards.
- The information provided was in a form accessible to the particular patient group according to each patient's needs.
- Staff made information leaflets available in languages spoken by patients if requested.
- Managers ensured that staff and patients had easy access to interpreters and/or signers. One Arabic speaking patient said that staff had arranged an interpreter to help him.
- Patients had a choice of food to meet the dietary requirements of religious and ethnic groups. A neighbouring service cooked food on site and this could be prepared according to the specific needs of patients.
- Staff did not always ensure that patients had access to appropriate spiritual support. Two patients said they had asked for spiritual support but staff had not responded to their requests.

Listening to and learning from concerns and complaints

- There had been 17 complaints in the last 12 months.
- The hospital had partly upheld six complaints. The hospital did not uphold nine complaints. One complainant had withdrawn their complaint. The hospital was still investigating one complaint.
- No complaints were referred to the Ombudsman in the last 12 months.
- Most patients knew how to complain or raise concerns. Staff displayed information about how to make a complaint on notice boards. Six out of eight patients we spoke with said they knew how to complain.

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

Requires improvement

- When patients complained or raised concerns, they received feedback. We reviewed records relating to five complaints. Four of the records included a detailed response to the patient. Managers were still investigating the other complaint.
- Staff knew how to handle complaints appropriately. Complaint records showed that managers completed thorough investigations and responded in a timely manner.
- Staff received feedback on the outcomes of investigations into complaints and acted on the findings. Managers discussed complaints at the integrated governance and took appropriate action. For example, managers redeployed a member of staff and initiated the performance management procedure after they upheld a complaint about staff attitude.

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

Good

Leadership

- Leaders had the skills, knowledge and experience to perform their roles. The ward manager and hospital manager had worked as mental health nurses before their promotion to managerial roles. They had both completed leadership and management courses prior to their appointment.
- Leaders had a good understanding of the services they managed. The ward manager had worked in the service for two years. They knew the service and the staff very well. The hospital manager had been with the service since November 2017. The quality assurance lead from the regional office visited the hospital at least once a month, to review the service and oversee investigations into incidents.
- Staff told us that they saw the hospital manager on the ward most days. However, staff said that senior managers from the regional office rarely visited the wards.
- There were some opportunities for staff members to have leadership training. Two staff had completed leadership training in the last year. Three staff members we spoke with were interested in receiving leadership training and promotion, but were not clear if they were eligible. The hospital manager said that no healthcare assistants or qualified nurses were having leadership training at the time of the inspection.

Vision and strategy

- Staff members knew and understood the provider's vision and values and how they were applied in the work of their team. The provider's vision and values were displayed throughout the service and staff members could tell us what they were. Staff members told us that they expected each other to uphold these values. Team leaders told us that they would challenge staff who did not display these values.
- Staff had limited opportunities to contribute to discussions about the strategy for their service. Six members of staff told us that they did not have the opportunity to contribute to discussions about the strategy. The organisation had recently merged with another provider resulting in changes to the way staff recorded patient information, the pay structure for staff, and the refurbishment of the environment. Staff said that managers had not consulted with them on any of these changes.

Culture

- Most staff did not feel valued and respected by senior managers of the organisation. We spoke to eight members of staff. Four members of staff said that they did not feel listened to by senior managers of the organisation. They said that when they raised concerns, nothing was done. Five members of staff said that morale was low because of the changes that had happened at the service during the past year and because they had no control or say in these changes. Members of staff said that this had resulted in a high staff turnover. Staff turnover for the service was 36%.
- A staff representative group met monthly. This group presented staff concerns to the organisation's board. In response to issues raised, the organisation was conducting a pilot to change the pay structure back to the previous arrangement. However, only one member of staff from the ward attended this group. Most staff felt that it was not an effective forum. Five staff members did not feel that senior managers would make any change on the recommendations from the staff representative group.

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

Requires improvement

- Staff were very proud of their work and their team. Staff said that their team leaders were very good and they had confidence in the hospital manager and the local service management. Staff said they were all passionate about patient safety and well-being and said that they tried their best for patients.
- Two members of staff said that they felt able to raise their concerns to their managers without fear of retribution. However, four staff members said that they did not have confidence that change would happen as a result of their concerns.
- Staff knew how to use the whistle-blowing process. There were posters displayed at the service with the contact details for the whistle-blowing service and examples of when whistle-blowing would be appropriate. The hospital manager said that no staff had used the service during the past year. Three members of staff doubted anything would change if they did use the service.
- Staff said that managers supported staff with poor performance with extra supervision and more training. Managers said they had not formally disciplined any staff in the service in the past year.
- Staff appraisals included conversations about career development and how it could be supported. However, some staff members said that senior managers had ignored their requests for leadership training.
- The service's staff sickness and absence were higher than the average for the provider. Staff sickness on this this ward was 7.7%, compared to 1.7% on the neighbouring ward.
- Staff had access to support for their own physical and emotional health needs through an occupational health service. Staff had used this service following traumatic incidents at work and for personal matters. Two members of staff said that their managers had supported them while they were off on long term sickness and had asked after their well-being regularly since they returned to work.
- The provider recognised staff success within the service. There were 'employee of the month' awards. The hospital displayed the results of these awards on notice boards.

Governance

- The service was well managed, with systems and policies in place to ensure that the ward was clean and that patients were assessed and treated well. Staff reported incidents and made safeguarding referrals when appropriate. However, there were some areas that managers had overlooked. For example, the quality of supervision records was poor and staff morale was low. Systems for cascading of learning from incidents, complaints and safeguarding referrals from senior managers to staff working directly with patients were not effective. This meant that ward based staff did not have the opportunity to formally discuss the many incidents that took place.
- We reviewed the past three months' minutes from integrated governance meetings (IGM) and incident learning meetings. We found that senior managers structured meetings well and covered upcoming changes to the service, incidents, restraints, safeguarding referrals and complaints. Team meetings for ward staff were also well structured and well documented. However, these meetings did not include feedback from the managers meetings. As the majority of staff did not attend the IGM and the incident learning meetings, this meant they did not have the opportunity to reflect on learning as a group.
- Staff could give examples of changes to the service in response to serious incidents at the service and at other locations within the organisation. For example, after a serious choking incident on the neighbouring ward, staff had included an assessment of choking risk within the initial physical health checks.
- Staff undertook and participated in local clinical audits. The audits were sufficient to provide assurance. Staff mostly acted on the results when needed. For example, the medicines management audit for the last six months showed a worsening of errors on medicine charts and compliance with the Mental Health Act. In response, the service had put in place an action plan to address these concerns. This included the introduction of competency checks for nursing staff in relation to medicines management.
- Staff understood the arrangements for working with other teams, both within the provider and external, to meet the needs of the patients. Staff liaised with the mental health teams in each patient's local area when this was appropriate. For example, the consultant psychiatrist frequently liaised with the patient's GP and psychiatrist in their local area when they made prescribing decisions.

Management of risk, issues and performance

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

Requires improvement

- Staff maintained and had access to the risk register at ward and directorate level. However, the risk register for the ward did not include the poor quality of supervision or staff morale due to the changes at the service. The risk register was available to staff on the hospital intranet. However, staff at ward level said that they were not confident that they could escalate concerns when required.
- Staff concerns did not match those on the risk register. For example, a number of staff were concerned that the changes to their pay would lead to many of their colleagues leaving. This was not reflected on the risk register.
- The service had plans for emergencies. A business continuity plan included all the telephone numbers for use in an emergency. There were also contingency plans covering foreseeable incidents such as bad weather, severe staff shortage, infectious diseases and serious disruption to information technology and telephones.

Information management

- The service used systems to collect data from wards and directorates that were not over-burdensome for frontline staff. Mangers had access to clear and well-presented data. None of the staff raised concerns about data collection.
- Staff had access to the equipment and information technology needed to do their work. The information technology infrastructure, including the telephone system, worked well and helped to improve the quality of care. Staff said that the introduction of computer based records and risk management had been helpful.
- Information governance systems included confidentiality of patient records. These systems ensured that paper records were kept in locked filing cabinets and electronic information was protected by passwords.
- 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. This also included information about other similar wards managed by Cygnet Health Care to allow services to compare their performance.
- Information was in an accessible format, and was timely, accurate and identified areas for improvement. Data was presented in spreadsheets with clear graphs and tables. This meant that staff could understand the information quickly.
- Staff made notifications to external bodies as needed. This included 18 notifications sent to the Care Quality Commission between January and March 2018. The service also sent regular notifications to the local authority about safeguarding matters.

Engagement

- Staff, patients and carers had access to up-to-date information about the work of the provider and the services they used. Staff could read the minutes of senior managers' meetings, which were available on the shared electronic system. There was also a monthly newsletter for staff and patients. The service emailed news about important changes, as well as learning from serious incidents, directly to staff members.
- Patients and carers had opportunities to give feedback on the service they received in a manner that reflected their individual needs. The ward held a weekly community meeting and the hospital held a monthly service user forum. The service also produced a newsletter for carers and had held a coffee morning for carers in December 2017. However, only three patients had completed a feedback survey between October 2017 and March 2018.
- Staff had access to feedback from the patients' community meetings; the minutes were displayed in the staff room. The service displayed a 'you said, we did' board. This showed changes the service had made in response to patients' requests such as introducing a daily kick-about after patients asked for more time to play football.
- Staff told patients and carers about changes to the service. Patients were involved in discussions about changes to the service in community meetings. The service held quarterly carers meetings.
- Patients and staff could meet with members of the hospital's senior leadership team to give feedback. Staff said that the hospital manager was very approachable. However, staff said they rarely saw managers from the regional office.
- Senior managers had meetings with commissioners to discuss changes to the service and patient welfare.

Learning, continuous improvement and innovation

- Staff had some opportunities to participate in research. For example, the specialty doctor had carried out research into the use of intramuscular medication on the ward.

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

Requires improvement

- The Royal College of Psychiatrists had accredited the ward through their accreditation for psychiatric intensive care units programme.

Good

Forensic inpatient/secure wards

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

Are forensic inpatient/secure wards safe?

Good

Safe and clean environment

Safety of the ward layout

- Staff did regular risk assessments of the care environment. The ward had completed the most recent risk assessment of the environment the day before the inspection.
- The ward layout allowed staff to observe all parts of the ward. The ward was laid out in a T-shape. The service had installed convex mirrors to improve visibility at potential blind spots.
- There were some potential ligature anchor points. The service had completed a completed a comprehensive ligature audit. Staff had mitigated the risks adequately through providing regular environment checks and individual risk assessment of patients. Staff ensured that patients only had supervised access to areas, such as the occupational therapy room, where there were ligature risks. During the inspection, 13 patient bedrooms had been fitted with new bathroom suites, incorporating anti-ligature features. The other three bedrooms were due to have these facilities installed as part of the refurbishment programme.
- Staff had easy access to alarms. Staff carried personal alarms that they checked each day. At the time of the inspection staff had disabled call buttons in patients' bedrooms after a patient had persistently activated the call button without reason to do so. Staff explained that patients presenting a risk that may require urgent attention were placed on enhanced observations.

Maintenance, cleanliness and infection control

- All ward areas were clean, had good furnishings and were well-maintained. The ward was completing a programme of refurbishment. The ward had recently installed new art work.
- A member of the facilities staff team carried out routine maintenance and minor repairs. Subcontractors carried out more extensive repairs. The hospital director met with the facilities staff member every morning to go through the repairs and assess urgency. The facilities staff member had weekly supervision to ensure they completed repairs and maintenance promptly. There were no outstanding repairs or maintenance issues at the time of the inspection.
- Cleaning records were not available during the inspection so we were not able to assess whether it was carried out regularly and included all areas. However, the ward appeared to be clean. Staff and patients did not raise any concerns about cleanliness.
- Staff adhered to infection control principles, including handwashing. The service displayed instructions on handwashing in all the communal toilets.

Seclusion room

- The seclusion room allowed clear observation and two-way communication. There were toilet facilities and a clock**.** The service had opened the seclusion room three months before the inspection. However, staff had not used this facility during this time.

Clinic room and equipment

- Clinic rooms were fully equipped with accessible resuscitation equipment and emergency drugs that staff checked regularly. Staff recorded checks of emergency equipment once a week.

- Staff maintained equipment well and kept it clean. However, there were no indications of when staff last cleaned the equipment such as the use of clean 'stickers'.

Safe staffing

- During the day, the establishment level of staffing was two nurses and three healthcare assistants (HCAs). At night, there were two nurses and one HCA.
- There was one vacancy for a nurse, giving a vacancy rate of 11%. There were no vacancies for HCAs.
- Between January and March 2018, bank staff had covered 89 shifts and agency staff had covered 25 shifts.
- No shifts had not been unfilled during the previous three months.
- The staff sickness rate was 1.7% during the previous 12 months.
- Staff turnover rate in the previous 12 months was 23.5%.
- Managers had calculated the number and grade of nurses and HCAs required using a matrix used across the organisation. If more than one patient required enhanced observations, the manager assigned additional staff to carry out these observations.
- There were sufficient staff to cover all the shifts. The ward manager said it was rare for a shift to go unfilled.
- The ward manager could adjust staffing levels daily to take account of the case mix. The ward manager agreed the allocation of any additional staff with the hospital manager each day, based on patients' needs and risks. The ward manager could also bring in extra staff at short notice if the level of risk on the ward increased during a shift.
- When necessary, managers deployed agency and bank nursing staff to maintain safe staffing levels. In the year from April 2017 to March 2018, agency staff had been used to cover 303 shifts.
- When agency and bank nursing staff were used, those staff received an induction and were familiar with the ward. Bank staff worked as regular staff at the hospital and had received an induction and ongoing training. The manager used the same agency staff regularly to ensure they were familiar with the ward.
- A qualified nurse was not in the communal area at all times. When nurses prepared and dispensed medicines, both qualified nurses were in the clinic room with the door locked to ensure they were not disturbed. This activity took between half hour and an hour each day. A healthcare assistant was available in the communal areas during this time.
- Staffing levels allowed patients to have regular one-to-one time with their named nurse. Patients told us that there was always a member of staff available on the ward.
- Staff shortages rarely resulted in staff cancelling escorted leave or ward activities. Staff and patients said that sometimes escorted leave or ward activities were delayed due to unforeseen incidents, such as a patient having to go to hospital, but not because of staff shortages.
- There were usually enough staff to carry out physical interventions safely. Incidents of violence and aggression could put pressure on the staffing numbers. For example, a full restraint of a patient involved six members of staff. This meant there could be no other staff available to care for the other patients on the ward at the time. However, incidents were relatively rare on this ward so this problem did not arise often.

Medical staff

- There was adequate medical cover day and night and a doctor could attend the ward quickly in an emergency. An associate specialist doctor worked on the ward during office hours from Monday to Friday. A consultant psychiatrist provided two sessions per week. Outside office hours, eight associate specialists provided an on on-call service. The doctors were based locally and could respond quickly to requests from the ward.

Mandatory training

- Staff had received and were up to date with appropriate mandatory training.
- Overall, staff in this service had undertaken 97.5% of the various elements of training that the trust had set as mandatory. This included equality, diversity and disability, fire awareness and emergency first aid.

Assessing and managing risk to patients and staff

Assessment of patient risk

- We reviewed five patient records in full. Records demonstrated good practice in relation to risk assessments.

- Staff completed a risk assessment of every patient within 24 hours of their admission. Staff updated risk assessments regularly.
- Staff used recognised risk assessment tools. This form evaluated a patient's risk across seven domains including violence to others, self-harm and substance misuse. Every six months, staff completed a more thorough assessment using the historical clinical risk management tool. The risk assessment tool specifically assessed the risk of violence in patients with a forensic history.

Management of patient risk

- Staff were aware of and dealt with any specific risk issues. Staff included details of the specific risks the patient presented in the risk assessments. For example, some patients presented specific risks in relation to violence and aggression, non-compliance with medication and being vulnerable to abuse or exploitation.
- Staff identified and responded to changing risks to, or posed by, patients. Each patient had a care plan entitled "My Safety Planning". Staff used these care plans to record details of situations in which the patient's risks may increase and how staff should respond to these risks. Staff reviewed patients' risks in handover meetings at the start of each shift. Staff assigned patients a risk rating of red, amber or green.
- Staff followed good policies and procedures for use of observation and for searching patients or their bedrooms. On the day of the inspection, no patients were on enhanced observations. The observation policy allowed for the nurse in charge to increase the observation level for any patient. The policy stated that the multidisciplinary team should review this as soon as possible. The policy on searches stated that staff should increase the level of observations of a patient, and inform the responsible clinician, if the patient refused a personal search.
- Staff applied blanket restrictions on patients' freedom only when justified. The service had a long list of items prohibited from the wards. This practice was reasonable and consistent with the level of security needed in a low secure forensic ward. For example, the service prohibited alcohol, glass bottles and sharp items.
- Staff adhered to best practice in implementing a smoke-free policy. The hospital did not permit smoking anywhere on the hospital site. The service offered nicotine replacement therapy to patient who requested it.

Use of restrictive interventions

- In the last 12 months, there had been no incidents of the use of seclusion. There had been 19 incidents of the use of restraint and 10 incidents of the use of rapid tranquilisation. There had been three incidents of restraint in the prone position.
- Although the service had introduced a seclusion room three months before the inspection, staff had not used this facility.
- The ward participated in the provider's restrictive interventions reduction programme. The clinical services manager led the restrictive interventions programme and produced a monthly audit of restrictive interventions, including analysis of restraints.
- At the last inspection in 2015, there had been five incidents of restraint on two different patients in the previous six months; one of which had been in the prone position. Staff had not noted two of these incidents of restraint in the restraint book. At this inspection, there had been five incidents of restraint, all involving the same patient, in the previous six months. None of these restraints had been in the prone position.
- We reviewed three records of restraint. Each incident had involved violence towards staff. Two out of three records specifically stated that staff attempted verbal de-escalation before the restraint. These records showed that staff used correct restraint techniques including precautionary standing and forearm holds.
- Staff understood and, where appropriate, worked within the Mental Capacity Act definition of restraint. Restraint records showed that staff identified when they restricted a patient's movement or used force to ensure a patient did something that they were resisting. For example, staff used force to prevent violence to staff.
- Staff followed NICE guidance when using rapid tranquilisation. We reviewed three records of rapid tranquilisation. Staff completed each record on a standard form. Staff recorded the medicine, the dose and the route of administration. Staff monitored the patient's pulse, blood pressure, respiration and level of consciousness at least every hour until there were no concerns about the patient's physical health. When

patients refused physical health checks, staff recorded the patient's level of consciousness and offered checks again every 30 minutes. When a patient fell asleep after rapid tranquilisation, staff monitored their physical health by ensuring the patient remained on enhanced observations.

Safeguarding

- Staff were trained in safeguarding, knew how to make a safeguarding alert, and did so when appropriate. All of staff completed safeguarding adults training and safeguarding children training. Staff said that they would speak to their manager or the social worker if they had safeguarding concerns about a patient at risk of abuse. At weekends, staff telephoned the local authority directly to make a safeguarding referral.
- Staff could give examples of how to protect patients from harm. For example, a member of staff told us they had reported suspected financial abuse to the local authority when a vulnerable patient was at risk from other patients who were asking for money and other belongings.
- Staff followed safe procedures for children visiting the ward. Patients could meet with accompanied children in a family room sited off the ward.

Staff access to essential information

- Staff recorded information on paper records and electronic records.
- Staff recorded daily progress notes on an electronic record. Staff recorded key documents, such as care plans and risk assessments on paper. Statutory documents relating to the Mental Health Act were kept in the Mental Health Act office.
- All information needed to deliver patient care was available to all relevant staff when they needed it and was in an accessible form. Information was easily accessible through the electronic patient record. Staff kept paper documents in the nurses' office.

Medicines management

- Staff followed good practice in medicines management and did it in line with national guidance. A specialist pharmacy service provided medicines management for the hospital. This included ensuring that appropriate arrangements were in place for the transport, disposal and medicines reconciliation for the hospital. The pharmacy service also provided a monthly audit of medicines charts to highlight any prescribing or administrative errors. This audit showed that in the six months from October 2017 to March 2018 there had been 56 errors including 31 prescribing errors, 17 administrative errors and eight errors in relation to the Mental Health Act. The number of errors was lower than the 169 errors recorded on the neighbouring ward.
- Staff reviewed the effects of medication on patients' physical health regularly and in line with NICE guidance. The ward recorded its regular monitoring of one patient receiving lithium and another receiving clozapine.

Track record on safety

- At the last inspection in 2015, the service recorded one serious incident in the previous 12 months. At this inspection, the service had recorded four serious incidents in the first four months of 2018.
- One of these incidents involved a patient failing to return from unescorted leave.

Reporting incidents and learning from when things go wrong

- All staff knew what incidents to report and how to report them. All staff we interviewed gave examples of incidents they had reported, including assaults, abuse and any incidents that created a potential risk. In the staff survey in 2018, 98% of staff said they were encouraged to report errors, near misses and incidents.
- Staff reported all incidents that they should report. We reviewed the reports of eight incidents that had occurred in the two weeks before the inspection. These incidents included a patient reporting that their bank card was missing, a medicines error and an incident that had led to rapid tranquilisation.
- Staff understood the duty of candour. They were open and transparent, and gave patients and families a full explanation when things went wrong. Staff spoke to us in an open and transparent manner about mistakes they made and how they were working to improve this.
- Some staff received feedback from investigations of incidents, both internal and external to the service. The service held an integrated governance meeting (IGM) each month. All the managers at the hospital attended these meetings. At these meetings, managers discussed incidents and shared learning. Managers then shared learning from incidents in monthly incident learning meetings, attended by senior clinical staff. Managers told us that staff then received this learning through

monthly staff meetings and supervision. However, when we reviewed the staff meeting and supervision records, there were no mention of incidents and the learning from them. Furthermore, the service did not always complete incident investigation reports on a timely manner. A patient had died in November 2017. National guidance for investigating serious incidents in NHS funded care states that hospitals should complete investigations within 60 days. At the time of the inspection, the ward had not produced a final report of the investigation with 107 working days having passed since the incident.

- There was evidence that staff had made changes as a result of feedback. For example, the ward had prohibited the use of e-cigarettes after several disputes between patients that had caused an increase in aggression on the ward. The ward had reverted to providing conventional nicotine replacement therapies instead.
- Staff were debriefed and received support after a serious incident. At the IGM, managers assured themselves that staff and patients received debriefing after all incidents. Two of the three restraint records we review specifically stated that de-briefing sessions with staff and patients had taken place. Staff also said that there was a helpline for them to call if they needed more support.

Are forensic inpatient/secure wards effective?

(for example, treatment is effective)

Requires improvement

Assessment of needs and planning of care

- The inspection team examined five care records. Some care plans demonstrated good practice in being comprehensive and person centred. Other care plans tended to be quite generic
- The service assessed patients before they were admitted to check they were suitable for admission. The service admitted patients for a period ranging from nine months to two years. The service had refused some referrals during the previous year. However, some staff said that sometimes the pre-admission assessments did not fully capture the risks that patients posed. The service had occasionally transferred patients to other placements after admission, after they had established that the ward could not meet these patients' needs.
- Staff completed a comprehensive mental health assessment of the patient in a timely manner at, or soon after, admission. These assessments covered the reason for referral, social circumstances, a history of the patient's mental health forensic background and a mental state assessment.
- Staff assessed patients' physical health needs in a timely manner after admission. All patients received a physical health examination on the day of admission. This assessment also included details of the patient's medical history and current medication.
- Staff developed care plans that met the needs identified during assessment. Patients had up to eight care plans, each relating to a specific aspect of their care. For example, care plans related to the patient's mental health recovery, managing problem behaviours and staying healthy. Most care plans related to matters identified in the risk assessment. However, one patient had an infection of the liver. Staff had not included the treatment of this in any care plans.
- Most care plans were personalised, holistic and recovery-oriented. For example, one care plan was very specific to the patient's needs and details of the patient's views of their care and treatment. This care plan also included specific goals and measured the patient's progress towards achieving these. However, other care plans were quite generic and lacked any information that was specific to the patient. Sometimes this depended on the extent to which the patient wanted to be involved in care planning.
- Staff reviewed and updated care plans once a month, more frequently when necessary.

Best practice in treatment and care

- The inspection team examined five care records. Most care records demonstrated good practice in treatment and care.
- Staff provided a range of care and treatment interventions suitable for the patient group. The interventions were those recommended by, and were delivered in line with, guidance from the National Institute for Health and Care Excellence (NICE). These included medication and psychological therapies.

Patients were experiencing psychosis or schizophrenia. The service primarily used antipsychotic medication to treat patients' symptoms. Doctors reviewed each patient's medication on admission. Doctors carried out a full physical examination prior to starting medication, including offering an electrocardiogram. The clinical psychologist provided cognitive behavioural therapy for psychosis and facilitated groups about mindfulness and 'life without violence'. Occupational therapists (OT) provided activities to support patients' long-term rehabilitation. Each patient had an individual programme of OT based on an assessment. OT programmes supported patients with activities of daily living such as cookery, personal care and shopping. The service had supported a patient to attend a ten-week music course run by a local organisation. The OT service also employed patients as representatives on the service user council and as kitchen technicians. The OT service did this with the aim of supporting patients back into employment.

- Staff ensured that patients had good access to physical healthcare, including access to specialists when needed. Two patients with diabetes were receiving care and support to manage their condition. Staff had referred one patient to neurosurgery to treat a neurological condition. The service facilitated a physical health clinic once a week.
- Staff assessed and met patients' needs for food and drink and for specialist nutrition and hydration. The service referred patients to a dietician whenever this was necessary.
- Staff supported patients to live healthier lives. The ward therapy programme included a men's health group and a smoking cessation group once a week. The ward also facilitated a swimming or walking group. Patients had access to gym equipment two mornings each week and every evening.
- Staff used recognised rating scales to assess and record severity and outcomes. Three of the records included the scores of assessments using the Health of the Nation Outcome Scales (HoNOS). Staff carried out these assessments during the three months before the inspection.
- Staff participated in clinical audit, benchmarking and quality improvement initiatives. For example, staff audited patient care records, risk assessments, incident reporting and physical health assessments. Staff acted in response to the findings of these audits. For example, managers gave feedback to staff members who needed support to improve their record keeping.

Skilled staff to deliver care

- The team included or had access to, the full range of specialists required to meet the needs of patients on the ward. As well as doctors and nurses, the service employed occupational therapists, clinical psychologists, a social worker, a pharmacist and a peer support worker. The service brought in dieticians and speech and language therapists when required.
- Staff were experienced and qualified, and had the right skills and knowledge to meet the needs of the patient group. Some of the staff had worked at the service for more than 18 years. One nurse was qualified in learning disability and autism to work with patients who required this support.
- Managers provided new staff with appropriate induction. During their induction, new staff received supervision once a week. New staff were required to complete their mandatory training within three months.
- Managers provided permanent staff with monthly supervision. The supervision records indicated that these sessions did not meet the objective, set out in the supervision policy, of providing the opportunity to reflect and develop professionally to achieve best practice. We reviewed the supervision records of four members of staff over six months. None of the records showed that staff had discussed patient related incidents such as restraints, safeguarding, and complaints. Only four out of 17 records included any reference to engagement with patients. Only one record showed there had been a discussion about the effects of violent behaviour from a patient. A staff member who had responsibility for supervising other staff said they had not been trained for this role. All staff received an annual appraisal. The ward usually held a team meeting once a month, although no meetings had taken place between December 2017 and March 2018. During these meetings, there was some discussion about learning from incidents and addressing specific issues on the ward and how to improve practice. In December 2017, the team discussed lessons learned from recent

incidents and the importance of ensuring that patients receiving Clozapine all had a specific care plan relating to this. In March 2018, the ward discussed concerns about prescribing errors.

- The percentage of staff that had an appraisal in the last 12 months was 94%.
- The percentage of staff that received regular supervision was 95% for the past year, although we were concerned that these sessions did not adequately support staff to carry out their role.
- Managers identified the learning needs of staff and provided them with opportunities to develop their skills and knowledge. Staff said that this formed part of the supervision process although this was not recorded in supervision notes.
- Staff received some specialist training to meet the needs of patients. For example, staff had received training in phlebotomy and electrocardiograms. Each year, the pharmacy service provided training to nursing staff on physical health needs of patients, including information about diabetes. However, although the service employed a specialist learning disability nurse, and the psychology department provided assistant to staff in working with patients with autistic spectrum disorders, staff did not receive specific training in these areas.
- Case conferences were held every month where healthcare assistants and qualified nurses could review the care and treatment provided to patients with complex needs. Doctors and the clinical psychologist attended these meetings to discuss different ways to meet patients' needs. The staff found this helpful.
- The ward manager initially addressed poor performance informally by providing extra support to staff members. The service had not disciplined or performance managed any staff during the previous year.

Multi-disciplinary and inter-agency team work

- Staff held regular and effective multidisciplinary meetings to review each patient once a week.
- Staff shared information about patients at effective handover meetings within the team in the morning and evening during shift change. There was also a handover meeting between staff members and the clinical team, such as the clinical psychologist and doctors, at 9am Monday to Friday. There was a morning briefing for ward managers, senior staff and doctors. At this meeting, the team discussed and planned new admissions, new referrals, incidents, scheduled events, and patient appointments. This ensured that managers and senior staff understood what had happened in the previous 24 hours and knew what colleagues would be doing that day.
- The ward team had effective working relationships with teams outside the organisation. Staff said that they had regular contact with patients' care coordinators and local mental health trusts. As patients were on the ward for up to two years, staff supported them to sign on to a local GP, and supported them to attend the GP when necessary. Staff also supported patients to go to the dentist.
- The ward team also worked regularly with the Ministry of Justice (MoJ) to support patients who had transferred from custody or prison. The social worker ensured staff were aware of any restrictions place on the patient by the MoJ.

Adherence to the MHA and the MHA Code of Practice

- All patients on Meridian Ward were detained under the Mental Health Act 1983 (MHA). On the day of the inspection, 11 patients had been admitted for treatment and two patients were subject to hospital orders with restrictions.
- Eighty-nine per cent of staff had had training in the Mental Health Act. Staff were trained in and had a good understanding of the Mental Health Act, the Code of Practice and the guiding principles.
- Staff had easy access to administrative support and legal advice on implementation of the Mental Health Act and its Code of Practice. The MHA administrator provided initial advice. If the matter was complicated, the MHA administrator could consult the MHA lead for Cygnet Health Care. The MHA administrator was based at the hospital and was well known to ward staff.
- The provider had relevant policies and procedures that reflected the most recent guidance. For example, the hospital had policies on each aspect of the MHA such as a policy on restricted patients, recording mental capacity and holding powers. The provider reviewed these policies every three years.
- Staff had easy access to local Mental Health Act policies and procedures and to the Code of Practice. Staff could access policies and the Code of Practice through the staff intranet.
- Patients had easy access to information about independent mental health advocacy. An independent mental health advocate visited the wards once a week.

Good

Forensic inpatient/secure wards

- Staff explained to patients their rights under the Mental Health Act in a way that they could understand, repeated it as required and recorded that they had done it.
- Staff ensured that patients could take Section 17 leave (permission for patients to leave hospital) when this has been granted.
- Staff requested an opinion from a second opinion appointed doctor when necessary.
- Staff stored copies of patients' detention papers and associated records (for example, Section 17 leave forms) correctly and so that they were available to all staff that needed access to them. Staff kept these form in the nurse's office.
- Care plans referred to identified Section 117 aftercare services to be provided for those who had been subject to section 3 or equivalent Part 3 powers authorising admission to hospital for treatment.
- Staff did regular audits to ensure that the Mental Health Act was being applied correctly and there was evidence of learning from those audits.

Good practice in applying the MCA

- At the last inspection, training in the Mental Capacity Act was not mandatory in the service. At this inspection, the service had introduced Mental Capacity Act and Deprivation of Liberties training as mandatory.
- Staff had a good understanding of the Mental Capacity Act, in particular the five statutory principles. At the last inspection in 2015, some staff did not have an understanding of the MCA. At this inspection, we found that all staff could explain the principles of the MCA. Staff explained that some patients' capacity could fluctuate depending on how ill they were. Staff said that they would raise concerns about a patient's capacity to make a decision at daily handovers, and at weekly ward rounds. The responsible consultant assessed a patient's capacity to make a decision when necessary.
- There had been no deprivation of liberty safeguards applications made in the last 12 months.
- The provider had a policy on the Mental Capacity Act, including deprivation of liberty safeguards. Staff were aware of the policy and had access to it. Staff said that they would talk to their team leader or the ward manager if they needed advice about a patient's capacity. The hospital social worker also provided advice about the MCA to their colleagues.

Are forensic inpatient/secure wards caring?

Good

CARING

Kindness, privacy, dignity, respect, compassion and support

- Staff attitudes and behaviours when interacting with patients showed that they were discreet, respectful and responsive, providing patients with help, emotional support and advice at the time they needed it. For example, we observed staff responding promptly to patients' requests for help or information. Staff responded to patients who became agitated in a calm and caring manner.
- Staff supported patients to understand and manage their care, treatment or condition. The clinical psychologist provided patients with psycho-education to help them understand their condition. Three patients said that staff gave them choices in relation to their care and treatment. For example, one patient said that staff had supported him in his decision to change his medication.
- Most patients said staff treated them well and behaved appropriately towards them. Four patients said that staff were always caring and respectful. One patient said that staff had given them helpful advice that they valued. However, one patient said that sometimes staff ignored patients because they were busy. Another patient said that staff talked about him behind his back.
- Staff did not always meet the individual needs of patients, including their personal, cultural, social and religious needs. Two patients said they had asked to speak to someone from their religious community but this had not happened.
- Staff said they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards patients without fear of the consequences. Staff we spoke with all said they could talk to a manager about any concerns they had.
- Staff maintained the confidentiality of information about patients. Staff kept all records in the nurses'

office. Staff only discussed patients in private meetings or in the nurses' office. Information about patients that staff displayed in the nurse's office could not be seen from the corridors.

Involvement in care

Involvement of patients

- Staff used the admission process to inform and orient patients to the ward and to the service. Staff had produced an information pack for patients. Patients said staff had shown them around the ward when they were admitted. During the inspection, a patient was admitted to the ward. Staff had planned for the admission over several days. A patient had volunteered to be a 'buddy' for the new patient to help them settle in.
- Staff involved patients in care planning and risk assessments. Four out of five care plans we reviewed included a record of the patient's views. On the other record, the patient did not wish to be involved in care planning. Four of the seven patients we interviewed said they had choices in their care and treatment and they felt involved in decision making. Three patients said they were not involved in decision making and did not have a copy of their care plan. Patients attended care programme approach meetings and multidisciplinary team meetings.
- Staff communicated with patients so that they understood their care and treatment. At the time of the inspection, none of the patients had specific communication needs. However, staff would read through risk assessments and care plans to ensure that patients understood them.
- Staff had made efforts to involve patients when appropriate in decisions about the service. The service had appointed a former patient as an expert by experience to support patients to give feedback about the service to senior staff. The service also held a monthly user council in conjunction with another local Cygnet hospital. Patients appointed a representative to attend these meetings to discuss any plans for the service.
- Staff enabled patients to give feedback on the service they received. The ward held a community meeting every week. In April, patients had asked for there to be more activities. Minutes of these meetings showed that staff usually reported back to patients on what they had done to address concerns raised at previous meetings. The hospital requested feedback from patients using a user satisfaction survey. Three patients had completed this survey between October 2017 and March 2018. All three responses were positive.
- None of the patients had made advance decisions, such as decisions to refuse treatment if they no longer had capacity to make the decision.
- Staff ensured that patients could access advocacy. An advocate visited the ward every Thursday.

Involvement of families and carers

- Staff informed and involved families and carers appropriately and provided them with support when needed. Four of the five patients we spoke with had some family involvement. This varied from occasional phone calls to weekly visits and attendance at care planning meetings. We spoke with two parents of patients currently on the ward. They both said that staff encouraged them to be involved in decisions about care and treatment. One parent said they phoned the ward each day and that staff always contacted them if their son had been involved in any incidents. Both parents said their sons had made a lot of progress and achieved a level of stability that had not been possible at other hospitals.
- Staff enabled families and carers to give feedback. The service produced a newsletter for families and carers every quarter. The most recent newsletter included details of how families and carers could provide feedback on the service. The hospital had held a coffee morning for families and carers in December 2017.

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

(for example, to feedback?)

Good

Bed management

- There was always a bed available when patients returned from leave. Patients did not go on overnight leave unless it was part of a transition to another service.

- Patients were not moved between wards during an admission episode unless it was justified on clinical grounds and was in the interests of the patient. For example, patients were transferred to the local general hospital if they required specialist medical treatment.
- When patients were moved or discharged, this happened at an appropriate time of day. The service ensured that discharges were planned in consultation with the patient's care co-ordinator and arrangements were made to transfer the patient with appropriate support.
- The average length of stay for patients discharged between April 2017 and March 2018 was 471 days (just under one year and four months).

Discharge and transfers of care

- In the last 12 months, there were no delayed discharges. At the last inspection in 2015, there was some difficulty with the discharge of patients subject to hospital orders with restrictions due to difficulties in finding appropriate accommodation. At this inspection, there were no concerns about discharge arrangements.
- Staff planned for patients' discharge by involving patients, their family and carers, and their care coordinators. Staff supported patients to visit different placements and arranged overnight leave, so that there was a smooth transition between the service and other placements.
- Discharge was never delayed for other than clinical reasons.
- Staff supported patients during referrals and transfers between services. For example, if patients required treatment in an acute hospital staff would go to the hospital with the patient. If the patient required enhanced observations, a member of staff would stay with the patient. Otherwise, staff would regularly visit the patient.

Facilities that promote comfort, dignity and privacy

- Patients had their own bedrooms. Patients were not expected to sleep in bed bays or dormitories. Bedrooms had ensuite facilities.
- Patients could personalise bedrooms although few patients chose to do so.
- Patients had somewhere secure to store their possessions. Each patient had a locker and a safe where they could store possessions.
- Staff and patients had access to rooms and equipment to support treatment and care. The clinic room had a couch for examining patients. However, space on the ward was limited. Staff and patients used a large room as a gym, an occupational therapy room and a meeting room. This meant that patients could not access the gym equipment or some occupational therapy activities when meetings were taking place. The ward was refurbishing the activities kitchen to provide more space.
- There were quiet areas on the ward. Most patients said they went to their bedroom when they wanted to be in a quiet area. There was a dedicated room at the hospital where patients could meet with visitors.
- Patients could make phone calls in private.
- Patients had access to outside space. Patients had unrestricted access to a balcony, situated off the lounge area. The responsible clinician authorised patients' access to a small garden near the entrance to the hospital.
- Patients could make hot drinks and cold snacks most of the time. However, four patients said they would like access to a microwave so they could have hot snacks when they wanted to.

Patients' engagement with the wider community

- Staff ensured that patients had access to educational opportunities. The occupational therapy department was accredited by the Unit Award Scheme to formally recognise patients' learning through awarding certificates issued by the Assessment Qualification Alliance (AQA). The ward also operated a scheme to employ patients to assist in maintaining the kitchen used in occupational therapy sessions and to participate in the service user council.
- Staff could support patients to maintain contact with their families and carers. Carers we spoke with said they found staff welcoming whenever they visited.
- Staff encouraged patients to develop and maintain relationships with people that mattered to them, both within the services and the wider community. For example, the hospital had supported a patient to attend an educational programme at a local music studio.

Meeting the needs of all people who use the service

- The service made adjustments for disabled patients. A lift was installed to ensure that people with physical disabilities could access the ward.

Good

Forensic inpatient/secure wards

- Staff ensured that patients could obtain information on treatments, local services, patients' rights, and how to complain. Staff displayed this information on notice boards.
- The information provided was in a form accessible to the particular patient group according to each patient's needs.
- Staff made information leaflets available in languages spoken by patients if requested.
- Managers ensured that staff and patients had easy access to interpreters and/or signers. One patient said they sometimes used an interpreter and found this to be helpful.
- Patients had a choice of food to meet the dietary requirements of religious and ethnic groups. Food was cooked on site and could be prepared according to the specific needs of patients. Occupational therapy staff had provided a Somalian cookery book to enable a patient to prepare dishes he was familiar with in occupational therapy sessions.
- Staff did not always ensure that patients had access to appropriate spiritual support. One patient said they would like to attend church or for a priest to visit. Another patient said they had waited a long time to be allowed to attend the local mosque.

Listening to and learning from concerns and complaints

- There had been 10 complaints in the last 12 months. The hospital had upheld three of these complaints. None of the patients or carers who had complained had referred their concerns to the Ombudsman.
- Patients knew how to complain or raise concerns. The service displayed information about how to make a complaint on notice board. All seven patients we spoke with said they knew to make a complaint. However, one patient said they may not have the confidence to do so and another said they would find it difficult to put things in writing.
- When patients complained or raised concerns, they usually received feedback. The complaints records we reviewed showed that complainants received feedback after investigations were completed. One patient said they had complained and not had any feedback. The patient complained again and the hospital upheld the complaint. Another patient said that his consultant had authorised unescorted leave after he complained about not having any.
- Staff knew how to handle complaints appropriately. Complaint records showed that managers completed thorough investigations and responded in a timely manner.
- Staff received feedback on the outcome of investigations into complaints and acted on the findings. For example, staff made a referral to the safeguarding team and reviewed their care for a patient after the patient complained about being bullied.

Are forensic inpatient/secure wards well-led?

Good

Leadership

- Leaders had the skills, knowledge and experience to perform their roles. The interim ward manager and hospital manager had worked as qualified nurses with patients before being promoted to manager, and had taken leadership and management courses prior to their appointment.
- Leaders had a good understanding of the services they managed. The interim ward manager had worked in the service for two years and knew the service and the staff well. The hospital manager had been with the service since November 2017. The quality assurance lead from the regional office visited the hospital at least once a month to review the service and to oversee investigations into incidents.
- Staff told us that they saw the hospital director on the ward most days. However, staff told us they rarely saw senior managers from the wider organisation.
- There were some opportunities for staff members to have leadership training. Two staff had completed leadership training in the last year. The hospital manager said that no healthcare assistants or qualified nurses were having leadership training at the time of the inspection.

Vision and strategy

- Staff members knew and understood the provider's vision and values and how they were applied in the

work of their team. The provider displayed information about its vision and values throughout the service. Members of staff could tell us what the vision and values were.

- Staff had limited opportunities to contribute to discussions about the strategy for their service. Three members of staff told us that they did not have the opportunity to contribute to discussions about the strategy. The organisation had recently merged with another provider resulting in changes to the way staff recorded patient information, the pay structure for staff, and the refurbishment of the environment. Staff said that managers had not consulted with them on any of these changes.
- Staff could explain how they were working to deliver high quality care within the budgets available. Managers reviewed key figures relating to income and expenditure each month, such as occupancy levels and staff costs. Managers said that the finance department understood the needs of the service well and were willing to authorise staffing costs above the standard allocation if this was necessary. Managers also said they were not under any pressure to accept referrals that they assessed as being inappropriate.

Culture

- Staff did not always feel respected, supported and valued. Staff spoke positively about the managers who worked at the hospital. However, staff had concerns about the higher management within the organisation. One nurse commented that there was a 'top-down' style of management. Many staff were unhappy about recent changes to their pay and working schedules. In the staff survey for 2018, 40% of staff said they would not recommend Cygnet as a place to work.
- A staff representative group met monthly. This group presented staff concerns to the organisation's board. In response to issues raised, the organisation was conducting a pilot to change the pay structure back to the previous arrangement. However, only one member of staff from the ward attended this group. Most staff felt that it was not an effective forum. Five staff members did not feel that senior managers would make any change on the recommendations from the staff representative group.
- Staff felt positive and proud about working within their team. Staff spoke positively about the support they received from their immediate colleagues.
- Staff felt able to raise concerns without fear of retribution. However, some staff said that they would not be listened to if they did raise concerns.
- Staff knew how to use the whistle-blowing process. The service displayed information about whistleblowing in staff areas. No members of staff had raised concerns through the whistleblowing process during the previous year.
- Staff said that managers supported staff with poor performance with extra supervision and more training. The hospital had not taken any formal disciplinary action against staff in the last year.
- Teams worked well together and where there were difficulties managers dealt with them appropriately. Staff spent time in team meetings talking about any challenges on the ward and worked together to address these.
- Staff appraisals included conversations about career development and how it could be supported. However, some staff members said that their request for leadership training had been ignored.
- Staff reported that the provider promoted equality and diversity in its day-to-day work and in providing opportunities for career progression. The provider had incorporated the Workforce Race Equality Standard into its equality policy. The provider had introduced monitoring of ethnicity into the staff survey. The provider also planned to include a question about discrimination into the next staff survey.
- The ward's staff sickness and absence were lower than the average for the hospital. The staff sickness rate for this ward was 1.7% compared to 7.7% for the neighbouring ward.
- Staff had access to support for their own physical and emotional health needs through an occupational health service.
- The provider recognised staff success within the service. There were 'employee of the month' awards. The hospital displayed the results of these awards on notice boards.

Governance

- The service was generally well managed, with systems and policies in place to ensure that the ward was clean, that staff were all trained and that patients were assessed and treated well. Incidents were reported and safeguarding referrals were made when appropriate. However, the service had overlooked some areas of

governance such as the quality of the supervision and staff morale. Whilst there was a strong focus on understanding and learning from incidents at a managerial level, notes of team meetings and supervision sessions showed that this was not cascading down to ward level.

- We reviewed the past three months' minutes from integrated governance meetings (IGM) and incident learning meetings. We found that senior managers structured meetings well and covered upcoming changes to the service, incidents, restraints, safeguarding referrals and complaints. Team meetings for ward staff were also well structured and well documented. However, these meetings did not include feedback from the managers meetings. As the majority of staff did not attend the IGM and the incident learning meetings, this meant they did not have the opportunity to reflect on learning as a group.
- Staff had implemented recommendations from reviews of deaths, incidents, complaints and safeguarding alerts at the service level. For example, after a serious choking incident on the ward, staff had included an assessment of choking risk within the initial physical health checks.
- Staff undertook and participated in local clinical audits. The audits were sufficient to provide assurance. Staff mostly acted on the results when needed. For example, the medicines management audit for the last six months showed a worsening of errors on medicine charts and compliance with the Mental Health Act. In response, the service had put in place an action plan to address these concerns. This included the introduction of competency checks for nursing staff in relation to medicines management.
- Staff understood the arrangements for working with other teams, both within the provider and externally, to meet the needs of the patients. The service liaised with the patient's care co-ordinator to plan for the patient's discharge.

Management of risk, issues and performance

- Staff maintained and had access to the risk register at ward or directorate level. The risk register was available to staff, it was on the shared internet drive which staff had access to, and displayed on the staff room wall. However, staff at ward level said that they were not confident that they could escalate concerns when required.
- Staff concerns did not match those on the risk register. For example, all staff at ward level said that there were serious concerns about the pay structure, which the service had introduced in November 2017. This had led to many staff feeling unhappy at the service and contributed to low morale. This concern was not on the risk register.
- The service had plans for emergencies. A business continuity plan included all the telephone numbers for use in an emergency. There were also contingency plans covering foreseeable incidents such as bad weather, severe staff shortage, infectious diseases and serious disruption to information technology and telephones.

Information management

- The service used systems to collect data from wards and directorates that were not over-burdensome for frontline staff. Mangers had access to clear and well-presented data. None of the staff raised concerns about data collection.
- Staff had access to the equipment and information technology needed to do their work. The information technology infrastructure, including the telephone system, worked well and helped to improve the quality of care. Staff said that the introduction of computer based records and risk management had been helpful.
- Information governance systems included confidentiality of patient records. These systems ensured that paper records were kept in locked filing cabinets and electronic information was protected by passwords.
- 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. This included information about other similar wards managed by Cygnet Health Care to allow services to compare their performance.
- Information was in an accessible format, and was timely, accurate and identified areas for improvement. Data was presented in spreadsheets and clear graphs and tables. This meant that staff could understand the information quickly.
- Staff at the hospital made notifications to external bodies as needed. This included 18 notifications sent to the Care Quality Commission between January and March 2018. The service also sent regular notifications to the local authority about safeguarding matters.

Good

Forensic inpatient/secure wards

Engagement

- Staff, patients and carers had access to up-to-date information about the work of the provider and the services they used. Staff could read the minutes of senior managers' meetings, which were available on the shared electronic system. There was also a monthly newsletter for staff and patients.
- Patients and carers had opportunities to give feedback on the service they received in a manner that reflected their individual needs. The ward held a weekly community meeting and the hospital held a monthly service user forum. The service also produced a newsletter for carers and had held a coffee morning for carers in December 2017. However, only three patients had completed a feedback survey between October 2017 and March 2018.
- Staff had access to feedback from the patients' community meetings; the minutes were displayed in the staff room. There was also a 'you said, we did' board on the ward which staff regularly updated.
- Patients and carers were told about changes to the service. Patients were involved in discussions about changes to the service in community meetings, and carers had quarterly meetings at the service.
- Patients and staff could meet with members of the provider's senior leadership team to give feedback. Staff said that the hospital manager was very approachable. The manager held an 'open door' session once a week at which any member of staff could speak with them about their concerns. However, staff said they rarely saw managers from the regional office.
- Senior managers had meetings commissioners to discuss changes to the service and patient welfare

Learning, continuous improvement and innovation

- Staff were not given the time and support to consider opportunities for improvements and innovation. Staff did not discuss these matters in supervision and there were only limited discussion about quality improvement within team meetings.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The service must ensure that staff receive appropriate supervision to enable them to carry out the duties they are employed to perform. This includes providing the opportunity to reflect and develop professionally in accordance with the provider's supervision policy.
- The service must ensure medicines are prescribed in accordance with law relating to consent to treatment under the Mental Health Act 1983.
- The provider must ensure that all staff teams have the opportunity to reflect on their work collectively and learn from incidents, safeguarding referrals and complaints.

Action the provider SHOULD take to improve

- The provider should ensure that patients feel safe.
- The provider should ensure that the decision to disable call buttons in patients' bedrooms is kept under review.
- The provider should ensure checks of equipment, fridges and clinic rooms are carried out regularly and consistently.
- The service should ensure that it employs sufficient permanent staff on Tyler Ward to avoid reliance on agency staff who do not receive supervision or have access to training opportunities which could impact on the consistency and quality of care.
- The provider should ensure that individual risk assessments are updated after patients are involved in incidents.
- The provider should ensure that measures remain in place to monitor and reduce the number of medicines errors.
- The provider should ensure that reports of investigations into incidents are produced in a timely manner in accordance with national guidance.
- The provider should ensure that staff receive specialist training in relation to the complex needs of many patients such as patients with learning disabilities autistic spectrum disorders or epilepsy.
- The provider should ensure there is sufficient space on ward to avoid patient activities being limited due to staff meetings.
- The provider should ensure that it listens to and acknowledges the views of all members of staff. The provider should also ensure there are opportunities for staff to engage with senior managers.
- The provider should ensure that patients are able to practise their religion and meet with religious or spiritual leaders

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 The provider had not ensured that medicines were prescribed in accordance with law relating to consent to treatment under the Mental Health Act 1983. This was a breach of regulation 11(1)(4)

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 Staff did not reflect on their work collectively to learn from frequent incidents. The provider was not doing all that is reasonably practical to mitigate the risks presented by incidents. This was a breach of regulation 12(1)(2)(b)

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 provider had not ensured that staff received appropriate supervision to enable them to carry out the duties they are employed to perform. This was a breach of regulation 18(1)(2)(a)