

Cygnnet Hospital Kewstoke







Quality Report

Beach Road Kewstoke
Weston super Mare
BS229UZ
Tel: 01934428989
Website: www.cygnethealth.co.uk

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

Ratings

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

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

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

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

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

Summary of findings

Overall summary

Our rating of this service stayed the same. We continued to rate it as good because:

The provider managed risks well. Staff completed regular environmental and patient risk assessments and had a good knowledge of individual patient needs. The hospital had an up-to-date risk register that highlighted key concerns and had plans in place to manage these. Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Patient records were person centred, up to date and overall were of a good standard. Physical health monitoring and care were well managed and staff were suitably trained and up to date with mandatory training requirements. The provider had clear processes for monitoring and investigating incidents and complaints and undertook a variety of audits to monitor and improve the quality and safety of the service. Systems were in place to learn from these and improve practice as a result.

Managers adjusted staffing levels to meet changing needs, utilising extra bank and agency staff who were familiar with the wards to cover any shortfall. The hospital ensured agency and bank staff were familiar with the wards and had access to the same induction, support and training as permanent staff.

Staff provided a range of care and treatment interventions suitable for the patients in line with guidance from the National Institute for Health and Care Excellence (NICE). Robust arrangements were in place to meet patients' physical and mental health needs. Staff were compassionate, respectful, responsive and discreet; providing patients with help, emotional support and advice at the time they needed it.

The ward managers and senior leadership team provided strong and effective leadership and staff members had confidence in them. Managers within the service promoted an open and honest culture. Staff felt able to raise concerns, report incidents and make suggestions for improvements without fear of consequences. Staff knew and understood the provider's vision and values and how they were applied in the work of their team. Staff felt respected, supported and valued by senior managers and leaders. They were proud to work at the hospital and felt positive about their work and the support they gave patients.

However

Information about patients was difficult to find in the care records. Although paper records had plenty of detail the notes were cumbersome to go through and was not user friendly.

There were no facilities in place to safely dispose of surplus or out of date medication on any of the wards. We found expired medication in a storage cupboard, this was stored separately from patients medication waiting to be disposed of on Knightstone ward. We raised this with the provider and they took appropriate action. The provider disposed of the expired medication and also checked other treatment rooms in the hospital to ensure this was not repeated.

Although care and treatment records showed that discharge planning was considered there were no detailed plans for discharge in any of the care records we looked at on Knightstone and Nash wards.

Summary of findings

Our judgements about each of the main services

Service

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

Good



Rating Summary of each main service

Our rating of this core service remained the same as the previous comprehensive inspection. We rated safe, effective, caring, responsive and well led as good. During this inspection we found that patient records were person centred, detailed and up to date. Staff knew their patients well. Physical health monitoring and care were well managed. Staff were suitably trained and were up to date with mandatory training. However we found that there was not a detailed plan for discharge in any of the care records we looked at.

Forensic inpatient or secure wards

Good



Our rating of this core service remained the same as the previous comprehensive inspection. We rated safe, effective, caring, responsive and well led as good. During this inspection we found that patient records were person centred, detailed and up to date. Staff knew their patients well. Staff were suitably trained and were up to date with mandatory training. Patients were actively involved in decisions about their care and care planning including involvement in decisions about medication and psychological treatment.

Long stay or rehabilitation mental health wards for working-age adults

Good



Our rating of this core service remained the same as the previous comprehensive inspection. We rated safe, effective, caring, responsive and well led as good. During this inspection we found that patient records were person centred, detailed and up to date. Staff knew their patients well. Physical health monitoring and care were well managed. Staff were suitably trained and were up to date with mandatory training. Patients were actively involved in shared decision-making and supported in self-management and there was a recovery focus.

Summary of findings

Personality disorder services

Good



Our rating of this service remained the same as the previous comprehensive inspection.

We rated safe, effective, caring, responsive and well led as good.

During this inspection we found that patient records were person centred, detailed and up to date. Staff knew their patients well. Physical health monitoring and care were well managed.

However we found that there was not a detailed plan for discharge in any of the care records we looked at. We also found that patient records did not always reflect actions taken as a result of physical observations.

Summary of findings

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Good 

Cygnnet Hospital Kewstoke

Services we looked at:

Acute wards for adults of working age and psychiatric intensive care units; Forensic inpatient or secure wards; Long stay or rehabilitation mental health wards for working-age adults; Personality disorder services.

Summary of this inspection

Background to Cygnet Hospital Kewstoke

Cygnet hospital Kewstoke is a 72 bedded mental health hospital, consisting of five wards. The hospital is registered to provide treatment of disease, disorder and injury and assessment or medical treatment of people detained under the Mental Health Act 1983. There is a registered manager in place. Cygnet Hospital Kewstoke aims to help patients learn how to manage their mental health and reinforce their daily living skills, to prepare for independent life back in the community, or for moving into mainstream rehabilitation.

Cygnet Hospital Kewstoke offers the following services:

Nash ward is a 12 bedded psychiatric intensive care unit (PICU) for men in the acute stages of psychosis. It is located on the ground floor of the main hospital. Patients are detained under the Mental Health Act.

Sandford ward is a 16 bedded female acute inpatient service, accepting emergency admissions. It is part of Cygnet's national network of acute and PICU emergency admission services. It is located on the first floor of the main hospital.

Milton ward is a 16 bedded low secure forensic mental health service, providing a recovery focused care pathway for women addressing complex needs through to rehabilitation. It is located on the ground floor of the main hospital.

Knightstone ward is a 16 bedded female specialist personality disorder service, supported by dialectical behaviour therapy and other therapy models. It is located on the first floor of the main hospital.

The Lodge at Cygnet Hospital, Kewstoke is a female locked rehabilitation unit offering a care pathway for 12 patients who have been in hospital and are preparing for community living before discharge. It offers treatment in a community setting within the grounds of the main hospital, but separate from the main building. Its stated aim is to form part of an integrated care pathway for

female patients only. It acts as a 'step-down' from medium secure, low secure and specialist services, and also as a 'step-up' from community living to prevent long-term admissions to secure services.

Our last comprehensive inspection of Cygnet Hospital Kewstoke was on the 19 January 2016. At that inspection, we rated the service as good overall. We also gave ratings for the core services provided by the hospital. For acute wards for adults of working age and psychiatric intensive care units we rated effective, caring, responsive and well led as good. However, we rated safe as requires improvement. We told the provider it must ensure that on Nash ward the cleanliness and damage to interior walls, fixtures and fittings are addressed immediately and adequately maintained there on.

On 24 January 2017 and 16 March 2017 we undertook an unannounced, focused inspection to see whether the provider had made the required improvements. We found that the provider had generally completed all the required improvements but that the bath panel and skirting board in the communal bathroom was still damaged, the bolted down tables in the dining room needed cleaning and that there were still some offensive odours in some bedrooms where the provider had not replaced the carpets. As a consequence, the requirement remained. The provider revised their action plan and informed us when it had addressed the outstanding issues.

We undertook a further unannounced, focussed inspection on 3 October 2017 to see if the provider had made the required improvements. We found that the provider had made all the required improvements. It had replaced the carpet in all patient bedrooms on Nash ward and the ward was free of odour. The provider had replaced the dining room furniture on Nash ward; the tables and the base of the tables were clean. The cleaning team regularly deep cleaned the ward areas. The provider had replaced the bath panel and skirting board in the communal bathroom which was in good order, and had installed CCTV to promote safety on the ward.

Summary of this inspection

Our inspection team

The team that inspected the service comprised one inspection manager, one CQC inspector, two assistant inspectors. The team had two specialist advisors; a mental health nurse and a consultant psychiatrist.

Why we carried out this inspection

We inspected this service as part of our ongoing comprehensive mental health inspection programme.

How we carried out this inspection

To fully understand the experience of people who use services, we always ask the following five questions of every service and provider:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

Before the inspection visit, we reviewed information that we held about the location, asked a range of other organisations for information.

During the inspection visit, the inspection team:

- visited the ward for two days, looked at the quality of the ward environment and observed how staff cared for patients
- spoke with 19 patients

- spoke with 35 staff members including doctors, nurses, support workers, activity co-ordinators, occupational therapists and clinical psychologists
- spoke with all ward managers and the clinical leads for each ward
- spoke with the senior management team, which included the medical lead, the interim hospital manager, the quality and compliance manager, the clinical manager, the safeguarding lead and clinical psychologist
- attended and observed three multidisciplinary clinical meetings
- attended two multidisciplinary meetings
- attended two therapeutic activity groups with patients
- looked at 21 care records
- 32 medication records
- looked at a range of policies, procedures and other documents relating to the running of the services.

What people who use the service say

Patients and carers we spoke with told us:

Staff who worked on all the wards were excellent. They listened to patients, were supportive and caring, and went above and beyond to support and advocate for patients.

Patients felt they were given information and choices and were included in decision making and they felt involved in decisions about their care.

Patients told us they had received copies of their care plan and were aware of the contents.

Patients told us that they understood and that staff explained their rights under the Mental Health Act 1983 or as informal patients.

Patients knew the complaints process and were confident that issues could be raised without this impacting on their care.

Summary of this inspection

Patients told us that although they felt safe and confident that staff would react quickly to safety

incidents, however there were times when wards could become tense and distressing following incidents.

The inspection team were unable to speak to any family members and carers when attempts were made to call them on the telephone numbers provided so were unable to seek their views

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?

We rated safe as good because:

Good



- All wards were clean and well maintained and patients on all wards told us that they felt safe. Staff told us they felt safe in the work environment.
- Staff had assessed environmental risks, including photographing ligature risks (a ligature point is anything which could be used to attach a cord, rope or other material for the purpose of hanging or strangulation). Ligature audits were completed on a six monthly basis and we saw evidence to show that these were up to date with actions completed.
- Staff had good systems in place to control contraband items and high risk property.
- Staff personal and hospital alarm systems were robust and well documented. There were regular medical emergency scenario tests.
- All patients had received a comprehensive and detailed risk assessment on admission. Staff used the 'short term assessment of risk and treatability' (START) tool to assess potential risks. We found that patients' risk assessments and plans were recovery focused and person centred.
- Where restraint had been used, efforts to de-escalate the situation through verbal communication had been made and paperwork relating to the use of restraint had been completed. Secondary and tertiary interventions were recorded as well as primary intervention strategies, so staff could demonstrate the use of a more holistic approach to de-escalation. At the Lodge and Knightstone, patients who required periods of time out from the communal areas could access a quiet room, external garden room or their bedroom.
- Staff were recording all episodes of rapid tranquillisation (the use of medication to calm/lightly sedate the patient, reduce the risk to self and/or others and achieve an optimal reduction in agitation and aggression) in line with policy and were recording both intra muscular and oral administrations.
- There was a safeguarding folder on every ward. All staff had received training in safeguarding vulnerable adults and children.
- Staffing vacancies had been recruited to and the team were able to access increased numbers of staff easily. Managers told

Summary of this inspection

us wherever possible, they employed bank and agency staff who had worked there before and were familiar with procedures and policies. This helped ensure continuity of care for patients.

- Eighty five per cent of staff had completed mandatory training. Staff demonstrated sound knowledge about recent prevention and management of violence and aggression training and the least restrictive principle.
- Medicines management was safe and regularly audited by an external agency. Medication errors were discussed in integrated governance meetings and ward rounds. Recent external audits from the hospital pharmacy had increased awareness around medication errors. Staff that were subject to performance monitoring due to medication errors were encouraged to write reflective practises which they submitted to the weekly audit feedback.

However:

- Although paper records had plenty of detail, it was not easy to learn about the patient quickly. Notes were cumbersome to go through and was not user friendly. For example, it was difficult to quickly find a summary of a patients risks and current plan of care without going through the entire folder which contained the care records.
- There were no facilities in place to safely dispose of surplus or out of date medication on any of the wards. We found expired medication in a storage cupboard on Knightstone ward separate from patients medication waiting to be disposed of.

Are services effective?

We rated effective as good because:

- Staff completed regular physical health care checks and recorded these in care plans. All patients had a physical health assessment on admission. All patients had access to a general practitioner who visited weekly.
- The senior management team shared 'the National Institute for Health and Care Excellence' (NICE) guidelines with the ward manager and to the teams directly and we saw them being used.
- The senior management team had improved the implementation of 'my shared pathway' (a programme to allow patients to chart their own progress through secure services and set their own agreed outcomes and achievements) by

Good



Summary of this inspection

providing regular training for staff on writing evidence based care plans in line with the guidance. This training was repeated annually. Each lead in the hospital had over all responsibility in the completion of each section of the care plan.

- The clinical psychology team were well resourced. Patients had access to a wide range of therapeutic services. The clinical psychology team were able to provide support to staff members following serious incidents. All clinical psychologists were trained in dialectical behaviour therapy, had broad expertise and offered a drug and alcohol service to patients.
- Patients had access to regular occupational therapy and patients told us they benefited positively from the therapy they received.
- Information detailing patients care and treatment was mainly paper based. The hospital had recently introduced an electronic care records system and information such as patient care plans could be printed electronically and was shared with the patient. All information was accessible on the ward and staff ensured information was stored securely
- Care plans were created with patients and their views and goals were recorded in their own words.
- Staff and managers received regular managerial, clinical and group supervision. We saw evidence of regular reflective practice group supervision meetings.
- There was a robust audit programme in place, with deadlines for actions to be completed and a quality assurance check. Staff took part in a range of audits, which had led to improvements in the service, this included audits of incidents, use of restraint, the Mental Health Act, medication errors, complaints and ligature audits. We saw how the weekly medication audit supported staff to improve on their performance when they made errors or omissions and we saw staff had made changes to the ward environment following the most recent ligature audit.
- The hospital's Mental Health Act and Mental Capacity Act training programme was up to date. All staff were up to date with training and staff we spoke to had a good understanding of the MHA and MCA.

Are services caring?

We rated caring as good because:

- Staff used the admission process to orientate patients to the ward environment, policies of the ward and the way the ward works.

Good



Summary of this inspection

- Staff spoke to patients in a way that was respectful and polite during group and individual interactions. We heard staff refer to patients in a non-judgemental and genuinely caring way during MDT handover meetings we attended. Staff spoke about patients with knowledge and understanding of their needs and patients told us staff supported their individual needs. Patients appeared comfortable when they talked to staff and patients knew staff by their names. Patient's comments about staff were overall good and stated for example "staff care" and "I feel listened to".
- Patient involvement was monitored through recovery meetings and the clinical manager had worked with patients to conduct presentations at local colleges. The hospital was developing a "peoples council" patients from each ward had the opportunity to apply and become involved to in the council and we saw evidence of patients being supported and encouraged to apply to be members.
- Patients had access to advocacy. There were regular visits by the advocacy service and sectioned patients had could access the Independent Mental Health Advocates (IMHA) as required. We saw posters displayed across the hospital advertising advocacy services.
- All staff we spoke with had a very in-depth knowledge about the patients including their likes, dislikes and preferences. They were able to describe these to us confidently, for example, preferred routines for patients and anxiety triggers.
- Families and carers received information where appropriate. There was a carers lead for the hospital and staff told us that she was very proactive at involving families and carers. Upcoming events such as birthdays and home visits were liaised through the carers lead, and often supported by her.
- The hospital is part of the 'triangle of care' carers group initiative and represent Cygnet at the quarterly meeting.

Are services responsive?

We rated responsive as good because:

- There were quiet rooms that patients could access during the day and a full range of therapy rooms and equipment. There was a varied, strong and recovery orientated programme of therapeutic activities available, every week including weekends.
- There was a clear process in place to admit and discharge patients from the ward. A referral criterion was used to assess

Good



Summary of this inspection

patients both from other wards and external services who may be suitable for the next stage of their care pathway to recovery. This enabled ward staff to assess if they could meet a patient's needs.

- Assessment of a new referral of a patient within ward was undertaken by an appropriate selection of staff, which could include ward manager, consultant and other senior staff.
- There were no delayed discharges last year. Staff planned for patients' discharge, including good liaison with care managers/co-ordinators, commissioners and community mental health teams. Care and treatment records showed that discharge planning was discussed at the ward round and individual Care Programme Approach reviews. There was always a bed available when patients returned from leave. Management of beds systems were robust and effective.
- Patients knew how to complain and had access to advocates who had assisted patients to make a complaint in the past. The hospital had a detailed policy and procedure about how they dealt with complaints.

However

- Although there was evidence and reference of discussion within the care records there were no formal or detailed discharge plans. This meant that it was difficult to find out detailed information about an individual patient discharge plan.
- Patients records on Milton ward did not reflect physical observations recorded on the Modified Early Warning Score (MEWS) form.

Are services well-led?

We rated well-led as good because:

- The ward managers and senior leadership team had the skills, knowledge and experience to perform their roles. They provided strong and effective leadership and staff members had confidence in them. Managers within the service promoted an open and honest culture. Staff felt able to raise concerns, report incidents and make suggestions for improvements without fear of consequences.
- Staff knew and understood the provider's vision and values and how they were applied in the work of their team.
- Staff felt respected, supported and valued by senior management. They were proud to work at the hospital and felt positive about their work and the support they gave patients.

Good



Summary of this inspection

- The hospital had monthly governance meetings for senior management staff to consider issues of quality, safety and standards. This included oversight of risk areas in the service to ensure quality assurance systems were effective in identifying and managing risks to patients. Any identified risks were discussed and added to the hospital's risk register or 'overarching local action plan' during the meeting.
- There was a high level of compliance with mandatory training. The senior management team shared updates on training figures in leadership meetings. The hospital worked with local colleges to support their staff through national vocational qualifications.
- Team morale was high at the time of the inspection and staff told us they enjoyed working at Cygnet Hospital Kewstoke. Staff were motivated to ensure they achieved the ward objectives.

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 staff had received MHA training. All staff we spoke to were able to confidently discuss the provider processes and practices for ensuring adherence to the MHA Code of Practice.
- Patients' care records were complete but information was difficult to find due to the size of the patients' paper records. The MHA documentation was present and available on all the files.
- Staff informed patients of their rights under the MHA. There was evidence in all patients files to show that they were regularly informed of their rights under section 132 of the MHA. We saw that there was active involvement of an independent mental health advocacy (IMHA) service and that information about the service was advertised on the notice board on the ward. Patients told us they knew how to request an appointment with an advocate and that they had done this.
- Patients were encouraged to contact the CQC if they chose to about issues relating to the MHA. Information about how to do this was contained in the information folders of all patients detained under the MHA.
- The Mental Health Act administrator for the hospital monitored requirements and compliance with the MHA and Code of Practice, daily. Six monthly audits were carried out on accuracy of T2 and T3 consent certificates; medicines charts and section 17 leave documentation.
- There was evidence of timely managers' hearings at the point of patients' section renewals. These were undertaken prior to, or very shortly, after the patient's section renewal date and when then made an appeal.
- Copies of up-to-date section 17 leave forms were kept in a file accessible in the nurses' office. The forms were comprehensive, clearly detailing the levels, nature and conditions of leave. Records showed that these were regularly reviewed and updated. Staff recorded which patients had been given copies of the section 17 leave forms. Copies of the section 17 leave forms were filed in the patients' care records.
- Assessments of patients' capacity to consent to treatment were available, at the point that T2 certificates were issued and reviewed. We found that relevant forms were reviewed in line with the provider's policy.

Mental Capacity Act and Deprivation of Liberty Safeguards

Mental Capacity Act training was included in mental health act training. Staff had a good understanding of the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS)

- There was a Mental Capacity Act policy in place and staff told us about the principles and how they applied to the patients.
- Where appropriate patients would have a mental capacity assessment relating to care and treatment. There were no current Deprivation of Liberty Safeguards (DoLS) applications and there had not been any applications made in the previous six month period.

Overview of ratings

Our ratings for this location are:

Detailed findings from this inspection

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

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

Good 

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

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

Good 

We rated safe as good because:

Safe and clean environment

- Patients, staff and visitors accessed the ward through a locked main entrance door; and ward staff operated and monitored the entrance by closed circuit television cameras and a buzzer. Closed circuit television cameras monitored all communal areas, corridors and the outside garden of the ward. All staff had access to an appropriate alarm system and personal alarms were issued on arrival at the main reception. Staff held key fobs to access locked areas of the ward and building. All patients' bedrooms on Nash ward had anti-ligature en-suite fittings. A ligature point is where someone intent on self-harm might tie something to strangle themselves.
- All areas appeared visibly clean, tidy and well maintained. Staff completed cleaning schedules and environmental risk assessments were up to date. However, infection control training for Nash Ward was recorded as 88% at the time of this inspection. There were wall mounted hand gels at the entrance of the ward
- There were poor lines of sight throughout the building; however, there were observation mirrors to mitigate blind spots, closed circuit television cameras in corridors and communal areas. Staff were also present

in communal areas. Staff observed patients according to their individual observation levels. They understood the observation policy and we observed staff carrying out and recording their observations of patients. All bedroom doors had viewing panels, which patients and staff operated.

- Nash ward was a male only psychiatric intensive care unit (PICU) meaning it complied with same sex accommodation guidelines and provided all patients with single rooms with en-suite toilet and washing facilities. The ward had a fully equipped clinic room with all emergency equipment and drugs checked regularly. Resuscitation equipment was kept within the ward office and this was checked on a weekly basis, we saw records to show this was the case. Staff checked fridge and room temperatures daily.
- The seclusion suite was bright and airy with temperature and ambient lighting controls. There was access to a toilet and shower and an additional area that patients could access directly outside the seclusion bedroom. Observation was good through the use of angular walls and wall mounted mirrors.
- Environmental risk assessments are undertaken monthly and we saw records to show that this was the case.
- The ward manager completed ligature audits for the ward. The hospital risk register was up-to-date and included how staff managed identified risks locally.

Safe staffing

- Nash ward operated a two-system shift roster. All staff either worked long days (from 07:30 hours until 19:45

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

Good 

hours) and or nights. Each shift had a minimum of two qualified staff. Day shifts were supported by four Support workers and nights shifts were supported by two support workers.

- At the time of the inspection we were told by the ward manager that Nash ward had two vacancies for registered nurses. The ward manager also told us that the organisation was continually recruiting for registered nurse posts. There were two clinical team leaders. There were six vacancies for support staff. We were told by the ward manager that two of these positions were staff who were seconded to pursue their nursing associate training.
- The ward manager used a Cygnet specific staffing matrix to estimate the numbers and grades of staff needed. On Nash ward, usually two registered nurses, four support workers, worked during the day. At night, staffing number reduced to two registered nurses and two support workers. The ward manager planned duty rotas in advance based. This meant that the ward manager used bank and agency staff where there was identified gaps in staffing levels or the ward occupancy and patients needs increased. Staff worked two shifts from 07.15 until 20.00 and from 19.30 until 07.45 on the ward.
- There was additional support from manager and therapy staff during the day. Bank staff were regular and familiar with the hospital and the manager tried to use familiar agency staff who were block booked in advance where possible. When there was last minute cancellation or sickness, agency staff were used, the ward manager used specific agencies and called upon staff how had previously worked on the ward to promote familiarity and continuity of care.
- The ward manager told us they felt comfortable with requesting additional staff and did not have to get senior management sign off to do so.
- There was always a qualified nurse present on the ward and a manager on duty during the day. Ward managers provided an on-call system covering evenings, weekends and bank holidays. Most patients we spoke with felt there was enough staff on duty and all patients and staff said they felt safe.

- One consultant psychiatrist and one staff grade doctor employed by Cygnet provided full time cover for the ward in addition to on-call cover. Staff had good access to medical staff who responded quickly in any emergencies.
- All staff underwent comprehensive mandatory training including bank staff. Training was online or offered face to face. This included equality and diversity, health and safety, information governance, manual handling, Mental Health Act, safeguarding adults, management of violence and aggression and medicine management training. The ward manager monitored compliance of mandatory training and told us the figure for compliance of mandatory training for Nash ward was 89% at the time of our inspection. Where less than 75% of staff had completed training this was identified and addressed quickly.

Assessing and managing risk to patients and staff

- The hospital provided information about incidents of, seclusion, long-term segregation; there had been one episode of use of long term segregation between 01 May 2018 and 31 October 2018.

There were 48 incidents of restraint used on 25 different patients between 01 May 2018 and 31 October 2018. Staff were recording all episodes of rapid tranquillisation (the use of medication to calm/lightly sedate the patient, reduce the risk to self and/or others and achieve an optimal reduction in agitation and aggression) in line with policy and were recording both intra muscular and oral administrations. There was a culture of promoting least restrictive practice on the ward and we saw evidence of this throughout the ward.

- Staff undertook a risk assessment of every referral before accepting admission to the hospital. We examined six care records and saw that staff completed the Short Term Assessment of Risk and Treatability (START) risk assessment tool with every patient on admission. Nurses undertook a risk assessment of every patient before they left the ward and if staff were concerned about a patient's level of risk, they explained this to the patient and reviewed individual observation levels. Staff said they reviewed risk assessments weekly at ward rounds and discussed patient's risk daily during handover and multidisciplinary meetings.

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

Good 

- All the patients were detained in hospital under the Mental Health Act at the time of our inspection. The ward manager told us the hospital had a policy in place to reduce or review restrictive interventions. However, blanket restrictions were still in use on the wards. These are restrictions placed on all patients that do not consider risks presented by individual circumstances. For example, staff said all patients' access to the garden was supervised and this was not individually assessed. Staff told us this was to mitigate risks of absconding from the ward.
- Patients had 24-hour access to the kitchen areas to make hot and cold drinks.
- Patients were informed about the ward's smoke free policy on admission. Nicotine replacement therapy was made available to patients.
- The ward manager carried out yearly ligature audits of the ward environment and where ligature points had been identified, staff managed these locally by individual patients' risk assessment and observations. Nurses carried out observations according to the engagement and observation policy and staff included levels of observation on the handover document. Staff informed patients of a list of contraband items such as sharp objects and lighters on admission and removed these items for the safety of all patients on the ward. Nurses carried out searches in line with the hospital policy and according to individual risk assessment.
- The hospital had a policy for seclusion and long-term segregation and staff were clear about the definition of seclusion. Nash ward had a seclusion room and staff said they did not use seclusion unless they had exhausted all other options. Nurses explained how they would always use de-escalation techniques first. None of the patients we spoke with had experienced restraint or seclusion.
- Staff used prone restraint to administer intra-muscular medication. Eighty one percent of staff received training in the management of violence and aggression at the time of the inspection. Staff knew how to report and record incidents of restraint and senior managers monitored incidents of restraint at the monthly integrated governance meeting.
- All staff received training in safeguarding adults and children as part of their mandatory training. Sixty seven percent of staff had completed safeguarding training to level 3, this included adults and children, at the time of inspection. Thirty three percent of staff had places booked to complete the training. Nash Ward had identified safeguarding link staff and staff understood their responsibilities to report safeguarding concerns to the ward manager, including out of hours arrangements. The hospital safeguarding lead made safeguarding referrals and described good working relationships with the local authority safeguarding team.
- The hospital reported eighteen safeguarding concerns and no safeguarding alerts between 31 March 2018 and 31 January 2019. Where incidents were reported as allegations or incidents of physical abuse, sexual assault or abuse by staff we saw the local safeguarding team was involved and appropriate action taken.
- All patients and staff we spoke with said they felt safe on the ward. No patients had experienced threats of harm or been the victim of verbal or physical abuse. Patients told us that generally, "people got on well together". We observed the ward to be quiet and calm with positive interactions occurring between staff and patients throughout our inspection.
- We reviewed the medicines management practice on Nash ward. There was suitably equipped clinical areas and secure storage for medicines available. Nurses regularly checked stock levels of drugs, emergency equipment, and fridge temperatures. Staff received and acted on medicine and equipment safety alerts. Staff told us the pharmacist regularly audited medicines practices and the ward manager alerted staff to identified errors or omissions for immediate action. We saw that staff recorded physical health monitoring and side effect monitoring.
- Children did not visit on the ward areas and staff arranged for children to visit in the visitor's room at the reception area.

Safeguarding

- All staff knew how to raise a safeguarding issue or concern. Staff completed an electronic incident form and informed the nurse in charge or the ward manager. All staff were aware of the hospital safeguarding lead and how to contact them.
- Staff told us how they keep patients safe from harassment and discrimination by observing behaviours on the wards of patients and visitors. The ward manager to us staff had strong working relationships safeguarding lead.

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

Good 

- Staff followed safe procedures for children visiting the hospital. All child visits were cleared by the social worker and visits took place in the family room located away from the ward.

Staff access to essential information

- Patient records were held across two systems; the paper system held most of the documentations (such as care plans, risk assessments, MHA paperwork) and the online system held daily risk assessment (which is colour coded dependent on risk) and the daily observation notes.
- Paper records had plenty of detail, were kept up to date but it was not easy to learn about the patient quickly. It was cumbersome to go through and was not quickly useable. Each patient had a folder of information which included relevant information such as family history, health records, risk assessments and care plans. Paper records were also used for medicine charts, consent to treatment documents and section 17 leave paperwork. Staff did not report any issues co-ordinating between paper and electronic records and we did not find any problems.

Medicines management

- There were appropriate arrangements on the ward for the management of medicines. Staff followed policies and procedures for ordering and storing medicines. Medicines were stored securely in clinic rooms and staff recorded that the room and fridge temperatures were within their recommended ranges. All medicines checked were available and in date. Controlled drugs (CD) were stored in appropriately located, locked cupboards and we reviewed the CD book which was complete and up-to-date.
- The pharmacist conducted weekly audits to ensure correct medicine management. Medical staff followed prescribing guidance from the National Institute for Health and Care Excellence.
- Staff gave patients information about their medicines. If patients had allergies, these were listed on the front of the prescription chart. Patients at risk of side effects from taking high dose antipsychotic medicines were monitored.
- There were good processes and procedures in place on the ward in relation to medicines reconciliation. This is where the ward staff would contact GPs on admission,

to confirm what medicines and dosages the patient was taking so that these medicines could continue while the patient was on the ward. Staff discussed medicines in multidisciplinary care reviews.

- Medical staff were aware of the National Institute for Health and Care Excellence guidelines regarding prescribing medication. Staff followed a variety of policies that were in keeping with national guidelines such as safeguarding and the prevention and management of violence.
- We reviewed all twelve prescription records on Nash ward and all were completed correctly with no omissions or mistakes. On admission, a record of the patient's medication history was taken, including what current medicines the patient had, what physical health medicines are needed, what medicines had been taken in the past 24 hours, any known allergies information was recorded.

Track record on safety

- There was one serious incident in the last 12 months. The ward manager told us that this incident had been reported and went through the necessary review processes. The incident was reported appropriately and investigated robustly.

Reporting incidents and learning from when things go wrong

- All staff we spoke with were aware of the incident reporting process and knew what to report. Staff were aware of their duty of candour policy and the need to be open and honest when things go wrong. Staff told us they would feel confident to admit a mistake, as they would be supported by ward manager to help make improvements.
- Nurses used a paper-based system of reporting which was sent to the ward manager. The ward manager carried out investigations and entered the data onto an electronic reporting tool. The senior team reviewed this information to identify themes and trends. Staff received feedback about incidents via emails, a "lessons learned log", team meetings and reflective meetings.
- Staff spoke about a recent serious incident and how ward manager ensured staff and patients had the opportunities for de-brief sessions.

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

Good 

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

(for example, treatment is effective)

Good 

Assessment of needs and planning of care

- We looked at six care records of patients on Nash ward. Patients had a comprehensive assessment commenced at the time of their admission including a physical health assessment and a furthermore detailed assessment thereafter. However, the ward manager told us some patients were recalled quickly back by the local NHS trust when a bed became available which meant staff could not always complete a comprehensive assessment.
- All patients had care plans in place at the time of admission and staff used a daily evaluation sheet to update the care plan. Staff used the “my shared pathway” framework with patients to plan their care and treatment. However, in the six care records we looked at the care plans focused mainly on mental health, managing behaviours and physical health and were not personalised or recovery orientated.
- Information detailing patients care and treatment was mainly paper based. The hospital had recently introduced an electronic care records system and information such as patient care plans could be printed electronically and was shared with the patient. All information was accessible on the ward and staff ensured information was stored securely.

Best practice in treatment and care

- Patients had good access to physical health care. Where there were concerns about the physical health of patients, staff referred patients to the GP who visited once a week or the ward doctor. Patients told us they received a lot of support with their physical health needs such as problems weight management.
- Therapy staff supported patients’ recovery by offering a range of therapies and activities six days per week. The hospital had a dedicated therapy area where patients attended for group and individual therapy between

Monday and Friday. There was no involvement from a clinical psychologist however patient could access psychological therapies on referral. The ward manager told us that this was due to the acuity of the patients group and the average length of stay of patients was very short.

- Patients who were not well enough to attend the therapy area were supported on the ward by therapy staff to participate in activities. Activities varied and patients who were able to, could attend the local gym, cinema and other local community facilities or walks on the beach front.
- Clinical staff and ward manager took part in a range of audits, which had led to improvements in the service. For example, this included audits of incidents, use of restraint, the Mental Health Act, medication errors, complaints and ligature audits. We saw how the weekly medication audit supported staff to improve on their performance when they made errors or omissions and we saw staff had made changes to the ward environment following the most recent ligature audit.

Skilled staff to deliver care

- The ward has access to a full range of mental health disciplines including a psychiatrist, a ward doctor, a psychologist, a social worker and occupational therapy staff. The independent mental health advocate (IMHA) visited the ward weekly and supported the patient at ward rounds where needed. The contracted pharmacist visited the ward weekly but did not take part in patient reviews.
- All staff had access to and completed specialist training for their roles. For example, health care support workers had been seconded to do their associate nurse training; nurses received training for medicines management.
- New staff had a personal induction book and programme which they completed and the ward manager signed off within a 12-week period. It was aligned to the care certificate standards and included the management of violence and aggression, safeguarding and the Mental Health Act. We saw staff had completed induction books in their personnel files and the manager ensured staff received timely reviews during their probationary periods.
- Staff received regular supervision and appraisal. Appraisals were due annually and supervision carried

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

Good 

out monthly. Appraisal figure was 88.2% for Nash ward for the date as of 30 September 2018. Staff told us they received regular management and clinical supervision and we saw this was recorded in their personal files. Nurses told us they had access to an independent supervisor and received regular peer support at handovers and team meetings and reflective practice meeting in addition to formal supervision sessions.

- The ward manager addressed poor staff performance promptly and recorded this in the staff member's personal file. The management of supervision document recorded issues such as sickness, timekeeping, and attitude. The ward manager also wrote to staff individually when medicine audits revealed omissions or errors and required the staff member to complete a reflective statement for their own learning.

Multi-disciplinary and inter-agency team work

- There was a weekly ward round, however we did not observe this meeting during our inspection. Patients we spoke to, told us that they were able to attend the ward round and contributed to discussion about their care and treatment.
- There were effective handovers between staff on a daily basis. The ward team had several handovers throughout the day. Nursing shift to shift handovers occur in the morning and evening and dependent on any risk changes amongst the patient group one would be held at midday. There was an MDT handover at 9am for any professional to attend. We observed the MDT handover during our inspection. All staff were professional and knowledgeable, discussing risk, observations and discharge plans for patients.
- Ward staff were engaged with the patients' parent trust care coordinators and invite these staff to ward rounds and care programme approach (CPA) meetings, however we were told they did not always attend.
- All staff members we spoke with described good working relationships between teams. We saw evidence that regular team meetings occurred on the ward where the ward manager, nurses and support workers attended.

Adherence to the MHA and the MHA Code of Practice

- Records showed that 100% of staff completed Mental Health Act training for Nash ward at the time of this inspection.
- The hospital had a Mental Health Act lead and administrator who completed audits and scrutinised documents. We saw that all documentation was completed and we were told all original documents were stored appropriately by the administrator. Staff we spoke with had a good understanding of the guiding principles of the Mental Health Act. Staff told us they referred to copy of the Mental Health Act Code of practice which was available in hard copy and electronically on ward.
- Medical staff completed consent to treatment forms, which were located with prescription charts. These were written in line with the Royal college of Psychiatrists and Mental Health Act Code of Practice.
- Staff informed patients of their rights verbally and in writing. Staff gave patients information about their rights of appeal and recorded their level of understanding in the patient's record. The ward manager completed monthly audits to ensure this was done in accordance with the requirements of the Mental Health Act. Staff supported patients to appeal against their detention and all patients had access to an independent advocate. Staff used a standardised process to authorise section 17 leave and staff gave patients a copy of their section 17 leave details.
- Staff gave all patients information about the ward on admission. This included how to complain to the Care Quality Commission. We did not see any information about patient's rights displayed on the ward but staff told us these were available to print as required. We spoke with two patients who told us that staff had explained their rights under the Mental Health Act and gave them information. Both patients also said they had been involved in their care plan and had been given copies of their written plan.
- Patient consent to treatment was documented appropriately. All patients detained under the Mental Health Act required specific consideration of consent to treatment. The ward was compliant with these requirements.

Good practice in applying the MCA

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

Good 

- All of the staff had completed the Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS) training at the time of this inspection. Staff had a good understanding of the Mental Capacity Act including the five statutory principles and how this applied in their practice. Staff accessed an up to date Cygnet policy, which included the Deprivation of Liberty Safeguards. There was no deprivation of liberty applications made by the hospital in the previous six months of the inspection.
- Staff we spoke with talked about capacity decisions and assumed patients had capacity. If there were doubts about a patient's capacity, staff completed a Mental Capacity Assessment (MCA). Medical staff completed a Cygnet document to record patients' consent on admission. Staff told us when they doubted a patient's capacity to consent to treatment, staff discussed capacity as part of the patients review using the principles of best interest.
- All patients on Nash ward were detained under the Mental Health Act and where necessary staff would conduct a capacity assessment. We saw evidence in patients' records of capacity assessments. Patients were given information about treatment options and this information was given in an accessible way to the patients.
- There were no patients subject to Deprivation of Liberty Safeguards.

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

Good 

We rated caring as good because:

Kindness, privacy, dignity, respect, compassion and support

- We observed all staff spoke to patients in a way that was respectful and polite during group and individual interactions. We heard staff refer to patients in a non-judgemental and genuinely caring way during MDT handover meetings we attended. Staff spoke about patients with knowledge and understanding of their

needs and patients told us staff supported their individual needs. Patients appeared comfortable when they talked to staff and patients knew staff by their names. Patient's comments about staff were overall good and stated for example "staff care" and "I feel listened to".

The involvement of people in the care they receive

- There was a comprehensive admission process on Nash ward. Patients were oriented to the ward on arrival and an information booklet was provided to each patient which gives information about the hospital and the ward. Family and carer information was documented and consent to share information was sought at the point of admission.
- All patients had care plans in place at the time of admission and staff used a daily evaluation sheet to update the care plan. The ward used a 'my shared care pathway' which encouraged active participation from patients in their own care and treatment. However, staff told us that this was not always possible due to the acuity of the patients especially at admission stage. Patients were offered copies of their care plans and could request these at any stage during their treatment.
- An advocate visited the ward weekly and all four patients we spoke with confirmed this was the case. Information about advocacy were available in the air lock at the entrance to the ward, in the corridors and in the ward information booklet.
- Some patient's families and carers lived far from the hospital. Staff were flexible with the visiting policy although this was sometimes difficult to facilitate due to the visiting facilities being off the ward and some patients not being able to leave the ward. Patients could call home as and when they requested. Patients could also have access to skype calls as another avenue of contact.
- Community meetings were held weekly on Nash ward. We saw minutes of meetings to show that actions were addressed and escalated to the appropriate department for action. For example, room temperatures were too cold at night which was escalated to the maintenance department. The maintenance staff resolved the issue.

Involvement of families and carers

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

Good 

- Families and carers received information where appropriate, and staff maintained and respected patients' choice for confidentiality and sharing of information.
- There was a carers' lead for the hospital and staff told us that she was very proactive at involving families and carers. Upcoming events such as birthdays and home visits were liaised through the carers lead, and often supported by her.
- The hospital is part of the 'triangle of care' carers group initiative and represent Cygnet at the quarterly meeting.

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

Good 

We rated responsive as good because:

Access and discharge

- Nash ward had agreed that beds would be made available specifically for NHS patients. One bed was reserved for national use, meaning that it could be used for any patients wherever they lived. Three beds were used by Avon and Wiltshire Mental Health Partnership (AWP) and six beds were used by Devon Partnership NHS Trust. The ward manager told us average length of stay for patients on Nash ward was between four to six weeks.
- We were told that patients do not take over night leave from Nash ward and have local community leave only.
- Staff we spoke with told us that they aimed to transfer patients from Nash ward as soon as possible so that they can continue their care in a more appropriate environment once their mental health symptoms were under control. Staff discussed patients discharge during weekly MDT review meetings, in patient's 1:1 engagement with primary nurse and recorded this discussion in care records however there were no detailed and robust discharge planning in the six care records we reviewed.
- We were told by ward staff that on occasion discharge could be delayed due to bed availability within the patients host Trust. The ward manager told us at the

time of this inspection there was one delayed discharge. However, access within the hospital to other ward beds was not delayed due to any reasons other than a clinical need.

The facilities promote recovery, comfort, dignity and confidentiality

- There was an activity room on the ward and access to this room was under supervision. There was a projector to watch films and a pool table and a range of board games and other activities. Other communal space was used to hold relaxation sessions. There was a fully equipped clinical room that could be used to examine patients. Most of the patients we spoke to, liked to use the gymnasium which was located in another part of the hospital.
- All visits took place off the ward. Families and carers could call the ward and make arrangement for visiting. All visits were escorted and supervised.
- Patients could request to use the ward office phone to make a personal phone call. All patients we spoke with told us that this was never a problem and all requests to use the office ward phone were granted. Patients could also access their mobile phone if they had been assessed and deemed as low risk.
- Patients had access to outside space however this was situated out of sight of the main areas of the ward. Because of this all access to the garden was supervised. Patients could request access and all four patients that we spoke with told us that when they asked to go into the garden they were able to.
- All four patients we spoke with said that they were satisfied with the quality of food and choice.
- There was a hot and cold water and drink making facility located within the dining room. All four patients we spoke with said that they could make drinks and had access to snacks 24 hours a day.
- Subject to risk assessment, patients were able to personalise their bedrooms and keep their belongings within their room. One patient had a TV and game console his room and one patient had pictures and music CD's.
- Sharp items were kept by the staff in a locked secure area. All bedrooms had a small safe for personal belongings.

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

Good 

- Activities occurred Monday to Saturday between the hours of 8am until 6pm by either the activity worker or the active life lead. Some of these activities, including gym work, board games and relaxation would be supported by nursing staff. Any activities delivered at the weekend would be done by the nursing staff but mainly consisted of patients taking leave outside of the ward.

Patients' engagement with the wider community

- We were told by staff that most patients had access escorted community leave. At the time of this inspection only one patient had access to unescorted community leave. Patients were encouraged to access facilities available for them in the community as part of their leave off the unit. Staff also told us that patients were encouraged to meet their family and carers in the local community rather on the unit as part of re-integration into the community.

Meeting the needs of all people who use the service

- We observed all patients on Nash ward were mobile at the time of this inspection. The building was accessible with a lift operated by staff if required. We noted that no doors opened automatically which could affect someone's independence if they could not operate the doors without assistance from staff. All bedrooms had ensuite facilities with a shower and were accessible for patients with mobility problems.
- The ward displayed information for patients such as how to complain and advocacy services. Staff told us that when information in other languages was required this was available through the interpreting service. We did not see information about patients' rights displayed on the ward and staff said this was given to individual patients as required. Patients confirmed they were aware of their rights and staff had given them information. Patients knew how to complain and how to contact the advocacy service.
- The ward provided patients with a wide range of foods, which included those required to meet religious or ethnic needs.
- Staff supported patients with appropriate spiritual support where required. Patients could access the local community religious facilities, staff arranged these visits if required and provided a multi-faith area, which was accessible to all patients.

Listening to and learning from concerns and complaints

- Patients we spoke with knew how to complain. Staff aimed to deal with any complaints quickly and effectively at ward level. Where a complaint was raised formally staff referred to the complaints policy. The ward manager responded positively to complaints and provided a timely and thorough response with written apologies to patients and their families where appropriate.
- Patients attended regular ward and community meetings where there was the opportunity to raise any concerns or complaints on the agenda. The "you said, we did" feedback was displayed on ward areas and reception area and updated following every meeting.
- The independent mental health advocate service was well embedded into the service and had positive working relationships with staff and senior managers. Nurses gave the independent advocate a handover every week and discussed progress with any issues previously raised. Staff also arranged appointments for patients with the advocate on a weekly basis where they could raise concerns about any aspects of their care and treatment. Senior managers were accessible and received monthly and quarterly reports from the advocate of the main themes raised.
- Ward manager provided verbal and written feedback to staff about the outcome of investigation of complaints to staff. We saw evidence of community meeting minutes how staff responded via the "you said, we did" display.

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

Good 

We rated well-led as good because:

Leadership

- Managers and lead nurses had the skills, knowledge and experience to perform their roles to a high standard. The ward manager knew the staff and patients well and could confidently describe the service.

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

Good 

- The senior management team had regular contact with all staff and patients. The senior management and clinical teams were visible to staff and staff said they regularly visited the ward. All staff and patients knew who the senior management team were and that they felt confident to approach them if they had any concerns.
- The ward benefited from the leadership provided by the new consultant psychiatrist. Staff felt that the new consultant psychiatrist had been a positive addition to the ward and the multi-disciplinary team. Staff said that the psychiatrist and the manager worked together to ensure good care on the ward.

Vision and strategy

- The provider had recently changed their values. Staff and leaders were still learning these values, but displayed an eagerness to learn them. The values were displayed around the ward and staff could demonstrate how they were giving care in line with these new values. There was a weekly newsletter sent by the director of nursing and this had promoted the new values.
- Staff felt very much a part of the service and were able to discuss the vision and values of organisation and the ward. Staff had opportunities to contribute to discussions about their service in regular team meetings.

Culture

- All staff we spoke with, felt respected, supported and valued in their work. They commented in particular about the support they received from their ward manager. Staff were proud to be working for the organisation.
- All staff we spoke with said that they knew how to raise concerns under the whistleblowing policy and most told us that they would feel comfortable to raise their concerns without fear of victimisation.
- The ward manager dealt with poor staff performance appropriately and in a timely manner.
- Staff had yearly appraisals that were objective and development based, contained specific, measurable, agreed upon, realistic and time-based (SMART) goals and action plans. Key skills and development areas were identified and plans to meet these objectives were clear and agreed upon by the manager and the staff member.

- Staff had access to physical and emotional support. The psychology team was open to all staff members and joined for debrief sessions after serious incidents. There was a designated occupational health program, known as the employee assist program, where managers can refer staff or staff can use self-referral. This provided psychological, emotional, physical and financial support to staff members.

Governance

- Effective systems and processes were in place to ensure the safe and effective running of the ward. There were clear responsibilities, roles, processes and systems of accountability.
- The provider had a clear governance framework at ward level, which local managers oversaw and fed into the providers overarching governance structure and assurance framework.
- Staff carried out checks to ensure the ward was clean, well-maintained and safe for patients. Incidents were reported, investigated, monitored and any learning shared. The manager ensured staffing levels were appropriate to meet the needs of patients.
- Overall, staff were trained and supported to carry out their roles and provided with opportunities for professional development. The multi-disciplinary team worked in collaboration with patients, carers and external stakeholders to provide effective, holistic, care planning, risk management and discharge planning. Staff ensured that legal requirements were met in relation to the Mental Health Act and the Mental Capacity Act.
- The ward manager was clear about the process for highlighting any significant risks. The hospital manager included these on the hospital risk register as there was no ward risk register.
- We saw the system for undertaking clinical audits, reporting on management data including training, absences, supervision and appraisal rates, data on incidents and complaints. This information was summarised and presented monthly in a key performance indicator dashboard. Examples of audits carried out included, patient engagement, physical health checks, and standard of care plans.
- The ward was reliant on the continued use of locum agency staff. The provider had ongoing recruitment

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

Good 

campaigns to bring in more staff. All locum staff were familiar with the ward, having worked there before. All locum staff had the same induction and training as permanent and wore the same uniform.

- Regular team meetings were held allowing staff discuss concerns, participate in educational or clinical supervision, debrief following incidents and to learn from the issues.

Management of risk, issues and performance

- The manager would take risks to the situation report meetings daily that would be looked at provider level and an item to be added to the hospital risk register. Staff at ward level could escalate concerns to the ward manager. These would also be addressed in the team meetings.

Information management

- Staff had access to the equipment and technology to do their work. There had been some problems with the change over from paper to electronic records, and this work is still ongoing. However, the manager had received specialised training that allowed her to support staff in the best possible way through the transition. The paper records were at times cumbersome, with care plans, risk assessments, mental health act paperwork, physical health assessments, admission and orientation checklists, observation checklists. Whilst all these were important information, the volume of information made the paper records cumbersome and hard to navigate.
- Information governance systems ensured confidentiality of patient records on the ward.
- The ward managers had access to information that allowed them to safely and effectively run the ward. This included staffing figures and budgets, agency staff

profiles to ensure that agency staff requested had the necessary skills. The manager kept records of staff training and supervision to keep track of what and who was due for updates. The manager held a spreadsheet with all patient paperwork that requires regular updating. This allowed her to keep track of when items needed updating and could have an oversight to ensure that updates happened.

Engagement

- Staff, patients and carers had up-to-date information about the ward and the services provided. This information was disseminated through the intranet, newsletters and team meetings. Patients could access information through staff members and the bulletin boards in the ward.
- Patients and carers had opportunities to give feedback on the service. This could be done directly to staff members, meetings arranged by the ward manager or anonymously through email and comment cards. Although patients and carers are not currently involved in ward based decisions, the People`s Council is being implemented which aims to include patients in ward decisions such as staff interviews. There were quarterly patient surveys and a carers survey.

Learning, continuous improvement and innovation

- Nash ward had obtained the Accreditation for Inpatient Mental Health Services (AIMS) and is a member of the National Association of Psychiatric Intensive Care Units.
- The hospital had devised a programme of learning for health support workers which aimed to inform staff about personality disorder. This training was delivered by patients themselves.

Forensic inpatient or secure wards

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

Are forensic inpatient or secure wards safe?

Good 

We rated safe as good because:

Safe and clean environment

- Ward layout did not allow staff to observe all parts of the ward. We identified blind spots on the main corridor where there were two recesses. Although this was covered by the new CCTV system it was not routinely monitored. We drew this to the attention of the ward manager who acknowledged the risk and ordered a convex security mirror to remedy the situation. A monitor was also installed in the nursing office to ensure that staff could monitor the blind spots.
- The ward only admitted female patients and so complied with single sex guidance.
- Staff did regular risk assessments of the care environment. We saw the evidence of the monthly environmental risk audit conducted by the nursing staff. This identified any issues and the remedial action taken by the estates team. There was an annual ligature audit which was comprehensive and we did not identify any ligature points that were not included. The ligature audit was linked to a ligature action plan that included using procedural and relational security risk assessments and physical changes to the environment.
- All rooms, except the bathroom, had observation panels. When open, these allow staff to observe the patient but when closed ensure patient privacy. Rooms had nurse call buttons allowing patients/staff to call for

assistance. CCTV was in operation. This was recorded for review purposes, in case of an incident. Patients were informed on admission and signed consent forms acknowledging this.

- Staff were all issued with personal alarms linked to a hospital emergency call system which would summon immediate assistance. There were nominated staff members who would respond to calls on other wards in case of emergency. We were present when alarms sounded and saw staff respond immediately.
- The ward clinic room was fully equipped with accessible resuscitation equipment and emergency drugs that staff checked weekly. Staff completed a checklist of items in the emergency bag each week. Fridge temperatures were checked daily.
- Cleaning records were up to date and demonstrated that the ward was cleaned regularly. Cleaning records included a list of tasks to be completed each shift. Housekeeping staff signed the form to confirm that these tasks had been completed. The ward was in a reasonable state of repair but was due for a redecoration later this year. There were some tears on the lino in the bathroom and it had rust on the radiator cover which spread onto the flooring.
- Staff adhered to infection control principles, including hand washing. Hand washing guidance was displayed in toilets. An infection control audit was carried out annually. This audit reviewed infection control compliance across all patient areas, including patient bedrooms and bathrooms.
- There was no seclusion facility on the ward. We saw no evidence to show that patients were secluded. Staff were able to share with us their understanding of how they would use the de-escalation area to support patients at difficult times.

Forensic inpatient or secure wards

Safe staffing

- There was usage of bank and/or agency staff, but these were block booked and regular staff. These staff have been working on the ward for long periods, up to one year, and were actively involved in the ward. Some bank staff were team leads on the ward and had named patients. All agency and bank staff were fully inducted, had familiarisation information that they were required to sign off as having understood. This included answering questions related to the information to verify understanding and the ward manager or senior staff would sign off approval. If it was the staff members first day on the ward they would be assigned a buddy for the day.
- The manager of the ward had autonomy over bringing in additional staff as needed. The manager had access to the staff budget to determine staffing capacity, however could bring in additional staff in order to maintain safety, activities or leave. The ward was always fully staffed and a nurse was always present on the ward. Leave or ward activities hadn't been cancelled in the last six months. If group activities were arranged the manager had the autonomy to increase staff numbers to allow this, for example staff had arranged a group trip to Wales.
- There was only one vacancy for a support worker .
- In the main office there was a board with staff members and the patient they were allocated for the day, for one to one support and updating daily records. Patients were involved in writing this information on the board.
- There was medical cover 24 hours a day, with an on-call doctor and an on-call consultant available for the entire hospital at night. There is a designate unit coordinator for the hospital that is assigned for the shift and is responsible for liaising with the on-call doctors and deciding if a patient should attend A&E.
- Staff were up to date with mandatory training, the manager had a matrix showing when staff were required to complete training. Notifications were sent to both the manager and the staff in question leading up to the training expiring.
- New staff received an induction and there was an induction checklist that staff had to work through. The manager ensured that staff were ready before signing them off the induction. This involved a set of questions

for policies that staff would have to complete. The ward had a policy of the week, which staff had to read and sign their understanding of the policy to keep up to date with any changes or to refresh policies.

- Staff had team training days to refresh or learn new things. For example, the most recent team training day was on incident reporting and safeguarding.

Assessing and managing risk to patients and staff

- We reviewed five patient care records. There was evidence in the care records that staff performed a risk assessment on admission. This was a recognised risk assessment, the short-term assessment of risk and treatability (START) and the historical clinical risk management (HCR-20) risk assessments. The risk assessments were updated every six months and as needed, for example after an incident or a rise in risk. These risk assessments were well written and there was evidence of patient involvement with the risk assessments, for example potential triggers were noted.
- Staff identified and responded to changes in risk, through changing the observation level, one to one support or through using the de-escalation suite. Care plans reviewed showed us that patients were often consulted on the best approach to dealing with difficult situations and staff would follow this patient led approach to changes in risk.
- Observations were proportionate and risk based, for example if there was an increased risk of ligature observations would be increased. There was an observation sheet that required staff to sign at the time of observation and note where the patient was and confirm if response was gained. Every patient was observed hourly and this was recorded in the same way.
- Staff followed the searching policy appropriately. Patients fed back at community meetings that they appreciated staff performing searches as this made them feel safer. Patients gave feedback on how staff could perform the searches.
- There were blanket restrictions, for example patients were not allowed to access the internet on the ward or have their personal mobiles on the ward. This was documented and in line with the ward policy and in place for safety reasons. Patients were given the information on admission and signed a consent form agreeing to the policy. The ward held a blanket restriction audit which was co-produced with the patients to get their views on the restrictions. This

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allowed staff to understand how the patients felt about the restrictions, and what the patients perceived as restrictions. This was documented and action planned for change or discussion.

- Patients were informed about the wards smoke free policy on admission. Nicotine replacement therapy was made available to patients.
- The ward employed the least restrictive practices, using de-escalation techniques. There was no seclusion room on the ward. Staff rarely had to use physical restraint or rapid tranquilisation. Where these interventions had to be used this was logged in specific log books, as well as incident forms filled in electronically. This allowed for tracking and monitoring of restrictive practices. Where rapid tranquilisation had to be used, this was done in line with National Institute for Clinical Excellence (NICE) guidance and the necessary observations were conducted.
- Staff were trained in safeguarding and knew how to apply this knowledge. The incident forms were able to refer to safeguard. The ward had good relationships with the local authorities and social workers, with social workers attending daily risk meetings where they can give feedback on open safeguards. Open safeguards are reported on at the daily hospital risk meetings. There were no open safeguards at the time of inspection.
- Staff used both paper and electronic records. The hospital had recently converted to electronic records and was still in the process of transferring their paper records to electronic ones. Staff said how there were initial problems but the ward manager was able to arrange ad hoc training to better support staff during the transition.
- There was a daily handover document that had all the relevant information for staff coming onto shift. This included any recent incidents, current and past risks, diagnosis and detention, physical and mental presentation. This handover sheet could be printed off for agency staff new to the ward to allow them to get to know the patients prior to going onto the ward floor.

Safeguarding

- All staff working at the hospital were required to complete safeguarding training in safeguarding of adults at risk. Compliance for this was currently at 88.2%. Staff also completed child safeguarding training; however, this was not part of the mandatory requirements.

- Staff on the ward we spoke with were aware of their responsibilities in relation to safeguarding and knew how to make safeguarding referrals. The manager told us they had a good relationship with the local authority. The provider had a policy in place which related to safeguarding and all staff were aware of how to access the policy.

Staff access to essential information

- We looked at five care records, including MHA documentation.
- Patient records were held across two systems; the paper system held most of the documentations (such as care plans, risk assessments, MHA paperwork) and the online system held daily risk assessment (which is colour coded dependent on risk) and the daily observation notes.
- Paper records had plenty of detail, were kept up to date but it was not easy to learn about the patient quickly. It was cumbersome to go through and was not quickly useable. Each patient had a folder of information which included relevant information such as family history, health records, risk assessments and care plans. Paper records were also used for medicine charts, consent to treatment documents and section 17 leave paperwork. Staff did not report any issues co-coordinating between paper and electronic records and we did not find any problems.

Medicines management

- We reviewed five medical records. We saw good practice of auditing the records and addressing any mistakes. For example, one signature was missing and through the audit process this had been picked up by the ward and addressed.
- Staff followed good practice for medicines management. Astons pharmacy provided pharmaceutical support to the ward. This included visiting the ward once a week to undertake duties such as audits and stock control. Staff had training in medicines management, including Clozapine titration, prescribing standards and rapid tranquilisation. Twice a month a staff nurse audits the medicine expiration dates to ensure good stock rotation. Staff followed good practice in controlled drugs management.
- Staff performed regular MEWS assessments and where several patients scored three or higher, there was no evidence of what staff actioned following these scores.

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There was no evidence that staff recorded normal scores for patients, in care plans or on medical charts, and therefore it can't be clear if appropriate action was taken when patients scored above three. For example, due to medication, a score above three could be considered normal and therefore emergency services would not need to be contacted, but there was no evidence this was the case.

- Although the medical fridge was well cleaned and temperatures monitored, the fridge was very full. This could affect the medications through preventing temperature circulation.

Track record on safety

- There were two serious incidents in the last 12 months. These incidents had been reported and went through the necessary review processes. The incidents were reported appropriately and investigated robustly.

Reporting incidents and learning from when things go wrong

- All staff knew how to report incidents and what type of incidents to report. This was done through a paper log book filled in by all staff. Senior staff would then review the incident and an electronic incident form would be completed. This allowed for tracking of the incidents and for ongoing/current incidents to remain in the patients files.
- Staff received feedback following incidents. This could be through formal debrief sessions with a clinical psychologist or informal ad hoc feedback sessions that were treated as reflective sessions. Feedback was also disseminated to staff through team meetings, meeting minutes and newsletters. Senior managers produce a lessons learnt newsletter that allows dissemination of lessons learnt from across the different wards. An example of lessons learnt is mental health act errors that were flagged, an action plan was created to include secondary checks and this has eliminated errors on mental health act paperwork.

Are forensic inpatient or secure wards effective?

(for example, treatment is effective)

Good 

We rated effective as good because:

Assessment of needs and planning of care

- Five care records were reviewed during the inspection. Staff completed a timely mental health assessment. This was done on admission or within 72 hours. This included risk assessments, brief psychiatric rating scales and general mental health state. There was also a physical health assessment conducted by a doctor in the same time frame.
- Staff developed care plans relevant to the patient. These were created by nursing staff, occupational therapists, clinical psychologists and doctors. These care plans were based on identified needs during assessments and were updated as needs changed or according to the patients wishes. The care plans reviewed showed that the patients were actively involved and led the development of the care plans. Care plans were offered to patients and it was documented if patients accepted or declined. Patients were also asked to sign their care plans in agreement. Where patients declined to sign this was documented. Care plans were holistic and goal orientated with SMART goals and patient-decided outcome measures included. Care plans were reviewed monthly and altered as necessary.

Best practice in treatment and care

- Care plans referenced any guidance that was utilised in the implementation of the care plan, for example medical care plans used NICE guidance. For example patients were given the opportunity to be involved in making decisions about their medicines and their physical health was monitored if prescribed specific medication.
- There was evidence of ongoing physical health monitoring, however this was not consistent. In reviewed care plans patients with physical health needs such as diabetes or weight management, did not have documented regular physical health checks over the period of their stay. All patients were offered ECGs every

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six months or as needed. There were active life leads employed that took lead on improving the patients physical health through exercise. The ward was subscribed to the commissioning for quality and innovation national goals on physical health.

- The ward had good access to psychological services, who utilised both cognitive and dialectic behaviour therapy, as well as schema therapy. Drug and alcohol support was given by the therapy teams and external groups such as narcotics and alcoholics anonymous.
- Patients were able to attend modules through the recovery college. They were awarded certificates if successful as proof of completion. Modules included pet handling, mental health awareness and musical lessons.
- Health of the Nation Outcome Measures (HONOS) were used by the ward to plot patients progress. Other clinical audits were conducted by staff. The manager had a list of audits and their due dates. Audit results and action plans were sent to the compliance officer monthly.

Skilled staff to deliver care

- The ward had access to a multi-disciplinary team (MDT) that included a full range of skilled staff. This included nurses, clinical psychologists, occupational therapists, psychiatric consultants and social workers. Patients could access these services when they needed, and we were told that rarely patients had to wait for services and never more than two weeks. Staff were experienced and had the necessary qualifications and skills to meet the needs of the patients.
- New staff were inducted onto the ward and given the required training, this prepared them for client group on the ward, as well as the broader organisational values and vision.
- Staff received regular supervision. The ward manager kept track of supervision and these records were signed off by supervisors. Minutes of supervision were then printed off and stored in the supervision folder. Supervisions were in depth and individualised. Appraisals were conducted yearly and were in depth. Staff were given two weeks notice so that they could gather any evidence or thoughts on what they would like to improve prior to the appraisal.
- Staff were able to access specialised, non-mandatory training that developed them personally and professionally. For example, level five leadership and management was given to the manager, other staff have received training in phlebotomy and ECGs.

Multi-disciplinary and inter-agency team work

- The ward held weekly MDT meetings for each patient. These were well attended by members of the MDT. Where the named therapist for that patient could not attend due to leave or other commitments, a representative was sent to ensure that no information was missed.
- Effective relationships were maintained both within the hospital and with external agencies. This includes relationships with the local authorities, social workers and local emergency departments. There were monthly meetings between the hospital and the local acute hospitals and emergency departments to improve working relationships and better understanding between the various organisations. Community psychiatric nurses and care coordinators were invited to MDT meetings.
- Staff shared information about patients at effective handover meetings. This was accompanied by the handover sheet. This sheet had relevant information for those staff coming onto shift, including diagnosis, detention, history, medication, medical and physical presentation and any incidents or changes in risk.

Adherence to the MHA and the MHA Code of Practice

- All patients were detained under the Mental Health Act or Ministry of Justice. All staff received training on the Mental Health Act and could demonstrate good understanding of the Mental Health Act and the code of practice. Access to support on the Mental Health Act was available, primarily through the senior staff and ward manager.
- Patients had easy access to independent mental health advocacy. Advocacy services were advertised on boards in the ward.
- Staff read patients their rights on admission. Patients were required to sign their understanding of their rights. Where patients were unable or unwilling to sign understanding staff would schedule in monthly readings to ensure they continuously attempted to read a patient their rights. Re-reading was done as necessary, for example if a patients situation or mental state changed.
- All Mental Health Act paperwork was clear and in patients records. This included consent to treatment orders, tribunals and leave documentation. Staff enabled patients to access leave and supported them in accessing leave. Where second opinion doctors were

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sought, this was well documented. Every week there is a review of Mental Health Act paperwork such as treatment orders to ensure the correct paperwork is in place.

Good practice in applying the MCA

- During reviews of records we saw evidence of staff conducting capacity assessments where necessary, such as for consent to treatment. Information about treatment options was given to patients and their capacity to consent was assessed.
- Staff understood the principles of the Mental Capacity Act and could seek guidance and advice from senior staff. Adherence to the Mental Capacity Act was audited monthly. All staff received mandatory training.

Are forensic inpatient or secure wards caring?

Good 

We rated caring as good because:

Kindness, privacy, dignity, respect, compassion and support

- Staff treated patients with kindness, dignity and respect. We saw this during the inspection and patients were very complimentary of the staff. Staff spoke and acted appropriately in front of patients.
- Patients had their treatment and medication explained to them and were able to ask questions of staff. Staff understood the individual needs of patients, and centred care on the individual.
- Staff told us that they were confident that any concerns they may have they were able to report to senior staff. Staff were able to raise concerns over abuse, disrespect or discriminatory behaviour without fear of repercussion.
- Staff maintained the confidentiality of patients information through computer security, locking patient files in offices and where important information was written on a white board there was a curtain that could cover the information.

- Patients were very complimentary of staff on the ward. We were told of examples where staff have accommodated patient requests, such as changing of named nurse. Patients told us how staff facilitate leave as best they can and promote family visiting.
- The hospital is part of the 'triangle of care' carers group initiative and represent Cygnet at the quarterly meeting.

Involvement in care

- Staff used the admission process to orientate patients to the ward environment, policies of the ward and the way the ward works. This includes, but not limited to, information related to CCTV, mobile phone rules and activities on the ward.
- Staff involved patients in the creation of the patients' care plans and risk assessments. Patients were asked for their opinions on the risk assessments, potential trigger areas and action plans for managing their risk. Care plans were collaborative and patients were able to read through their care plans, give feedback and discuss this with staff prior to the final product being signed by staff and patient.
- Staff generally communicated well with patients. However, there were not methods of communication with patients who have communication or learning difficulties on the ward. Staff were able to access this externally, for example if someone needed an interpreter or an easy read document.
- Patients gave feedback to the ward on the service they received. This was in the form of written compliments/complaints and during morning meetings. There were also dedicated meetings for service users, for example the blanket restriction audit meeting where patients could give feedback on blanket restrictions and what they perceived as blanket restrictions. The ward also held 'care and share' meetings. There were initiatives to introduce the 'peoples council' which promotes co-production of service delivery with the patients, giving them more chance to input into the running of the ward, for example attending new staff interviews.
- Patients had easy access to advocacy, with staff promoting and advising how to get advocacy and there were posters on the ward with advocacy details.
- Families and carers received information where appropriate, and staff maintained and respected patients' choice for confidentiality and sharing of information.

Forensic inpatient or secure wards

- There was a carers lead for the hospital and staff told us that she was very proactive at involving families and carers. Upcoming events such as birthdays and home visits were liaised through the carers lead, and often supported by her.
- The hospital is part of the 'triangle of care' carers group initiative and represent Cygnet at the quarterly meeting. The 'triangle of care' is a working collaboration, or "therapeutic alliance" between the service user, professional and carer that promotes safety, supports recovery and sustains well-being.

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

Good



We rated responsive as good because:

Access and discharge

- Occupancy rates were currently 89.7% on the ward. It was defined as a forensic inpatients/secure ward with an average length of stay of 314 days.
- There was a clear process in place to admit and discharge patients from the ward. A referral criterion was used to assess patients both from other wards and external services who may be suitable for the next stage of their care pathway to recovery. This enabled ward staff to assess if they could meet a patient's needs.
- Assessment of a new referral of a patient within ward was undertaken by an appropriate selection of staff, which could include ward manager, consultant and other senior staff. The catchment area was generally from the West Country but had included patients from Wales and the Midlands in the past.
- There were no delayed discharges last year. Staff planned for patients' discharge, including good liaison with care managers/co-ordinators, commissioners and community mental health teams. Care and treatment records showed that discharge planning was discussed at the ward round and individual Care Programme Approach reviews. There was always a bed available when patients returned from leave.

The facilities promote recovery, comfort, dignity and confidentiality

- The ward was located on the ground floor of the hospital. Entry was via the main hospital reception and there was a secure airlock. There were lockers and equipment to search patients and visitors within the airlock area. All rooms, except the bathroom, had observation panels (a panel in the doors that can be opened to allow staff to observe a patient or closed to maintain privacy or windows in the doors that allow staff to view inside the room).
- Patients had their own en-suite bedrooms. They were able to decorate and personalise their rooms as they liked, with many choosing to hang family photographs. Their valuables were safe in their rooms, or they could ask staff to keep valuables in a security cupboard.
- The ward had two lounges, one being a quiet room. The furnishings in the lounges were comfortable and allowed the patients to relax.
- Patients had access to outside space. Patients had assessed access to a secure garden space.
- There was a room where patients could meet visitors.
- Although patients could not have their personal mobile phones on the ward for security reasons, each patient was given a ward mobile phone for their personal use. The patients were responsible for purchasing their own sim card and managing their phones.
- The food was of a good quality. All patients had their meals in a bright and well-presented dining room. Patients had a choice of food at each meal. This included healthy options and gluten-free meals.
- Patients could make hot drinks and snacks during the day but at night this was restricted due to security concerns.
- Patients had access to a variety of therapy rooms, such as a gym, occupational therapy kitchen, art and music therapy room, subject to appropriate risk assessments. There was an activity schedule developed primarily by the occupational therapists which included activities seven days a week, for example African drumming, film club and weekend plans. There were often group excursions, for example a trip to Wales was planned for patients. We observed one cooking session led by staff and attended by six patients. This session was well received by patients and we saw good staff involvement with the patients.

Patients' engagement with the wider community

- Patients could access education and vocational opportunities. They were assessed for previous

Forensic inpatient or secure wards

experience and when appropriate they could access education. For example, college courses and recovery college modules, which they received certificates of completion for.

- Staff supported patients to maintain contact with their families and friends. This was done by giving patients a personal ward mobile phone, access to the I.T. suite where, once assessed, the patients could access the internet. Families and carers could visit patients, there were visitors rooms off the ward. The carers lead liaised with families and carers to facilitate visits and leave visits.
- Every Tuesday there was a social trip organised but the occupational therapists where a group of patients would go into the community. This was often done to integrate into community living by going to the cinema, shopping or going out for a meal.

Meeting the needs of all people who use the service

- The ward was located on the ground floor which facilitated access for people with physical disabilities. The ward did not always meet peoples communication needs, for example patients with a learning disability or autism did not have easy read or adjustments made for them, in a timely manner.
- Patients could access all the necessary information. For example, information on treatment, advocacy services and patients' rights. There were posters describing the independent mental health advocacy services and how to access this.
- Patients had access to a dietician and had a choice of food to meet their individual needs. There was a multi-faith room where patients could practice their religious needs. Patients praised the psychology team at the hospital and the therapy they offered. The dialectic behavioural therapy program was especially praised by patients.

Listening to and learning from concerns and complaints

- Patients knew how to complain or raise complaints. Patients had various ways to complain and could do so anonymously via an email service or through written comments to the ward manager to protect those who raise concerns. Patient meetings were held weekly where patients could raise any concerns.
- When patients complained or raised a concern they received feedback from the ward manager. This was

often done through the weekly caring and sharing meetings, and through caring and sharing meeting minutes. These meeting minutes had a 'you said, we did' section, that was to be discussed at the current meeting and was displayed on the ward notice boards.

- Learning from complaints and comments was given to staff as well. This was done through monthly supervision, team meetings and via newsletters. For example, there was a senior manager produced lessons learnt newsletter that shared learning from across the wards.

Are forensic inpatient or secure wards well-led?

Good 

We rated well-led as good because:

Leadership

- Leaders had the necessary skills, knowledge and experience to perform their roles. During our interview with the ward manager this was made apparent, and they had access to further development in their leadership. For example, the manager had recently completed a level five leadership and management course.
- The manager and senior leaders on the ward had a good understanding of the service and the patients they were treating. They could tell us about the different patients and how the teams were working to give them high quality care.

Vision and strategy

- The provider had recently changed their values. Staff and leaders were still learning these values, but displayed an eagerness to learn them. The values were displayed around the ward and staff could demonstrate how they were giving care in line with these new values. There was a weekly newsletter sent by the director of nursing and this has promoted the new values.
- The manager had access to the staffing budget and therefore could make decisions autonomously about the ward in order to maintain safety and quality of care on the ward.

Forensic inpatient or secure wards

Culture

- Staff felt respected and supported on the ward. Staff praised the manager and senior team. Staff did not always feel valued by the provider as an organisation. For example, there were concerns raised by staff about the changes to how they were paid.
- Staff on the ward felt positive and proud of the work they did. We were told by staff of the different therapy options available to patients, including schema therapy, dialectic and cognitive behavioural therapy, which both staff and patients praised. Staff also felt proud of how involved patients were in their care, for example the Milton Folder contained compliments, sharing and caring meeting minutes, self soothe forms, family liaison details and plans and patient activities.
- Staff felt they were able to raise concerns and complaints to the manager and to senior managers of the provider without fear of retribution. Staff knew of the whistle-blowing process.
- The staff team worked well together and the manager dealt with poor performance or difficulties appropriately. Staff had yearly appraisals that were objective and development based, contained SMART goals and action plans. Key skills and development areas were identified and plans to meet these objectives were clear and agreed upon by the manager and the staff member.
- Staff had access to physical and emotional support. The psychology team was open to all staff members and joined for debrief sessions after serious incidents. There was a designated occupational health program, known as the employee assist program, where managers can refer staff or staff can use self-referral. This provided psychological, emotional, physical and financial support to staff members.
- Staff carried out checks to ensure the ward was clean, well-maintained and safe for patients. Incidents were reported, investigated, monitored and any learning shared. The manager ensured staffing levels were appropriate to meet the needs of patients.
- Overall, staff were trained and supported to carry out their roles and provided with opportunities for professional development. The multi-disciplinary team worked in collaboration with patients, carers and external stakeholders to provide effective, holistic, care planning, risk management and discharge planning. Staff ensured that legal requirements were met in relation to the Mental Health Act and the Mental Capacity Act.
- The ward manager was clear about the process for highlighting any significant risks. The hospital director included these on the hospital risk.
- We saw the system for undertaking clinical audits, reporting on management data including training, absences, supervision and appraisal rates, data on incidents and complaints. This information was summarised and presented monthly in a key performance indicator dashboard. Examples of audits carried out included, patient engagement, physical health checks, and standard of care plans.
- The ward was reliant on the continued use of locum agency staff. The provider had an ongoing recruitment campaigns to bring in more staff. All locum staff were familiar with the ward, having worked there before.
- Regular team meetings were held allowing staff discuss concerns, participate in educational or clinical supervision, debrief following incidents and to learn from the issues.

Management of risk, issues and performance

- The manager took risks to the situation report meetings daily that would be looked at provider level. Staff at ward level could escalate concerns to the ward manager. These would also be addressed in the team meetings.

Information management

- Staff had access to the equipment and technology to do their work. There had been some problems with the change over from paper to electronic records, and this work is still ongoing. However, the manager had received specialised training that allowed him to support staff in the best possible way through the

Governance

- Effective systems and processes were in place to ensure the safe and effective running of the ward. There were clear responsibilities, roles, processes and systems of accountability.
- The hospital had a clear governance framework at ward level, which local managers oversaw and fed into the providers overarching governance structure and assurance framework.

Forensic inpatient or secure wards

transition. The paper records were at times cumbersome, with nine care plans, risk assessments, mental health act paperwork, physical health assessments, admission and orientation checklists, observation checklists and advanced statements/decisions. While all important information, the volume of information made the paper records cumbersome and hard to navigate.

- Managers had access to information that allowed them to safely and effectively run the ward. This included staffing figures and budgets, agency staff profiles to ensure that agency staff requested had the necessary skills. Manager kept records of staff training and supervision to keep track of what and who was due for updates. The manager held a spreadsheet with all patient paperwork that requires regular updating. This allowed him to keep track of when items needed updating and could have an oversight to ensure that updates happened.

Engagement

- Staff, patients and carers had up to date information about the ward and the services provided. This information was disseminated through the intranet, newsletters and team meetings. Patients could access information through staff members and the bulletin boards in the ward.
- Patients and carers had opportunities to give feedback on the service. This could be done directly to staff members or anonymously through email and comment cards. Although patients and carers are not currently involved in ward-based decisions, the Peoples Council is being implemented which aims to include patients in ward decisions such as staff interviews. There were quarterly patient surveys and a carers survey.

Learning, continuous improvement and innovation

- Milton ward was a member of the college centre for quality improvement (CCQI) forensic network and the peer review network.
- The ward held a focussed action plan folder. This contained any issues that had been identified and action plans to address the issues.

Long stay or rehabilitation mental health wards for working age adults

Good 

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

Are long stay or rehabilitation mental health wards for working-age adults safe?

Good 

We rated safe as good because:

Safe and clean environment

- The Lodge was clean and tidy with fixtures and fittings in a good condition. The Lodge had an environmental risk assessment in place which included a list of ligatures. The risk assessment showed all ligatures identified were mitigated against.
- The Lodge adhered to infection control principles. There were appropriate hand washing facilities and alcohol gel dispensers available for staff. This helped staff to maintain safety and cleanliness. The hospital employed domestic, housekeeping and maintenance staff to carry out immediate work within the service. Cleaning records were in place to ensure that all areas were regularly cleaned. Cleaning records showed that staff had completed the required tasks in line with these requirements. Spillages and body fluids were cleaned up immediately by domestic staff. Infection control audits were carried out regularly and any identified actions were completed in a timely manner.
- All areas to which patients had access had nurse call systems. This included bedrooms, bathrooms, dining areas and activity rooms. All staff that went into the Lodge carried personal alarms and these were used to summon help if staff felt they needed urgent assistance.

- The Lodge had a fully equipped clinic room. The clinic room had a door that could be opened at the top only, for safe dispensing of medicines. The clinic room was equipped thermometer, weight scale, blood pressure machine, fingertip pulse Oximeter (SpO2), blood glucose monitoring equipment and alcohol breathalyser. The equipment was labelled with clean stickers that were visible and in date. Staff knew how to calibrate all this equipment.
- Staff kept an emergency bag with relevant emergency equipment in the clinic room. Staff checked the equipment regularly and these checks were audited weekly.
- Temperatures of the room and clinical fridge was checked and recorded daily.

Safe staffing

- The Lodge employed registered mental health nurses, support workers, a psychiatrist, occupational therapist, and psychology was available by referral.
- There was a core staffing level set each day of one qualified and two support staff. The lodge manager could adjust staffing levels daily to take account of the needs of the patients. For example, if patients required increased observations, patient escorts, staff sickness cover and activities in the community. One member of staff was identified as a security lead each day. Any staff shortages were responded to quickly and adequately by the manager.
- Sickness levels within the service were 2.3%.
- The hospital managers discussed staffing levels at the morning meeting each day to ensure that staff and patients were safe on the lodges.
- When agency or bank staff were required the service used staff that were familiar with the running of the

Long stay or rehabilitation mental health wards for working age adults

Good 

Lodge and its patients to ensure continuity of care. Bank and agency staff were required to participate in the induction process to ensure they were familiar with the provider's policies and procedures.

- All patients within the Lodge had a named nurse. Patients had regular reviews with their named nurse and staff recorded what care had taken place.
- Staff were visible on the lodge. We saw staff spent time supporting patients with daily activities, engaging them in discussions and spending time on a one to one basis.
- Staff told us there were regular organised activities both in the hospital and outside. We looked at the activities timetable and saw that there was a varied activity programme. Staff told us that activities were rarely cancelled due to staff shortages. Section 17 escorted leave was rarely cancelled as there were enough staff on duty to ensure that leave could go ahead as planned. Section 17 leave is the legal means by which a detained patient may leave a hospital site.
- The Lodge had a dedicated consultant psychiatrist who worked in the hospital throughout the week. The psychiatrist conducted weekly ward rounds with other members of the multi-disciplinary team.
- Out of hours arrangements were in place to ensure staff could access medical help if needed. In addition, staff could contact the on-call manager out of hours if there was a need for help or advice.
- There was a programme of mandatory training that staff are required to undertake. As well as supervision, appraisal and induction. Staff were also required to complete training in the Mental Health Act and Mental Capacity Act. Eighty four percent of staff had completed mandatory training. Staff appraisal rates were 85%. The managers we spoke with told us they monitored staff mandatory training to ensure it had been completed.

Assessing and managing risk to patients and staff

- Staff did a risk assessment of every patient on admission, and these were updated every two weeks.
- Staff did daily risk assessments. They told us that if there was an informal conversation and they felt something was relevant to the patients risk, they would update on the electronic notes, and the risk assessment in the paper folder.
- We looked at the care records of four patients and found they were detailed and person centred. Staff completed individual risk assessments for each patient on their admission and carried out regular monthly reviews.

Additional reviews were carried out if patients had been involved in an accident or incident, or if staff noticed a change to a patient's presentation. Any incident forms would be printed as well to go alongside the risk assessment.

- Staff used the 'short term assessment of risk and treatability' (START) tool to assess potential risks. A risk assessment was completed for each patient.
- In three of the four records, there were updates under the heading of 'since admission' which noted any incidents that had occurred under the different domains, for example with the self-neglect or self-harm domains. Evidence of these incident forms were also found in the risk assessment section of the folder.
- Risks were assessed, monitored and managed daily on the electronic system. Risk assessments were reviewed in MDT meetings.
- Room searches happened randomly if staff suspected anything untoward about a patient's behaviour.
- Staff members ensured there were no inappropriate blanket restrictions in place. Restrictions to patients were limited to the least possible. Any restrictions that were in place were highlighted in care records.
- Patients had access to the Lodge through a locked door. Informal patients were able to leave the Lodge at any time however, an immediate risk assessment would be carried out by a member of staff.
- All staff at the service was trained in the use of restraint. The service used the management of actual and potential aggression using a positive behaviour support approach. Restraint was not used over the last six months.

Use of restrictive interventions

- The Lodge did not have a seclusion room and did not use seclusion. Staff told us patients were not restricted to their room and we found no evidence to suggest this practice ever occurred.
- Staff described that the training they received (PMVA and breakaway) was good. They felt confident that they can deal with the situations that arise.
- Staff all stated that they felt that restrictive interventions were not used very often. If they were used it was only used after de-escalation techniques failed. Staff all spoke about their relationships and understanding of the patients helps them talk to them and calm the

Long stay or rehabilitation mental health wards for working age adults

Good 

situation. Evidence we saw indicated that there were 24 incidents of restraint used for two patients in the last six months. Both of these patients were transferred to more acute care to meet their increased care needs.

- The staff showed an awareness of the physical health assessments and observations necessary following a restrictive intervention and felt that doctors attended the Lodge quickly to check the patients.

Safeguarding

- All staff working at the hospital were required to complete safeguarding training in safeguarding of vulnerable adults. Compliance for this was currently at 85.7 %. Staff also completed child safeguarding training; however, this was not part of the mandatory requirements.
- Staff on the Lodge we spoke with were aware of their responsibilities in relation to safeguarding and knew how to make safeguarding referrals. The manager told us they had a good relationship with the local authority. The provider had a policy in place which related to safeguarding and all staff were aware of how to access the policy.

Staff access to essential information

- We looked at four care records, including MHA documentation. Patient records were held across two systems; the paper system held most of the documentations (such as care plans, risk assessments, MHA paperwork) and the online system held daily risk assessment (which is colour coded dependent on risk) and the daily observation notes.
- Paper records had plenty of detail, were kept up to date but it was not easy to learn about the patient quickly. It was cumbersome to go through and was not quickly useable. Each patient had a folder of information which included relevant information such as family history, health records, risk assessments and care plans.

Medicines management

- Staff ensured that medicines were well managed. Medicines requiring refrigeration had been stored correctly. Staff ensured appropriate stock levels. We randomly checked a sample of medicines and did not find items past their expiry date. Staff felt well supported by the pharmacist visiting the Lodge each week.
- The prescription and dispensing of medicines were managed effectively. We reviewed four medicine

records. All prescriptions were signed, dated and reviewed in ward rounds. The records had correct consent to treatment forms attached. Prescriptions complied with the T2 forms and were within BNF limits. There were no errors or omissions observed.

- The provider had systems in place to monitor patient's physical health. In all records we looked at physical health monitoring had been completed.

Track record on safety

- There were no serious incidents in the last six months.

Reporting incidents and learning from when things go wrong

- The service incident reporting system consisted of writing it in the incident book, then put it on "my path" electronic system along with the incident log numbers.
- Staff we spoke with gave us mixed feedback regarding feedback from incidents or regarding any learning from. One felt that there was no feedback, one felt the manager gave feedback and another said it was via emails.
- Staff were debriefed and received support after incidents. Staff stated that these were helpful and happened quickly after the incident. Nursing staff debriefed both staff and patients after incidents. The psychology team was also very supportive and readily accessible if needed. The manager also supported with debriefs of the staff team.

Are long stay or rehabilitation mental health wards for working-age adults effective?
(for example, treatment is effective)

Good 

We rated effective as good because:

Assessment of needs and planning of care

- We reviewed the care and treatment records of four patients. There was a holistic approach to assessing, planning and delivering care and treatment to support the rehabilitation pathway. Staff had completed a comprehensive mental health assessment of the patient

Long stay or rehabilitation mental health wards for working age adults

Good 

in a timely manner after admission. This included an immediate management plan, mental state examination, history, details of medical investigations that needed to happen on admission.

- Patients received a thorough physical health assessment. We saw evidence of ongoing physical health needs, such as neurologist appointment for concerns regarding a movement disorder, quarterly bloods due to a vitamin d insufficiency and an MRI scan for a knee problem.
- We saw evidence in all four records of the staff using a physical health checklist for the admission assessment.
- Care plans were holistic and recovery focused. For example, there were care plans specific to drug and alcohol problems which was completed with a member of the psychology team. All care plans contained a goals section, how they would know they have achieved the goal and timelines for said goals. Each of the care plans were developed with different members of the MDT, for example the moving on care plan was done with the social worker and the physical health care plan with the doctor.
- Care plans were personalised.

Best practice in treatment and care

- Staff provided a range of care and treatment interventions suitable for patients who required rehabilitation. The interventions were those recommended by, and were delivered in line with, guidance from the National Institute for Health and Care Excellence, for example staff used psychosocial interventions which supported patients with social interaction, community access and integration, life skills development, managing challenging behaviour.
- There was evidence in the care records of rating scales used to record and assess severity and outcomes (the Health of the Nation Outcome scales).
- In the four care records we reviewed, there was evidence of the therapy timetable and specific group work detailed in the care plans. We spoke with three patients and one told us they did not find the groups that useful as they wanted to get a job instead. However, they were being supported to attend courses at the local adult education centre to help with employment. Another patient told us they enjoyed the shopping and cooking groups.

- Physical health was monitored and recorded within the patient's records. Patients had regular weight checks, nutritional reviews and general observations. In addition, the hospital ensured patients were registered with a local GP whom visited the service regularly.

Skilled staff to deliver care

- The Lodge employed a range of staff including; mental health nurses, occupational therapist, healthcare assistants, psychologist, and an external pharmacist was contracted to carry out medicines audits and medicines reconciliation. Clinical psychology services were available via referral within the hospital.
- Staff employed were experienced and qualified to carry out their roles. Prior to starting work at the service staff were required to provide suitable references and to have disclosure and barring checks carried out.
- All staff were required to participate in induction. This included information on the policies and procedures that were in place both nationally and locally. This included any long-term agency staff as well as the hospital internal bank of staff.
- Managers provided staff with supervision. They had one to one supervision monthly, could attend weekly group supervision lead by the clinical psychologist. Staff stated that they discussed any issues that have arisen, as well as any training they would be interested in. Staff spoke positively about the supervision they had, one saying that the Lodge manager had come back out of their work hours to ensure they had their supervision.
- The manager told us they felt confident to deal with poor performance. Where there were concerns about a staff member's performance there was advice from the human resource department.

Multi-disciplinary and inter-agency team work

- Staff held ward rounds weekly on the lodge. Each patient had a multidisciplinary lodge round every two weeks. Those attending included the consultant, nurses, occupational therapist.
- Handover meetings occurred twice a day, once in the morning and once in the evening at the changeover of staff.
- Staff told us they were clear about the roles and responsibilities of visiting NHS professionals in delivering patient care. A general practitioner from a local practice attended the hospital every week and visited the lodge on a rotating basis each week.

Long stay or rehabilitation mental health wards for working age adults

Good 

- Staff we spoke with told us there were good working relationships with external stakeholders. This included the local authority safeguarding team, local pharmacy, and commissioners.

Adherence to the MHA and the MHA Code of Practice

- At the time of our inspection all the staff working in the hospital had completed their mandatory training in the Mental Health Act (MHA). Records confirmed that 90% of staff had received training on the Mental Health Act.
- There was evidence in the care records of the patients being regularly informed of their rights, including information leaflets.
- Copies of up-to-date section 17 leave forms were clear and detailing conditions of leave. However, in two of the records, there were additional handwritten notes stuck to the section 17 leave paperwork at the front of the folder. One stated that leave had been suspended since an episode of self-harm, the other that the patient needed to be breathalysed on return from leave.
- Information on the rights of patients who were detained was displayed on the wall. Staff were aware of the need to explain patients' rights to them to ensure they understood their legal position and rights in respect of the MHA.
- Staff were aware of the need to receive consent to treatment and we saw evidence of consent being recorded in patient records. Where patients were unable to consent to treatment, we saw evidence of second opinions being sought and best interest outcomes recorded.

Good practice in applying the MCA

- At the time of our inspection 100% of staff working in the service had completed training in the Mental Capacity Act. Staff we spoke with demonstrated a good understanding of the Act and were confident in their knowledge of least restrictive practice.
- We saw good evidence of capacity assessments in patient care notes. We found that the capacity assessments were decision specific and we saw evidence that assessments showed staff had assisted patients to make decisions.

Are long stay or rehabilitation mental health wards for working-age adults caring?

Good 

We rated caring as good because:

Kindness, privacy, dignity, respect, compassion and support

- Staff engaged with patients in a way that was respectful and caring, spending time carrying out activities with patients. Staff told us that they enjoyed working with patients and showed they were passionate about their care. We observed staff treating patients in a calm and supportive manner. We heard staff talking with patients in an empathic and non-judgemental manner.
- Patient care records showed staff had taken time to get to know their patients. Care plans demonstrated that staff had used the knowledge gained to complete patient histories.
- On the Lodge staff demonstrated a good understanding of patients' needs and understood individuals care plans.
- Patients were offered a variety of appropriate activities. An activities co-ordinator planned group and individual activities throughout the week and weekends. Staff working at the service supported patients to carry out activities.

Involvement in care

- We saw evidence in the four care records, how patients were orientated to the Lodge on admission.
- Staff told us how patients could provide feedback during the morning meetings they had each day. These meetings were an opportunity for patients to feedback issues about the service. Minutes from these meetings with action points were displayed on a noticeboard.
- Staff stated that they would invite carers and families to ward rounds, and the nursing team called the family members if the patient gave permission to.
- Staff involved patients in care planning and risk assessments. The care plans were signed by the patient which also stated if they had a copy or not. The care plans had documented if patients had not wanted to engage or disagreed about what was in the care plans.

Long stay or rehabilitation mental health wards for working age adults

Good 

- Patients we spoke with stated they knew what their care plans involved and had been offered copies of them. In one care record there were printed copies of care plans to give to the patient if they changed their mind about wanting a copy.
- Patients were encouraged to give their feedback on the service and the care and treatment they received. The service used annual surveys, comments boxes and meetings to gather information relating to the running of the service.
- Patients had access to advocacy. There were regular visits by the advocacy service and detained patients under the Mental Health Act had could access the Independent Mental Health Advocates (IMHA) as required. We saw posters displayed across the hospital advertising advocacy services.
- The hospital is part of the 'triangle of care' carers group initiative and represent Cygnet at the quarterly meeting. The 'triangle of care' is a working collaboration, or "therapeutic alliance" between the service user, professional and carer that promotes safety, supports recovery and sustains well-being.

Are long stay or rehabilitation mental health wards for working-age adults responsive to people's needs?
(for example, to feedback?)

Good 

We rated responsive as good because:

Access and discharge

- The Lodge took referrals from anywhere in the country and did not have a catchment area. Occupancy rates were currently 45% on the lodge. It was defined as a high dependency rehabilitation unit with an average length of stay of nine months.
- There was a clear process in place to admit and discharge patients from The Lodge. A referral criterion was used to assess patients both from other wards and external services who may be suitable for the next stage of their care pathway to recovery. This enabled The Lodge to assess if they could meet a patient's needs.
- Assessment of a new referral of a patient within The Lodge was undertaken by an appropriate selection of

staff, which could include The Lodge manager, consultant or occupational therapist. The catchment area was generally from the West Country but had included patients from Wales and the Midlands in the past.

- There were no delayed discharges last year. Staff planned for patients' discharge, including good liaison with care managers/co-ordinators, commissioners and community mental health teams. Care and treatment records showed that discharge planning was discussed at the ward round and individual Care Programme Approach reviews.
- There was always a bed available when patients returned from leave.
- Patients were not moved during an admission episode unless it was justified on clinical grounds and was in the interests of the patient. The manager reported that patients were only moved if they required admission to the general hospital or their mental health deteriorated and they required an acute admission ward.

The facilities promote recovery, comfort, dignity and confidentiality

- The Lodge had sufficient facilities to promote dignity and confidentiality.
- Apart from two, bedrooms on the unit were en-suite and contained plenty of furniture. Patients were able to have their belongings with them and personalise their rooms. All patients had a key to their bedroom and could gain access at any time. There was a bathroom available for the one bedroom that was not en-suite.
- There was a dining area with tables and chairs to fit all the patients comfortably. There was an assessment kitchen, dining area, large garden and an activity room located in the garden.
- There was a small dedicated quiet lounge which could also be used for patients to meet visitors.
- Food was cooked fresh on site each day. There was always a variety of choice and specialist diets were well catered for.
- Patients were able to access food and drinks when they wanted them.

Patients' engagement with the wider community

Long stay or rehabilitation mental health wards for working age adults

Good 

- When appropriate, staff ensured that patients had access to education and work opportunities. For example, a patient was being supported to attend an external college course and another undertook voluntary work in a local shop.
- The occupational therapist carried out a comprehensive assessment of each patient to find out their hobbies, interests and goals. Following the assessment, they developed a specific activity plan with the patient, for example, we saw that a patient liked cooking and a care plan was in place to support them with this.
- The occupational therapist provided a programme of activities, which met the individual needs of each patient. The timetable was available in written and pictorial format and changed monthly. Activities included relaxation and cooking groups.
- Patients could also access the hospital's recovery college where a variety of short courses were available. This programme was set up with patients each term.

Meeting the needs of all people who use the service

- The service made adjustments for any potential disabled patients. Although the Lodge was located over two floors there was a ground floor bedroom and bathroom were available for patients with mobility issues. Patients' specific communication needs were identified at assessment and where required easy read information was provided.
- Staff ensured that patients could obtain information on treatments, local services, patients' rights and how to complain. This information was displayed on notice boards throughout the Lodge. Staff could access translators for patients and could also have information translated for patients and carers if necessary to provide accessible information.
- Meals were available to meet individual cultural, religious or dietary requirements. Patients spoke positively about the food provided and told us that choices were available to meet their specific needs and preferences.
- Fact sheets relating to detention under the Mental Health Act were accessible to patients and carers.

Listening to and learning from concerns and complaints

- The Lodge had received one complaint in the last year and this was currently being investigated. The staff worked with potential complainants to resolve these informally before the formal process was required.
- Complaints information was available both on notice boards and within the patient information pack, which was shared with relatives. Monitoring and feedback about complaints was a standing item for the hospital governance group.
- Patients we spoke with knew how to make a complaint or raise concerns. The staff we spoke with took complaints seriously and knew how to respond appropriately in order to improve the quality of care. Patients were reminded at the weekly community meeting to raise any concerns with staff or the advocate.

Are long stay or rehabilitation mental health wards for working-age adults well-led?

Good 

We rated well-led as good because:

Leadership

- Leaders had the skills, knowledge and experience to perform their roles. Staff we spoke with had confidence in the manager and the current hospital leadership team. They had a clear understanding of the service and could explain how the team worked to provide good rehabilitation care.
- The manager was visible in the service and approachable for both patients and staff. Staff felt that the Lodge manager was pivotal in holding the team together. The Lodge manager would regularly work within the clinical team to keep updated and to provide support to both staff and patients.
- Leadership development opportunities were available for staff who wished to progress within the service.

Vision and strategy

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

Long stay or rehabilitation mental health wards for working age adults

Good 

team. The provider's senior leadership team and the Lodge manager had communicated the provider's vision and values to their staff. The teams felt the visions and values linked well to how they were working.

- Staff were positive about the senior management team within the hospital. They told us that they were approachable and they felt supported by their manager.

Culture

- The staff we spoke with were positive about working on the Lodge. They told us they felt able to raise concerns, report incidents and make suggestions for improvements. They were confident their line manager would listen and act on them. Staff were able to describe the whistleblowing process and the whistleblowing policy.
- The lodge manager explained the process for managing poor staff performance. This included obtaining support and advice from the service manager and the provider's human resources department.
- Staff morale was good and the staff we spoke with had a clear commitment to their roles.
- Staff appraisals included career development and how it could be supported. Staff received an appraisal in the last year.
- Staff were provided with opportunities for development within their roles. This included specialist training, lead roles and the support to complete a registered nurse conversion course.
- Managers within the service promoted an open and honest culture. All staff had received training on their responsibilities under the duty of candour and additional information was available on the intranet.

Governance

- Effective systems and processes were in place to ensure the safe and effective running of the Lodge. There were clear responsibilities, roles, processes and systems of accountability.
- The hospital had a clear governance framework at ward level, which local managers oversaw and fed into the providers overarching governance structure and assurance framework.
- Staff carried out checks to ensure the Lodge was clean, well-maintained and safe for patients. Incidents were reported, investigated, monitored and any learning shared. The manager ensured staffing levels were appropriate to meet the needs of patients.

- Overall, staff were trained and supported to carry out their roles and provided with opportunities for professional development. The multi-disciplinary team worked in collaboration with patients, carers and external stakeholders to provide effective, holistic, care planning, risk management and discharge planning. Staff ensured that legal requirements were met in relation to the Mental Health Act and the Mental Capacity Act.
- The Lodge manager was clear about the process for highlighting any significant risks. The hospital director included these on the hospital risk register as there was no Lodge risk register.
- We saw the system for undertaking clinical audits, reporting on management data including training, absences, supervision and appraisal rates, data on incidents and complaints. This information was summarised and presented monthly in a key performance indicator dashboard. Examples of audits carried out included, patient engagement, physical health checks, and standard of care plans.
- The lodge was reliant on the continued use of locum agency staff. The provider had an ongoing recruitment campaigns to bring in more staff. All locum staff were familiar with the lodge, having worked there before.
- Regular team meetings were held allowing staff discuss concerns, participate in educational or clinical supervision, debrief following incidents and to learn from the issues.

Management of risk, issues and performance

- There were systems to assess, monitor and manage risks to patient safety. Staff told us they could escalate concerns through their manager when this was necessary. The hospital risk register was reviewed at the monthly hospital governance meeting attended by the senior management team.
- The hospital had protocols in place for major incidents and business continuity in the event of emergencies.
- We did not find any examples of financial pressures compromising patient care.

Information management

- Staff used the systems in place to collect data from the lodge and had access to the equipment and information technology needed to do their work. Information governance systems included confidentiality of patient records.

Long stay or rehabilitation mental health wards for working age adults

Good



- The manager had access to information to support them with their management role. This included information on the performance of the Lodge, staffing and patient care.
- Staff made notifications to external bodies as needed. Staff provided notifications on patients absent without leave, allegations of abuse and any incidents involving the police to the Care Quality Commission (CQC) as required.

Engagement

- Patients and carers had opportunities to give feedback on the service they received through community meetings and feedback questionnaires. Managers and staff had access to this feedback which they shared at team meetings in order to make any changes.
- Senior managers of the hospital engaged with external stakeholders, such as commissioners and the local safeguarding teams.

Learning, continuous improvement and innovation

- At the time of the inspection no research or quality improvement programmes were taking place on the lodge. The ward is continuously looking at their learning and continuous improvement but we didn't see anything specific during our inspection.

Personality disorder services

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

Are personality disorder services safe?

Good 

We rated safe as good because:

Safe and clean environment

- The layout of Knightstone ward enabled staff to observe the majority of the ward area. Where observation was restricted risks were mitigated by using staff to safely observe patients. In addition, convex mirrors were used to assist clear lines of sight through the ward.
- The physical and procedural security on Knightstone ward was provided to a consistently effective standard. Staff applied strong operational policies and procedures effectively which ensured the safety of patients, visitors and staff. We saw a comprehensive range of effective procedures across the service, which enabled staff to establish and maintain clear boundaries across the site. Staff and patients told us that the procedures assisted them in feeling safe across the hospital site.
- There was a single main entrance to enter and exit to the hospital site with an air lock operated by reception staff. An air lock is an additional locked room to pass through before gaining access to or exit from the hospital. This strengthened security in and out of the hospital. The entrance environment for patients, visitors and staff was welcoming, with comfortable furniture, cold water to drink, bathroom facilities and a variety of relevant leaflets and information. Knightstone ward was on the first floor and also had an airlock to access the ward operated by an entry fob system.

• Staff carried out an audit of potential ligature points and completed risk assessments for the ward. All staff we spoke to were familiar with all potential ligature points throughout the ward and ligature management plans. For example the laundry room, which had a lot of potential ligature points, was only used with staff supervision.

• Knightstone ward was for female patients only and therefore met the Department of Health guidance on same sex accommodation.

• Emergency equipment was stored on the ward in the nursing office. An automated external defibrillator and anaphylaxis pack were in place. The staff carried out checks regularly to check the equipment was in order, fit for purpose and we saw evidence of these checks. The ward manager told us that equipment such as weighing scales and the blood pressure machine were regularly calibrated and that the equipment was checked on a regular basis to ensure it was fit for purpose. We saw evidence of this in audit records and by looking at equipment. The ward clinic room was fully equipped and had an examination couch. Ligature cutters were available in the clinic room and in the nursing office.

• There was no seclusion room on Knightstone ward.

• Knightstone ward was visibly clean, with good furnishings and was well maintained. The ward had dedicated housekeeping staff. Cleaning records were complete and up-to-date. Cleaning schedules were available and were up to date. We saw staff following effective infection control practice including hand washing.

• Environmental risk assessments were undertaken regularly and we saw evidence of work carried out as a result.

Personality disorder services

• Alarms were available throughout the ward and all staff carried personal alarms. We were told by all staff that alarms were responded to quickly. We saw staff respond to several alarms during the inspection. They responded quickly to ensure that patients and staff were safe. We saw that the use of alarms and testing was well documented.

Safe staffing

• There were 24 staff working on Knightstone ward. There were six staff vacancies between July 2018 and September 2018. There were four staff nurse and two support worker vacancies at the time of our inspection. Over a three month period from July to September an average of 392 shifts were filled by temporary staff. All temporary staff were bank or agency staff who were familiar with the service. The providers own staff covered many the available shifts. The sickness rate was 4% for February 2019. There were 194 substantive staff between October 2017 and September 2018. 39 staff had left over the same period.

• All staff we spoke to told us there were enough staff to deliver care to a good standard and we saw that there were enough staff on duty. Knightstone ward had two qualified nurses and two support workers during the day shift. Night shifts were also covered by two qualified nurses and two support workers. The ward manager was working in addition to the minimum number of staff on each shift. We looked at the staffing rotas and saw that there were enough staff working on each shift.

• Arrangements were in place, to provide effective support and processes to enable clinical staff to spend their time in direct contact with patients. This meant staff had time released to be able to prioritise the care and treatment of the patients.

• Staff told us that they could always access a psychiatrist if required. There was a full time consultant psychiatrist and a specialist ward doctor for Knightstone ward. Doctors were flexible and responsive to requests to attend the wards when required. This included in an emergency. Staff told us that there were adequate doctors available over a 24 hour period, seven days a week, who were available to respond quickly to the ward in an emergency.

• We were told by the nurses that senior managers were flexible and responded well if the needs of the patients' increased and additional staff were required.

• Staff told there was usually enough staff to escort patients on leave. Patients told us that leave was rarely cancelled. We did not see and evidence of this and staff kept cancellations of escorted leave to an absolute minimum and recorded this.

• Patients told us they were offered and received a one-to-one contact with a member of staff every day. We looked at six patients' care records and saw that this was the case.

• Knightstone ward staff had an 84.5% completion rate for mandatory training which included training on first aid, equality and diversity, health and safety, infection control, medication management, risk management, safeguarding adults and children, engagement and observation, prevention and management of violence and aggression, the Mental Health Act, recovery and the my shared pathway approach. We looked at the Knightstone training records to verify the training course content and adherence figures.

Assessing and managing risk to patients and staff

• There was no seclusion room facility on Knightstone ward. There were 71 incidents of restraint, involving eight patients, over a six month period prior to our inspection. We saw that those patients liable to require restraint had a clear care plan describing this and the rationale behind. We looked at the records on restraint and saw that there was 17 incident of prone restraint, 12 which did not result in rapid tranquilisation. There was a culture of promoting least restrictive practice on the ward and we saw evidence of this throughout the ward.

• We looked at six care records on Knightstone ward; all of these were of patients detained under the Mental Health Act. We found a comprehensive risk assessment in place for all patients on admission. All patients, where they had wanted to, and had consented to, had been actively involved in the risk assessment process.

• The overarching risk documentation and assessment method used on Knightstone ward was called the 'short term assessment of risk and treatability' tool. Risk formulations and plans were consistently well planned, of a good standard and used structured professional judgement risk assessment schemes which staff had been trained to use. A structured decision support guide, called the Historical Clinical Risk Management-20 (HCR-20), was used to assess risk factors for violent

Personality disorder services

behaviour. The structured assessment of protective factors was used to help reduce the risk of any future violent behaviour as well as offering guidance for treatment and risk management plans.

- A range of additional and nationally recommended assessment methods were also used and included, the trauma symptom inventory, the cognitive analytic therapy file, cognitive assessments, schema assessments, the international personality disorder examination and dialectical behaviour therapy assessments. A range of outcome measures were used to inform the ongoing risk assessment process and included, the Beck depression inventory, anxiety and hopelessness inventories and drug and alcohol screening assessments. All this information was reviewed regularly and documented in the care records. Reviews of risk were part of the multidisciplinary care review process.
- Blanket restrictions were implemented for items such as contraband items and locked doors to access and exit. These were justified and clear notices were in place for patients, staff and visitors explaining why these restrictions were being used. Staff and managers we spoke to told us that they promoted least restrictive practice and we saw evidence during our inspection.
- Staff told us that where risks were identified, measures were put in place to ensure the risk was safely managed. For example, the level and frequency of observations of patients by staff was increased. Individual risk assessments were viewed and took account of patients' previous risk history as well as their current mental state.
- All staff were trained in promoting safer and therapeutic services and all staff were trained to use their engagement and observation policy. We saw repeatedly that when a patient was in distress and called for assistance the staff responded.
- All patients we spoke with told us that they felt safe on Knightstone ward.
- We spoke with staff about protecting patients from abuse. All the staff we spoke with were able to describe what constitutes abuse and were confident in how to escalate any concerns they had. Staff had received training in safeguarding vulnerable adults and child protection and were aware of the organisation's safeguarding policy.
- We reviewed 11 medicine charts on Knightstone ward. A number of patients were prescribed regular medication and the same as required medication. It was not clear on the prescription chart that the maximum dosage could have been exceeded if both had been administered together. We raised this with the doctor who took action to remedy this. One patient was on high unlicensed doses of antipsychotic medication which was discussed and consented to. We discussed this with the prescribing doctor who confirmed that this was clinically indicated.
- The medicines were stored securely in the clinic room on the ward. Daily checks were made of the room and refrigerator temperatures to ensure that the medicines remained suitable for use and we saw records to show that this was the case. All medicines needed were available. We looked at the ordering process and saw the process for giving patients their regular medicines and we heard from patients about the information they were given. A pharmacist visited the ward every week and there were endorsements and signatures on the charts to indicate the pharmacist had been.
- Staff gave patients information about medicines. Staff discussed medicines in a multidisciplinary care review. Staff discussed changes to the patients' medicines with them and provided leaflets with more information. We saw this happening during our inspection.
- Staff used clear protocols for patients to see children from their family. Each request was risk assessed thoroughly to ensure a visit was in the child's best interest. There was a meeting room available for visitors outside of the ward areas.

Safeguarding

- All staff working at the hospital were required to complete safeguarding training in safeguarding of adults at risk. Eighty eight percent had received training. Staff also completed child safeguarding training; however, this was not part of the mandatory requirements.
- Staff on the ward we spoke with were aware of their responsibilities in relation to safeguarding and knew

Personality disorder services

how to make safeguarding referrals. The manager told us they had a good relationship with the local authority. The provider had a policy in place which related to safeguarding and all staff were aware of how to access the policy.

Staff access to essential information

- We looked at six care records, including Mental Health Act (MHA) documentation. Patients' records were held across two systems; the paper system held most of the documentations (such as care plans, risk assessments, MHA paperwork) and the online system held daily risk assessment (which was colour coded dependent on risk) and the daily observation notes.
- Paper records had plenty of detail, were kept up to date but it was not easy to learn about the patient quickly. It was cumbersome to go through and was not quickly useable. Each patient had a folder of information which included relevant information such as family history, health records, risk assessments and care plans. Paper records were also used for medicine charts, consent to treatment documents and section 17 leave paperwork. Staff did not report any issues co-ordinating between paper and electronic records and we did not find any problems.

Medicines management

- Staff ensured that medicines were well managed. Medicines requiring refrigeration had been stored correctly. Staff ensured appropriate stock levels. We randomly checked a sample of medicines and did not find items past their expiry date. Staff felt well supported by the pharmacist visiting the ward each month.
- The prescription and dispensing of medicines were managed effectively. We reviewed 11 medicine records. All prescriptions were signed, dated and reviewed in ward rounds. The records had correct consent to treatment forms attached. Prescriptions complied with the T2 forms and were within British national formulary (BNF) limits. The BNF is a book which is published twice yearly which has up to date medication prescribing guidelines. There were no errors or omissions observed.
- The provider had systems in place to monitor patients' physical health. Staff had completed patients' physical health monitoring in all the records we reviewed.
- However we found that there were some out of date medication waiting to be disposed of in a storage

cupboard in the treatment room. The medication was clearly awaiting disposal and staff were able to tell us that this was the case. There were no facilities on the ward to dispose of surplus or expired medication.

Track record on safety

- There were 12 serious incidents on Knightstone ward in the preceding year. These included incidents of serious including: self-harm, use of ligatures, absconson and assaults on staff. These incidents had been reported appropriately and investigated robustly.
- Staff on Knightstone ward were high reporters of incidents due to the nature and characteristics of the client group as a specialist personality disorder treatment service. This was a more challenging and high risk service.

Reporting incidents and learning from when things go wrong

- Staff knew how to recognise and report incidents. All incidents were reviewed daily by managers and senior clinicians in a morning meeting called the 'situation report' (Sit Rep) meeting. We attended the Sit Rep meeting and saw evidence of this. The meeting involved representatives from all wards. The senior management team discussed all incidents and analysed recommendations from all serious incidents and reported these back weekly to the wards for discussion in team and service-wide meetings. Staff investigated all incidents to try to establish the root cause. We looked at recently reported incidents on Knightstone ward and tracked them back to the patients' care records. We saw in all cases that patients and staff had received a de-brief session following the incidents to immediately address any lessons to be learnt.
- Staff told us about an incident which had occurred over the weekend. We were told that staff had assisted the patient and the incident had been well managed. Staff involved had discussed with the ward manager and we saw evidence that the incident was discussed at the Sit Rep meeting. We were able to track the incident in the patient's records and it was reflected in the patient's care records.

Personality disorder services

- Patients told us that they were actively involved in discussing their risk behaviour with the multidisciplinary team. Patients told us that they worked more effectively under the positive risk taking model used on Knightstone ward.
- Staff told us that they received feedback from investigations in regular team meetings and that they learnt key themes and lessons and developed action plans if they needed to make changes. Staff said there was always a debrief session arranged after a serious incident and that a facilitated, reflective session would take place to ensure, as well as learning lessons, that staff felt adequately supported.

Are personality disorder services effective?

(for example, treatment is effective)

Good 

We rated effective as good because:

Assessment of needs and planning of care

- We reviewed the care and treatment records of six patients. There was a holistic approach to assessing, planning and delivering care and treatment to support the rehabilitation pathway. Staff had completed a comprehensive mental health assessment of the patient in a timely manner after admission. This included an immediate management plan, mental state examination, history, details of medical investigations that were required on admission.
- Patients received a thorough physical health assessment. We saw evidence in all six records of the staff using a physical health checklist for the admission assessment.
- Staff assessed patients' needs and delivered care in line with the patients' Individual care plans. All patients received a detailed assessment prior to being admitted to Knightstone ward. All patients received a thorough physical health assessment; staff identified and managed risks to physical health. We saw that in addition to psychiatrists working as part of the

multidisciplinary team, a GP visited the ward every week. All staff we spoke to were very confident in their ability to assess physical health care needs and provided robust care and treatment plans.

- Patients' told us that they received a copy of their care plans.
- Staff stored patients' care records securely in the nursing office and were easily accessible.

Best practice in treatment and care

- In keeping with the National Institute for Health and Care Excellence (NICE) guidance, patients had access to a variety of psychological therapies either on a one-to-one basis or in a group setting, as part of their treatment. Clinical psychologists, occupational therapists, social workers, nurses, support workers and activity co-ordinators were part of the multidisciplinary team and were actively involved.
- Staff completed detailed psychological assessments. All the patients on Knightstone ward were receiving an individually tailored programme of therapy, delivered flexibly and in response to their individually assessed needs. The range of therapies included trauma work, dialectical behaviour therapy, mentalisation-based therapy which helped patients differentiate and separate out their own feelings from those around them, cognitive analytic therapy, family therapy and schema focused therapy.
- A GP attended Knightstone ward routinely on a weekly basis and provided physical health advice and consultancy for patients. Regular physical health checks were taking place for all the patients on the ward.
- Occupational therapy assessment and outcome measures were in place for all patients.
- Staff assessed patients using HoNoS, health of the nation outcome scales. These covered 12 health and social domains and enabled clinicians to build up a picture over time of the patients' responses to interventions. A range of additional outcome measures were used to inform the ongoing evaluation of interventions made and included, the Beck depression inventory, anxiety and hopelessness inventories and drug and alcohol screening assessments.

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- Staff participated in clinical audits to monitor the effectiveness of services provided. Audits carried out included an annual review into the effectiveness of care and treatment for patients with a diagnosis of personality disorder, a detailed incident review, identifying trends and ensuring adherence to outcome measures through a review of care records.
- In keeping with the NICE guidance for patients with a personality disorder, Knightstone ward staff encouraged patients to make informed decisions about their care and treatment in partnership with them. Families were given the opportunity to be involved with the consent from patients.

Skilled staff to deliver care

- The staff on Knightstone ward came from a variety of professional backgrounds, including medical, nursing, psychology, occupational therapy, social work, drug and alcohol workers, alternative therapists such as in art, dance and music and activity specialists and were all fully integrated into the team. All staff were trained in a minimum of three days of dialectical behaviour therapy with eight staff fully trained as dialectical behaviour therapists.
- Staff received appropriate training, supervision and professional development. Eighty five percent of staff had updated mandatory training refresher courses recorded. All new staff attended a comprehensive and thorough induction programme followed by a mentorship period. Healthcare support workers were required to complete the care certificate. We saw this in the records we looked at. We saw that staff were also encouraged to attend longer internal and external training courses. We saw that all staff participated, at least weekly, in reflective practice sessions. All aspects of clinical training took into account the needs of the patient population for example safeguarding adults at risk and updates on the Mental Capacity Act and the revised Code of Practice for the Mental Health Act.
- All staff we spoke to said they received individual and group supervision on a regular basis, at least every six weeks, as well as an annual appraisal. We looked at staff records which showed that all staff had received regular

supervision and an appraisal. All staff participated in regular reflective practice sessions where they were able to reflect on their practice and incidents that had occurred on the ward.

- The ward had a regular team meeting and all staff we spoke with described morale as very good. Staff said their ward manager and senior clinical team were highly visible, approachable and supportive. Topics recently covered included managing and learning from incidents, care planning and setting boundaries.
- All patients we spoke to told us that they had been involved in decisions about their care. All patients we spoke to told us that the psychology input was exceptional and we saw evidence of a number of compliments from patients that had received therapy from psychology.

Multi-disciplinary and inter-agency team work

- The Knightstone staffing team were a fully integrated and adequately staffed multidisciplinary team. Regular and fully inclusive team meetings took place. We observed care reviews and clinical hand over meetings on the ward and found these to be effective and involved the whole multidisciplinary team. All members of the team were given the opportunity to feedback and add to discussions in meetings.
- We observed inter-agency working taking place with discussions about and with the patients' 'homecare' team and commissioners.

Adherence to the MHA and the MHA Code of Practice

- All staff had received Mental Health Act (MHA) training. All staff we spoke to were able to confidently discuss the provider processes and practices for ensuring adherence to the MHA Code of Practice.
- Patients care records were complete but information was difficult to find due to the size of the patients' paper records. The MHA documentation was present and available on all the files.
- Staff informed patients of their rights under the MHA. There was evidence in all patients files to show that they were regularly informed of their rights under section 132 of the MHA. We saw that there was active involvement of an independent mental health advocacy (IMHA) service

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and that information about the service was advertised on the notice board on the ward. Patients told us they knew how to request an appointment with an advocate and that they had done this.

- Patients were encouraged to contact the CQC if they chose to about issues relating to the MHA. Information about how to do this was contained in the information folders of all patients detained under the MHA.
- The Mental Health Act administrator for the hospital monitored requirements and compliance with the MHA and Code of Practice, daily. Six monthly audits were carried out on accuracy of T2 and T3 consent certificates; medicines charts and section 17 leave documentation.
- There was evidence of timely managers' hearings at the point of patients' section renewals. These were undertaken prior to, or very shortly, after the patient's section renewal date and when then made an appeal.
- Copies of up-to-date section 17 leave forms were kept in a file accessible in the nurses' office. The forms were comprehensive, clearly detailing the levels, nature and conditions of leave. Records showed that these were regularly reviewed and updated. Staff recorded which patients had been given copies of the section 17 leave forms. Copies of the section 17 leave forms were filed in the patients' care records.
- Assessments of patients' capacity to consent to treatment were available, at the point that T2 certificates were issued and reviewed. We found that both T2 and T3 certificates were reviewed in line with the provider's policy.

Good practice in applying the MCA

- Mental Capacity Act training was included in mental health act training. Mental health Act training had been attended by 100% of the ward staff.
- There was a Mental Capacity Act policy in place and staff told us about the principles and how they applied to the patients.
- Where appropriate patients would have a mental capacity assessment relating to care and treatment. There were no current Deprivation of Liberty Safeguards (DoLS) applications and there had not been any applications made in the preceding six month period.

Are personality disorder services caring?

Good 

We rated caring as good because:

Kindness, privacy, dignity, respect, compassion and support

- All the patients we spoke with complimented staff providing the service throughout Knightstone ward. Professional, responsive and respectful staff supported patients consistently. One patient we spoke to said that staff listened and their opinions were always sought.
- We were unable to contact any carers to seek their opinion despite efforts to contact them by phone numbers provided.
- Patients we spoke with told us that staff were busy, however, they were generally available for them. One patient we spoke to commented about staff been caring and having time to listen.
- Despite the complex, and, at times very challenging needs of the patients on Knightstone ward, the atmosphere throughout the ward was very calm and relaxed. Staff were particularly calm and not rushed in their time with patients. Staff could spend time individually with patients, talking and listening to them.
- During our inspection, we saw a lot of positive interaction between staff and patients on the ward. Staff spoke to patients in a friendly, professional and respectful manner and responded promptly to any requests made for assistance or time.
- All staff we spoke with had a very in-depth knowledge about the patients including their likes, dislikes and preferences. They were able to describe these to us confidently, for example, preferred routines for patients and anxiety triggers.
- We received many commendations by patients about individual staff on Knightstone ward. Comments about them included them being caring, perceptive, kind, warm and supportive.

Involvement in care

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- Staff spoke confidently and passionately about their approach to patients and the model of care practiced across Knightstone ward. They spoke about enabling patients to be as independent as possible to work towards living in less restrictive and non-clinical environments, generally in the community. Staff told us they assisted the patients to look out for and overcome obstacles, turning challenges into opportunities and inspiring the patients to be self-resourceful in dealing with their negative thoughts and behaviours.

Staff were non-judgemental towards their patients and empowered them consistently to encourage their involvement. Staff we spoke to were optimistic and hopeful about the patients and their achievements, no matter how small. No staff were anything other than positive about caring for the patients, despite often extremely challenging circumstances.

- There was evidence of patient involvement in the care records we looked at and all patients had a copy of their care plans. Staffs' approach was person-centred, highly individualised and recovery orientated. We also saw that all patients reviewed their care plan at least once every two weeks with the multidisciplinary care team and at least once each month with a member of the ward nursing team. Patients prepared well for care reviews with the help of staff and were present throughout all discussions.
- Patients we spoke with told us that they were involved in the care planning process and that the plans were recovery focused. We saw many examples of staff applying this individualised approach to patients.
- Patients received a comprehensive handbook on admission to the ward and this was also available electronically. The handbook welcomed patients and gave detailed information. This included information about health needs, the multidisciplinary team, care and treatment options, therapy available, medication and physical health needs, arrangements for health records, the my shared pathway approach and care plans. Patients told us the handbook helped to orientate patients to the service and patients we spoke to had received a copy and commented on it positively.
- There were initiatives to introduce the "peoples council" which promoted co production of service delivery with

the patients, giving them more chance to input the running of the ward, for example attending new staff interviews. Two patients had applied to join the peoples council from Knightstone ward.

- Local advocacy services were advertised widely. A visiting mental health advocate was available twice each week. Patients told us that they had accessed the advocate.
- Staff discussed patients' views and wishes with them. During our inspection we saw this happen in all the multidisciplinary care review meetings we attended. Patients told us that they were actively involved in finding solutions to their problems and that this included how to manage a crisis. Patients told us that staff listened to and acted on their suggestions which showed them that the staff genuinely wanted to collaborate with them.
- Patients could get involved in their care through a number of initiatives. Patients told us that they had advance warning of any meeting held to review their care. They said that staff spent time with them to assist them in preparing for meetings. Patient told us about their involvement in care planning.
- Relatives and carers were invited to care review meetings, with patients' consent.
- All patients were invited to contribute to the Knightstone ward annual review. There was no data available from the most recent annual review as it had just been collected.

Are personality disorder services responsive to people's needs?
(for example, to feedback?)

Good 

We rated responsive as good because:

Access and discharge

- Knightstone ward took referrals from anywhere in the country and did not have a catchment area. The average occupancy over between April 2018 and September 2018 was seventy seven percent. The average length of stay for patients on Knightstone was 500 days. As a

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specialist service, a number of patients were admitted from outside of their home areas. No patients were moved to other wards in the hospital unless clinically indicated.

- There were no delayed discharges reported from Knightstone ward during the previous six months. Staff planned for patients' discharge, including good liaison with care managers/co-ordinators, commissioners and community mental health teams. Care and treatment records showed that discharge planning was discussed at the ward round and individual care programme approach reviews. However, there was no clear discharge plan in the patients' records and discharge discussions were brief and not in detail.
- There was a clear process in place to admit and discharge patients from ward. A referral criterion was used to assess patients both from other wards and external services who may be suitable for the next stage of their care pathway to recovery. This enabled the ward to assess if they could meet a patients needs.
- Patients were able to move from Knightstone ward to the Lodge, an onsite step-down ward for patients who had completed the therapy programme on Knightstone ward and were preparing for community living before discharge.
- There was always a bed available when patients returned from leave.

The facilities promote recovery, comfort, dignity and confidentiality

- Knightstone ward had a full range of rooms and equipment to support care and treatment delivery. The ward had a good standard of environment and provision with quiet spaces to use, therapy rooms and meeting rooms. The ward was light and airy and patient bedrooms were of a very good size, with large en-suite bathrooms. Most rooms had a panoramic sea view and visitor rooms were available on and off the ward and were well furnished and maintained.
- Patients were encouraged to personalise their bedrooms and the communal areas of the wards, which they had done. Patients and staff showed us around some bedrooms and we could see that they had created

a pleasant and homely environment. All patients had a key to their bedroom and could gain access at any time. Patients were all able to store their possessions securely.

- Patients had access to their own mobile phones at all times and had signed an agreed contract for safe usage, such as not using the camera facility and switching phones off during therapy and activities. In addition, patients were able to keep their laptops and other electronic devices with them at all times, again having agreed to a contract for boundaries around usage. The ward had access to a small central courtyard area. In addition and generally when the weather was good the Knightstone patients could use the larger garden facilities on another female ward on the ground floor at arranged times and for exclusive usage.
- All the patients on Knightstone ward we spoke with said that the food was good most of the time. Efforts were made to include all patients in decisions about the food on the menu and there was always at least two choices of main course. There were facilities available on the ward for patients to make cold or hot drinks or to have snacks throughout the night and day.
- Daily and weekly activities were advertised and available on an off the ward. An excellent range of activities and therapy groups were available to patients on the ward, facilitated by the activity co-ordinators, occupational therapists, clinical psychologists, alternative therapists and ward staff. Patients had access to the hospital wide therapy unit which was on site and included very well-equipped facilities including a gym, kitchen and workshops for crafts.
- The activities were varied, therapeutic, recovery focused and aimed to motivate patients. Patients were actively encouraged to make suggestions for activities they would like. Sessions were available on a wide variety of skills based learning and included educational courses, social skills training, therapy and creative groups. Patients told us that staff were responsive to patient requests for activities. The option of going out in a hospital car, with staff, into the local community was available. This was also available for those patients detained under the MHA.
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- Many educational and vocational opportunities were available for patients to access. Service users at Cygnet

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hospital had designed a prospectus of introductory courses which support recovery, this was called the recovery college. Examples of courses offered were mental health awareness, creative art skills, healthy cooking on a budget, yoga, animal care workshop and creative writing. Patients we spoke to told us that they really enjoyed attending these courses and were given certificates for completing the course.

Patients' engagement with the wider community

- When appropriate, staff ensured that patients had access to education and work opportunities. For example, the occupational therapist carried out a comprehensive assessment of each patient to find out their hobbies, interests and goals. Following the assessment, they developed a specific activity plan with the patient. For example, we saw that a patient liked cooking and a care plan was in place to support them with this.
- Patients could also access the hospital's recovery college where a variety of short courses were available. This programme was set up with patients each term. Patients we spoke to told us that they really enjoyed the recovery college and looked forward to attending the sessions.
- The occupational therapist provided a programme of activities, which met the individual needs of each patient. The timetable was available in written and pictorial format and changed monthly. Activities included relaxation and cooking groups.

Meeting the needs of all people who use the service

- All the wards had full disability access.
- There was up-to-date and relevant information on the ward and in communal areas which included information for visitors, contact details and information for advocacy, information on mental health problems and available treatment options, local services (for example on benefits advice) and how to raise a concern or make a complaint.
- Staff respected patients' diversity and human rights, and asked about people's cultural, language and religious needs at admission. Contact details for local faith representatives were available. A dedicated multi-faith area was available.

- Interpreters were available and used when required. Leaflets were available explaining patients' rights under the Mental Health Act.
- A choice of meals was available which enabled patients with dietary needs connected to their religion or culture, and others with individual needs or preferences, to eat appropriate meals.

Listening to and learning from concerns and complaints

- There were 17 complaints from patients on Knightstone ward between February 2018 and September 2018. The provider fully upheld four of these and partially upheld five complaints, which showed us that the provider was fair and transparent when dealing with complaints. Records showed that the provider followed duty of candour. Some of the themes around the complaints were staff attitudes, medication issues, therapeutic interventions and cancelling visits due to weather. We looked at four complaints from Knightstone ward and saw that the provider had investigated thoroughly and completed them quickly and responded with letters explaining the outcome.
- Copies of the complaints process were on display in Knightstone ward and in the ward information handbooks. Patients we spoke with all knew how to make a complaint through the hospital complaints procedure should they wish to do so.
- Staff confidently described the complaints process and how they would handle any complaints. Staff told us that they try to deal informally with concerns and to do this promptly to provide a timely resolution to concerns. Informal complaints were tracked as well as formal complaints.
- Knightstone ward held a daily community meeting where patients were encouraged to discuss any issues which were causing them concerns on the ward. We looked at the minutes from these meetings and saw that a wide variety of topics were raised. These included practical issues to do with the general organisation of the ward as well as relationships between patients and between staff and patients.
- Staff met regularly to discuss learning from complaints. This informed a programme of improvements and

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training, for example upholding privacy and dignity, maximising patient choice and briefing sessions for staff on dealing with complaints and the importance of duty of candour.

Are personality disorder services well-led?

Good 

We rated well-led as good because:

Leadership

- Knightstone ward was well-led. There was evidence of clear leadership at a local level. The ward manager and clinical team lead were visible on the ward during the day-to-day provision of care and treatment, they were accessible to staff and they were proactive in providing support. The culture on the ward was open and encouraged staff to bring forward ideas for improving care.
- At the time of our inspection there were performance management procedures being pursued within the ward, the provider was able to show evidence of this.
- During the Sit Rep meetings performance issues would be identified and resolved with the need to pursue a more formal process. An example of this was that ward manager could identify staff issues and discuss possible ideas to resolve any staffing performance issues.
- Staff were provided with opportunities for development within their roles. This included specialist training, lead roles and the support to complete a registered nurse conversion course.

Vision and strategy

- The provider's vision, values and strategies for the service which had recently been updated were evident and on display throughout the ward. Staff on the ward understood the vision and direction of the service and wider organisation. Staff at every level felt very a part of the service and were able to discuss the philosophy of the unit confidently. Staff told us that the purpose of Knightstone ward was to offer patients a safe environment and structured therapy programme to enable them to understand and moderate their

thoughts, feelings and behaviours to be able to live independent and fulfilling lives. Patients would be able to develop a meaningful and quality future outside of a hospital setting, living in the community.

- The ward manager had daily contact with the hospital manager and senior clinical team in the morning Sit Rep meeting. The senior management and clinical team were highly visible and staff said that they regularly visited the wards.
- Staff commented on the high quality support they received from ancillary services such as housekeeping, catering, human resources, maintenance and general administration.

Culture

- The staff we spoke with were positive about working on the ward. They told us they felt able to raise concerns, report incidents and make suggestions for improvements. They were confident their line manager would listen and act on them. Staff were able to describe the whistleblowing process and the whistleblowing policy.
- The ward manager explained the process for managing poor staff performance. This included obtaining support and advice from the service manager and the provider's human resources department.
- Staff morale was good and the staff we spoke with had a clear commitment to their roles.
- Staff appraisals included career development and how it could be supported. Staff received an appraisal in the last year.
- Managers within the service promoted an open and honest culture. All staff had received training on their responsibilities under the duty of candour and additional information was available on the intranet.
- All the ward staff we spoke with, without exception, were enthusiastic and engaged with developments on the wards. They told us they felt able to report incidents, raise concerns and make suggestions for improvements. They were confident they would be listened to by their line managers.
- Sickness and absence rates were low at 4%.
- Staff were aware of the whistleblowing process if they needed to use it.
- There were no allegations of bullying or harassment.

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Governance

- Effective systems and processes were in place to ensure the safe and effective running of the ward. There were clear responsibilities, roles, processes and systems of accountability.
- The provider had a clear governance framework at ward level, which local managers oversaw and fed into the providers overarching governance structure and assurance framework.
- Staff carried out checks to ensure the ward was clean, well-maintained and safe for patients. Incidents were reported, investigated, monitored and any learning shared. The manager ensured staffing levels were appropriate to meet the needs of patients.
- Overall, staff were trained and supported to carry out their roles and provided with opportunities for professional development. The multi-disciplinary team worked in collaboration with patients, carers and external stakeholders to provide effective, holistic, care planning, risk management and discharge planning. Staff ensured that legal requirements were met in relation to the Mental Health Act and the Mental Capacity Act.
- The ward manager was clear about the process for highlighting any significant risks. The hospital manager included these on the hospital risk register as there was no ward risk register.
- We saw the system for undertaking clinical audits, reporting on management data including training, absences, supervision and appraisal rates, data on incidents and complaints. This information was summarised and presented monthly in a key performance indicator dashboard. Examples of audits carried out included, patient engagement, physical health checks, and standard of care plans.
- The ward was reliant on the continued use of locum agency staff. The provider had ongoing recruitment campaigns to bring in more staff. All locum staff were familiar with the ward, having worked there before. All locum staff had the same induction and training as permanent and wore the same uniform.

- Regular team meetings were held allowing staff discuss concerns, participate in educational or clinical supervision, debrief following incidents and to learn from the issues.

Management of risk, issues and performance

- There were systems to assess, monitor and manage risks to patient safety. Staff told us they could escalate concerns through their manager when this was necessary. The hospital risk register was reviewed at the monthly hospital governance meeting attended by the senior management team.
- The hospital had protocols in place for major incidents and business continuity in the event of emergencies.
- Staff did not raise any examples of financial pressures compromising patient care.

Information management

- Staff used the systems in place to collect data from the ward and had access to the equipment and information technology needed to do their work. Information governance systems included confidentiality of patient records.
- The manager had access to information to support them with their management role. This included information on the performance of the ward, staffing and patient care.
- Staff made notifications to external bodies as needed. The provider made notifications to external bodies in line with legislation.

Engagement

- Patients and carers had opportunities to give feedback on the service they received through community meetings and feedback questionnaires. Managers and staff had access to this feedback which they shared at team meetings in order make any changes.
- Senior managers of the hospital engaged with external stakeholders, such as commissioners and the local safeguarding teams

Learning, continuous improvement and innovation

- During our visit we were not told of or given any evidence to show that Knightstone ward had initiated any quality improvement ideas.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider **SHOULD** take to improve

- The provider should ensure that staff complete patients' care records which include thorough physical health assessments and action from Modified Early Warning Score forms and these should be kept in accessible format.
- The provider should ensure that every patients has a formal discharge care plan.
- The provider should ensure that they provide facilities for the safe disposal of out of date or surplus medication.