Cygnet Health Care Limited

Cygnet Hospital Beckton

Inspection report

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

Ratings

Overall rating for this location	Good
Are services safe?	Good
Are services responsive to people's needs?	Good

Summary of findings

Overall summary

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

We rated both services that were open at the time of the inspection as good overall. Our overall rating for wards for people with learning disabilities or autism improved from requires improvement to good, as we now rated it good for all five key questions. We rated wards for people with a personality disorder as good overall, although it remained requires improvement for the safe question. The hospital's acute ward for adult of a working age, which we rated inadequate when we previously inspected it in May 2021, was not open at the time of this inspection. We will inspect this ward again when it reopens.

The hospital had made progress in addressing the concerns identified at previous inspections. This included achieving a reduction in the use of restraint and a reduction in safeguarding incidents. The service was recruiting new staff. The hospital had increased training in managing violence and aggression, training in ward specific skills and training in leadership for ward managers.

Managers and staff had a good understanding of the risks and pressures on the wards. Each ward held a multi-disciplinary team meeting each morning to review any concerns or incidents that had arisen on the previous shifts. These concerns were escalated to the daily meeting for senior staff.

Wards were clean and well-maintained.

On Hansa Ward, staff provided safe, person-centred care. Staff were aware of patients' needs and could easily access information providing instructions on how to engage positively with each patient. The ward employed a specialist speech and language therapist to improve communication with patients.

However,

Over the last year there were times when the staffing on the wards fell significantly below the minimum required for safe nursing. On New Dawn and Upping Wards, a high number of staff vacancies, high turnover of staff and high use of agency staff had led to unfilled shifts, inconsistencies in care and an increased risk of harm to patients.

Incidents of self-harm continued to occur when patients were on one-to-one observations. The service recognised there needed to be better communication and engagement with patients when staff were assigned to close observations.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Personality disorder services	Good	Staffing on the personality disorder wards fell below the minimum required for safe nursing. The wards vacancy rate for registered nurses was 40% on New Dawn and 31% on Upping. Since August 2021, there had been 37 staff shifts short by more than one member of staff, placing patients and staff at risk. The provider was recruiting more staff, but further progress was required. The service used agency staff to cover many shifts, which meant there was less consistency in the staff caring for patients. In the three months prior to the inspection, there had been 11 incidents in which patients were involved in self-harm while on one-to-one continuous observations. Whilst the service had taken steps to improve the quality of observations, including improvements to the accuracy of records, the service recognised there needed to be better communication between staff and more engagement with patients during these observations. However: Staff minimised the use of restrictive practices, managed medicines safely and followed good practice with respect to safeguarding. Staff completed risk assessments for each patient on admission using a recognised tool, and reviewed this regularly, including after any incident. Staff had completed and kept up-to-date with their mandatory training. Ward areas were clean, well maintained, well-furnished and fit for purpose.
Wards for people with learning disabilities or autism	Good	The service provided safe care. The ward environments were safe and clean. The wards had enough nurses and doctors. Staff assessed and managed risk well, managed medicines safely, followed good practice with respect to safeguarding and minimised the use of restrictive practices. Staff had the skills required to develop and implement good positive behaviour support plans to enable them to work with patients who displayed behaviour that staff found challenging.

Summary of findings

Staff planned and managed discharge well and liaised with services that would provide aftercare. As a result, discharge was rarely delayed for other than a clinical reason.

Summary of findings

Contents

Summary of this inspection

Background to Cygnet Hospital Beckton

We undertook this unannounced, focused inspection of Cygnet Hospital Beckton to follow up on changes made as a result of our inspections in March and May 2021. We inspected the domains of safe and responsive on wards for people with learning disabilities and autism. We inspected the domain of safe within services for people with personality disorders.

The inspection in March 2021 was of the learning disability ward and psychiatric intensive care unit. We found instances of unjustified restraint, use of unauthorised restraint techniques and the physical abuse of a patient. We served a section 31 notice which placed a number of conditions on the providers registration, including that the hospital could not admit any more patients until further notice. The Chief Inspector of Hospitals also put the hospital into special measures. In October 2021, CQC granted permission to admit further patients to the hospital. This permission was withdrawn in December 2021, following concerns and whistleblowing reports about staffing on the wards.

The psychiatric intensive care unit was closed for building work during the inspection in May 2021. It was closed again during this inspection. However, the ward had been open between October and December 2021. The psychiatric intensive care service continues to be rated as inadequate overall, and inadequate in the domains of safe, caring and well-led, based on our inspection in March 2021. We will inspect this ward again when it reopens.

At this inspection, we inspected the following wards:

Hansa Ward provided care and treatment for up to 13 women with a learning disability or autism and mental health problems. However, the CQC had limited the maximum number of patients to eight. There were eight women on the ward at the time of the inspection.

New Dawn Ward provided care and treatment for up to 18 women with a personality disorder.

How we carried out this inspection

During this inspection, the inspection team:

- spoke with 15 patients
- conducted a review of the ward environments and observed staff supporting patients on the wards
- spoke with the registered manager
- spoke with the ward managers on each ward. We also spoke with the deputy manager of New Dawn Ward and the acting ward manager of Upping Ward
- spoke with 17 other staff members across the two wards including registered nurses, non-registered nurses and social therapists
- reviewed eight patients care records, and 11 medical charts and physical observation records. We reviewed the risk assessment and risk management plans for six patients on Hansa Ward
- reviewed other documents concerning the operation of the service
- attended two multi-disciplinary handover meetings and the daily safety huddle for senior staff.

The inspection team included four inspectors, two inspection managers and two specialist advisors.

Summary of this inspection

Outstanding practice

No areas of outstanding practice identified.

Areas for improvement

What the provider MUST do:

- The provider must ensure that there is safe and consistent staffing on the wards at all times. Regulation 18 (1)

What the provider SHOULD do:

- The provider should continue to take action to prevent incidents in which patients self-harm while on one-to-one continuous observations.

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Personality disorder services	Requires Improvement	Not inspected	Not inspected	Not inspected	Not inspected	Good
Wards for people with learning disabilities or autism	Good	Not inspected	Not inspected	Good	Not inspected	Good
Overall	Good	Not inspected	Not inspected	Good	Not inspected	Good

Good

Personality disorder services

Safe | Requires Improvement

Are Personality disorder services safe?

Requires Improvement

Our rating of safe stayed the same. We rated it as requires improvement.

Safe and clean care environments

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

Safety of the ward layout

Staff completed and regularly updated thorough risk assessments of all ward areas and removed or reduced any risks they identified. Staff could observe patients in all parts of the wards with convex mirrors installed to cover any blind spots. There was also CCTV available for communal areas and corridors.

Staff knew about any potential ligature anchor points and mitigated the risks to keep patients safe. They had a ligature anchor point map on each ward, with symbols indicating each area of concern, in addition to a detailed ligature risk assessment. Staff signed a record to say they had conducted a 'ligature tour' of the ward. There were also photos of ligature points (including doors and light fittings) displayed in the nursing offices. The ward gardens were listed as 'restricted' areas due to ligature risks. The doors to the gardens were generally left open for patients to use. Staff said these areas were checked regularly by security staff and staff carrying out observations on patients. Each ward had a variety of ligature cutters available for staff to use, if required.

There was adequate space to carry out physical restraint on the wards if needed, and all doors were fitted with anti-barricade hinges. The New Dawn ward manager advised that there were plans in place to change some of the furniture on the ward including replacing bedroom wardrobes with a ligature free alternative.

Wards were secure. A staff member allocated as the security person checked that all doors were locked every hour (although these checks were not recorded). They also ensured potentially risky items were kept locked away, including counting and locking away cutlery, and checking for contraband items.

Staff had easy access to alarms and patients had easy access to nurse call systems All staff carried personal alarms which they tested at the start of each shift. Patients had access to call bells in their bedrooms. Patients confirmed that staff responded to alarms when sounded, although this could be delayed at busy times or when there were staff shortages.

Patients had access to their rooms throughout the day and had personalised their bedrooms with their own duvet covers and pictures on the walls. All bedrooms had ensuite toilets and sinks. There were shower rooms and a bathroom on each ward. All patients had secure locked cabinets in their room to store possessions. They had access to hot and cold water throughout the day.

The wards were single gender (female only) complying with guidance around mixed sex accommodation. There was a lift for disabled access.

New Dawn Ward was separated into two areas. Both areas were accessible to patients and staff were deployed to both areas of the ward. Upping Ward had a de-escalation room with a viewing panel into the nursing office, and an adjoining toilet. New Dawn 2 Ward had a quiet room, which could also be used as a sensory room. Each ward had an activities room, and a multi-disciplinary team room for ward rounds and Care Programme Approach meetings.

Maintenance, cleanliness and infection control

Ward areas were clean, well maintained, well-furnished and fit for purpose. Staff made sure cleaning records were up-to-date and the premises were clean. We observed up to date cleaning schedules, including four-hourly disinfecting of high-risk areas, such as door handles.

Staff followed infection control policy, including handwashing. Each ward had an infection control lead, who led on handwashing audits. There was a hospital infection control lead who visited to check patient areas regularly.

Staff had access to sufficient personal protective equipment to minimise the risk of cross infection and to enable them to follow current national guidance in respect of COVID-19. As the wards were designated as 'Green' wards in line with the hospital's Covid-19 policy, staff tested for Covid -19 twice weekly and wore face masks at all times. Staff advised that most patients did not like to be tested. If any patient showed symptoms of Covid-19 staff asked them to isolate. Arrangements were made for patients to meet with visitors off the ward. There was a visiting room for children outside of the ward.

The hospital had an outbreak of Covid -19 between 13 December 2021 and 7 January 2022. On the second day of the inspection there was one positive case of Covid-19.. Staff took appropriate action, wearing enhanced personal protective equipment, and increasing cleaning regimes.

Nursing staff and maintenance staff identified if maintenance work required urgent completion due to risks to patients or staff. Outside of weekday working hours, a member of the maintenance team was on-call to respond to urgent maintenance requests.

Clinical waste was removed to a secure area in the car park from where it was collected by an external contractor.

Clinic room and equipment

Clinic rooms were fully equipped, with accessible resuscitation equipment and emergency drugs that staff checked regularly. New Dawn Ward had two clinic rooms, one for each ward area. Upping Ward had one clinic room. A sign on clinic room doors indicated that resuscitation equipment was stored inside. Each ward had a sealed emergency grab bag. Staff checked its contents regularly.

Staff checked, maintained, and cleaned equipment. The clinic rooms were clean and tidy. Staff checked the automated external defibrillators daily. Staff completed a clinic room audit weekly, including resuscitation equipment and emergency medicines. Records showed that equipment, such as weighing scales and the glucometer, was serviced and calibrated regularly. Cleaning records showed that equipment was cleaned regularly and labels were applied to equipment after cleaning. Clinical waste bags and sharps bins were in place and stored appropriately.

Staff carried out daily checks on the room and fridge temperature of the clinic rooms to ensure that they were within the appropriate range for safe medicines storage.

There was a couch in the clinic room on Upping Ward, but there was no space for a couch in the clinic rooms on New Dawn Ward.

Safe staffing

Over the last year there were times when the staffing on the wards fell significantly below the minimum required for safe nursing. The service had enough medical staff, who knew the patients. All staff received basic training to keep people safe from avoidable harm.

Nursing staff

The service did not always have enough nursing and support staff to keep patients safe. During this inspection we found there were a high number of shifts that had not been filled. In December 2021, CQC received whistleblowing concerns about staff shortages on the wards, and a culture of fear and blame amongst the staff team, with insufficient management support.

The service had high vacancy rates, although these were reducing by the time of the inspection. On 6 January 2022, the vacancy rate for registered nurses was 40% on New Dawn Ward and 31% on Upping Ward. The vacancy rate for non-registered nurses was 20% on both New Dawn and Upping wards. On average, during the first week of January 2022, 30% of shifts on New Dawn Ward and 18% of shifts on Upping Ward were covered by agency staff.

During the inspection staff told us that the staffing situation was improving, but there had been significant staff shortages in recent months. The emergence of the Omicron variant of Covid-19 exacerbated difficulties the service was already experiencing, as a number of staff needed to isolate. This also had an impact on the availability of bank and agency staff.

We looked at the number of staff shifts which were short by more than one staff member in the six months between 26 July 2021 to 23 January 2022. On New Dawn Ward, there was one shift short by four staff members (in August 2021), and a further eight shifts short by three staff members between 5 September to 21 November 2021. On Upping Ward there were two shifts short by four staff members (one in September and one in December 2021) and four shifts short by three staff members between 30 September and 20 December 2021. Overall, on New Dawn Ward there was more than one staff member short on five days in each of three months (August, September, and November 2021) and on six days in October 2021. Overall, on Upping Ward there was more than one staff member short on seven days in November 2021, five days in October 2021, and four days in September 2021.

The service had high turnover rates of staff particularly on New Dawn Ward. From January to December 2021 the turnover of staff on New Dawn Ward was 27.5% and on Upping Ward was 22%. Following analysis of leaver data for 2021 the provider had strengthened the hospital's recruitment approach with a focus on recruiting staff with more experience. They had also implemented retention bonuses, a new pay strategy that supported pay progression, enhanced the recruitment and induction process to ensure candidates were better prepared, and introduced a new wellness co-ordinator role to focus on staff well-being.

The service had high rates of bank and agency nurses. Patients we spoke with told us that the wards were often understaffed and that there were many different agency workers on duty who did not know their needs well. We looked

at the number of different agency staff working on each ward between July to December 2021, to have a measure of the consistency of staffing. This confirmed that there had been several months with a significant number of different agency staff members working on the wards. The service distinguished between regular agency staff who frequently worked on the ward and 'ad-hoc' agency staff who just worked one-off, or occasional shifts. In October 2021, 16 different nurses and 15 different health care assistants worked ad-hoc shifts on New Dawn Ward. In November 2021, 10 different nurses and 15 different health care assistants worked ad-hoc shifts on Upping Ward.

Managers told us that they limited their use of bank and agency staff as far as possible and requested staff familiar with the service. To address staff shortages, the provider was undertaking ongoing staff recruitment, and arranged for rotas to be prepared three months in advance. The provider was aiming for a maximum of 15% staff vacancies. Other steps taken included confirming that agency staff would be coming in for shifts on the next day. The provider reported steady progress against care and support vacancies particularly in the second half of 2021. Staff shared key information to keep patients safe when handing over their care to others. Managers made sure all bank and agency staff had a full induction and understood the service before starting their shift.

Levels of staff sickness on New Dawn Ward averaged 2.5% in 2021. It was highest in February at 6.3% and March at 4.4%. On Upping Ward staff sickness averaged 2.3% in 2021, at 5% in October 2021, and 4.6% in September 2021.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants for each shift. However, despite their best efforts there were times when they were unable to get sufficient cover for each shift. Ward managers could adjust staffing levels according to the needs of patients and overbooked some shifts to ensure safe staffing levels in the event of staff sickness.

Patients rarely had their escorted leave or activities cancelled, even when the service was short staffed. Staff told us that the service generally had enough staff on each shift to carry out any physical interventions safely, but there could be a lot of pressure on staff when they were short by three or four staff members on any shift. An extra staff member was booked for all patients requiring one-to-one observations.

New Dawn ward had recruited to an additional post of a deputy ward manager who was not included in the day to day staffing of the ward. The ward manager indicated that there were plans to separate the two parts of the ward, into separately staffed units, to improve the care for patients. New Dawn Ward also had a dedicated clinical practice lead who supported new staff through induction, and training to develop high quality nursing practice on the ward. Upping Ward also had access to support from a practice development nurse.

At the time of the inspection, one ward at the hospital was temporarily closed. Staff from that ward had been reallocated to the wards for patients with personality disorders. Patients expressed concerns about some of the substantive staff helping on the personality disorders wards while Hooper Ward was closed, being due to return to their roles. They were concerned about the impact this would have on staffing numbers, and consistency of staffing on New Dawn and Upping wards. They were particularly concerned about the lack of substantive staff on night shifts. They also indicated that there had been times when there were no staff on New Dawn 2 Ward, due to an incident occurring on New Dawn 1 Ward, and they had raised this issue with the ward manager. The ward manager advised that the plan to have the two parts of the ward staffed separately should ensure that issues of this nature did not occur in future.

Medical staff

The service had enough daytime and night-time medical cover and a doctor available to go to the ward quickly in an emergency. Managers could call locums when they needed additional medical cover and made sure locum staff had a full induction and understood the service before starting their shift.

Each ward had its own ward doctor working five days a week, in addition to part-time consultant psychiatrists. Outside of weekday working hours, an on-call doctor was available.

Mandatory training

Staff had completed and kept up-to-date with their mandatory training. The mandatory training programme was comprehensive and met the needs of patients and staff.

Managers monitored mandatory training and alerted staff when they needed to update their training. The provider aimed for 95% compliance with mandatory training.

At the time of the inspection overall compliance with mandatory training was 86% on both New Dawn and Upping wards. Ward managers indicated that gaps were largely due to a high number of recent recruits who had not yet completed their induction training.

Training in basic life support was at 91% on New Dawn Ward and 95% on Upping Ward. Training in immediate life support was 92% on New Dawn Ward and 100% on Upping Ward.

Staff training in infection prevention and control was 82% on New Dawn Ward and 95% on Upping Ward. Physical health training was 92% on New Dawn Ward and 100% on Upping Ward. Prevention and management of violence and aggression (PMVA) training was 86% on New Dawn Ward and 100% on Upping Ward. Only staff who had undertaken this training were able to participate in the physical restraint of patients.

Training in personality disorders awareness was 53% on New Dawn Ward and 67% on Upping Ward. Training was 80% in dialectical behaviour therapy on New Dawn Ward, and 78% on Upping Ward. Staff also had training in relevant areas to support the individual needs of patients on the ward, including epilepsy, diabetes, and self-harm.

All new staff completed a detailed induction for what they need to be aware of on the wards. There was a bank staff induction checklist which all new staff needed to complete. This included information on alarms, observing patients and ligature risks, and the location of ligature cutters. The provider had introduced new staff induction training over five weeks including a week of basic induction, a week of PMVA training, a week of online training, and two weeks of shadowing.

Assessing and managing risk to patients and staff

Staff assessed risks to patients and themselves. Staff had systems to anticipate, de-escalate and manage challenging or high-risk behaviour. However, the use of these systems, such as one to one observations, was not always sufficient to keep patients safe. Staff used restraint only after attempts at de-escalation had failed.

Assessment of patient risk

Staff completed risk assessments for each patient on admission using a recognised tool, and reviewed this regularly, including after any incident.

We reviewed eight patient records across the two wards. All of the patients had a risk assessment when admitted to the hospital. A range of potential risks were assessed and recorded. Patients' risk assessments were updated following incidents. Patients consistently had a daily risk assessment review and staff identified and recorded any changes in patient risks.

Staff told us that if there were any new risks to patients, they reviewed risk assessments and increased observation levels if needed. They also informed the ward managers, and kept the patient informed of the change to their care plan. For example, following incidents when patients self-harmed using pens on the ward, staff reviewed the practice of having observation charts and pens in patient's room whilst on continuous observations. There was a daily multi-disciplinary staff team handover meeting during which observation levels were reviewed for all patients.

Staff noted that there had been several new admissions on Upping Ward in October and November 2021 during which time there was an increase in incidents. The ward manager took steps to place a hold on new admissions until the ward had stabilised, to ensure that each new patient's risks could be assessed and addressed fully.

Patients on New Dawn and Upping wards frequently presented a risk of impulsive, high risk and self-harming behaviours. The hospital had a referrals team for patients with emotionally unstable personality disorders. The multi-disciplinary team assessed all new referrals to ensure that they were suitable for admission at any particular time. Staff said that if a patient could not be supported appropriately on the ward, they would decline the referral or request further information. All new referrals had virtual or face to face assessments.

When new patients arrived on the wards they were introduced to their primary nurse who completed an initial assessment, and went through the ward policies, explaining their rights and any ward restrictions including the use of CCTV cameras in communal areas. All patient saw a doctor within 72 hours of admission.

Management of patient risk

Staff knew about any risks to each patient and acted to prevent or reduce risks. Staff were able to tell us about specific patients' needs and risks and how they reduced the risks to particular patients as far as possible. They identified and attempted to respond to any changes in risks to, or posed by, patients. We reviewed eight risk management plans across the two wards, and found that these were reviewed regularly, although some of these appeared to include generic strategies for managing risk rather than an individualised care plan.

Staff could observe patients in all communal areas of the wards and followed procedures to minimise risks where they could not easily observe patients in private areas.

Staff followed the organisation's policies and procedures when they needed to search patients or their bedrooms to keep them safe from harm. Staff said there had been some instances of patients attempting to bring alcohol onto a ward and many incidents of patients attempted to bring in items with which they could self-harm.

At the previous inspection of the personality disorder wards in June 2021, we found that staff on New Dawn Ward did not always undertake intermittent observations of patients in line with the provider's observation and engagement policy and record these observations accurately. Patients had told us that they could predict the times when staff would observe them, which made it easier for them to self-harm. At this inspection we found an improvement in this practice,

with all staff (including bank and agency staff) completing competency checks prior to undertaking observations on the wards. We sampled current records of intermittent observations for patients on both wards and found that they were being undertaken at irregular intervals as outlined in the provider's policy. Over 95% of staff had completed competency checks in undertaking observations. Ward managers indicated that they were also looking at staff performance on observations. Assessments for carrying out formal engagement/observations included reviewing the provider policy and answering a range of questions. For example, what to do if you thought a patient needed a different level of observation, and what to do if the emergency alarm went off whilst on one to one observations. The answers to the questions were read by the ward managers who then met with staff to discuss if the competency was a pass or fail. This was mandatory for all staff. Staff told us that they had learned that observations were not passive, and that they needed to engage with patients, and distract them from traumatic experiences. They were clear about when they needed to escalate potentially harmful behaviours to other members of the staff team. However, some patients on the wards presented a high risk of impulsive and unpredictable self-harm. Between October 2021 and January 2021, there were 11 instances of patients harming themselves whilst on one-to-one observations.

Each ward had an allocated security nurse for each shift, who was not involved in enhanced observations. Their duties included hourly checking of the ward environment including locked doors.

Staff used 'Safe Wards' methodology to support patients in as least restrictive an environment as possible. This included creating an enabling environment, with occupational therapy and psychology groups available to patients. Each patient had their own sensory box to use when in distress. Staff told us that some patients found it helpful to use 'toxic sweets' with a very strong taste to distract them from their distress.

Staff used head injury checklists to check on any damage after some patients used head banging, when in distress. Patients told us that most substantive staff were very good at picking up when they were withdrawn or upset. They indicated that following a chaotic period in the autumn, they now received more consistent support. They said that the impact of insufficient staff on shifts had a big impact on them, and whether they felt safe, particularly at night. Staff also indicated that there had been improvements in the management of the wards since staffing levels had been more consistent. They noted that there were areas for improvement in communication between staff on the ward.

All patients had a risk assessment before they had leave from the hospital and following their return from leave. Whilst staff tried to limit blanket restrictions across the wards, some practices remained due to the risks posed to patients. For example, plastic bags were not allowed on the wards and certain items were 'restricted' and only to be used with staff supervision. The hospital had a no smoking policy. Patients could access smoking cessation support and nicotine replacement treatment. Patients could also use vapes on the wards.

Staff participated in simulated emergencies undertaken on each ward each month, such as a patient overdose or use of ligature. These unannounced simulations had a facilitator who produced a report including any areas for improvement and actions to be taken.

Use of restrictive interventions

Levels of restrictive interventions were reducing in the last three months after a peak in September 2021. Staff participated in the provider's restrictive interventions reduction programme including implementing Safe Wards methodology on each ward.

Staff told us that they made every attempt to avoid using restraint by using de-escalation techniques and restrained patients only when these failed and when necessary to keep the patient or others safe. Most patients said that staff

attempted to de-escalate situations before using any physical restraint. Ward managers reviewed the CCTV of restraint incidents to ensure that they were conducted safely using the minimum physical intervention necessary. They also conducted weekly reviews of other wards, looking at their observations and patient care, to help determine if they could reduce observations and the use of restraint. This ensured that learning was shared across the hospital and that patients' privacy and dignity was affected only when necessary.

Staff followed National Institute for Health and Excellence (NICE) guidance when using rapid tranquilisation. They completed physical health checks in line with provider policy after each use of rapid tranquilisation. Staff were trained in the administration of rapid tranquilisation through the deltoid muscle (in the arm) to avoid restraining patients in the prone position. However, they noted, that it was not always possible to administer rapid tranquilisation in this way if a patient was very agitated.

All staff involved in physical restraint had recently completed training in Prevention and Management of Violence and Aggression. The service monitored how long patients were restrained. The main reason for staff restraining patients was due to them self-harming.

Safeguarding

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

Staff received training on how to recognise and report abuse, appropriate for their role. Managers monitored staff training and ensured that their teams were up-to-date with their safeguarding training. Training in safeguarding adults level 3 was 100% on both New Dawn and Upping wards. All staff were also trained in when to contact the provider's Freedom to Speak Up Guardian.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. They described how they supported patients identifying as male on the wards.

Staff knew how to recognise patients at risk of or suffering harm and worked with other agencies to protect them. They knew who to inform if they had concerns and made safeguarding referrals with support from the social work lead when needed. Staff followed clear procedures to keep children visiting the hospital safe, with a family visiting room outside of the wards. Managers took part in serious case reviews and made changes communicated to all ward staff, based on the outcomes.

Each ward had a safeguarding champion and safeguarding flow charts were displayed in staff offices and areas. There were also posters reminding staff of their duty to report all instances of the abuse of patients. The hospital safeguarding lead reviewed all reports of safeguarding issues and ensured sufficient information was available to decide on actions to be taken. There was always a senior member of staff on call to refer an incident out of hours.

Staff gave examples of safeguarding referrals made including trauma disclosed in psychology sessions, concerns about relatives misusing a patient's finances, and inappropriate patient relationships on the ward. All incidents of self harm whilst a patient was on one-to-one observations were referred as safeguarding incidents. Learning from safeguarding included the need for staff to be more vigilant in communal areas, and increased vigilance on one-to-one observations.

Staff access to essential information

Good

Personality disorder services

Staff had easy access to clinical information and it was easy for them to maintain high quality clinical records – whether paper-based or electronic.

Patient notes were comprehensive and all staff could access them easily. The service used a combination of electronic and paper records, and staff made sure they were up-to-date and complete. All information needed to deliver patient care was accessible to all staff, including temporary staff. Staff recorded information on the care records system and there were no difficulties with staff entering or accessing the information they needed to deliver patient care.

Paper records were stored securely in locked areas. All electronic records were password protected.

Medicines management

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

Staff followed systems and processes to prescribe and administer medicines safely. They reviewed each patient's medicines regularly and provided advice to patients about their medicines.

Staff completed medicines records accurately and kept them up-to-date and stored and managed all medicines and prescribing documents safely. Medicines were stored safely. Medicine refrigerator and clinic room temperatures were checked and recorded to ensure medicines were stored at a temperature where they remained effective. All of the medicines we checked were within their expiry dates.

Staff followed national practice to check patients had the correct medicines when they were admitted or discharged from the wards. Medicine charts were fully completed and included patients' allergies when this applied. Patients receiving the medicine clozapine had regular blood tests. Patients had an electrocardiogram (ECG) prior to antipsychotic medicines being prescribed. This followed best practice guidance. A pharmacist also visited the wards weekly, auditing prescriptions and providing feedback and advice regarding medicines management. The pharmacist also provided training on medicines.

Staff told us that they learned from safety alerts and incidents to improve practice, for example making sure that they observed patients taking their medicines. All medicines were administered by two registered nurses.

The service ensured people's behaviour was not controlled by excessive and inappropriate use of medicines. Staff reviewed the effects of each patient's medicines on their physical health according to NICE guidance. They completed physical health observations for each patient, at a frequency determined by risk assessment and reviewed regularly. Staff were clear about when they would need to seek medical advice about patients based on their physical health observations.

Track record on safety

The service was taking action to improve patient safety on the wards.

There had been 11 incidents in the three months prior to the inspection, in which patients were involved in self-harm while they were on one-to-one continuous observations. Seven of these involved one patient. Many of these incidents involved agency staff. The ward managers advised that each incident of this kind was reported as a safeguarding alert to

the local authority. They had arranged for all staff undertaking observations to complete competencies, including agency staff. They investigated each incident, and where necessary took disciplinary action against staff involved. Learning from these incidents included a need for better communication between staff members, and the importance of engaging with patients during observations, and staff not becoming distracted by patients.

Incidents on both wards were predominantly related to patients self-harming. Patients self-harmed in a number of ways including head banging, swallowing and inserting objects, cutting and using a ligature.

Reporting incidents and learning from when things go wrong

The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

Staff knew what incidents to report and how to report them. They gave us examples of incidents they had been involved in and reported. They raised concerns and reported incidents and near misses in line with provider policy. The service had no never events on either ward.

Staff understood the duty of candour. They said that they tried to be open and transparent and gave patients and families a full explanation if and when things went wrong. For example, staff had apologised after a medicines error, and improved practice to ensure they handover information related to medication when they pass the medicines keys on to a new staff member.

Staff confirmed that managers provided them with a debrief and support after any serious incident. Staff also provided patients involved with a debrief after incidents, for example after any incidents of rapid tranquilisation.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations. We looked at incidents from the last few months on the wards and found that they had been investigated appropriately with information recorded for the outcomes and learning actions. Staff received feedback from investigation of incidents, both internal and external to the service. Staff met to discuss the feedback and look at improvements to patient care. Staff meetings held monthly included discussion of any learning from recent incidents across the hospital.

There was evidence that changes had been made as a result of feedback. Following the death of a patient following discharge, for example, staff had identified the need to improve how they supported patients to monitor for constipation which is a common side effect of some anti-psychotic medication. Staff also told us that they had learned to introduce new staff to patients on the ward and arrange for them to get to know each other before they left them to carry out one-to-one observations. This followed some incidents when staff found patients were more likely to harm when being observed by a new staff member.

Ward managers review CCTV after any incident, and at least four times a month they picked a random time period to review footage. As a result of this, they had found observations not being carried out correctly, and taken action to address this. They had changed practice to ensure that staff kept the recording sheet for observations with them and recorded the exact time they observed each patient (with a digital watch attached to the observation board). Ward managers also tried to attend morning handovers, to meet with night nurses, or stay to meet staff at night handovers.

Good

Personality disorder services

There was a staff relations group (SRG) meeting, which looked at how to support staff and to improve staff wellbeing. Staff received 'learning from incidents' bulletins with information about lessons learned from within the hospital, and other provider services. Staff also had reflective practice sessions to discuss recent incidents. For example, one patient ordered blades online, and told staff the package contained something else. Since then staff ensured that they opened all packages in front of patients and remove all staples from packages. Similarly, when food was delivered to the wards, staff needed to check the contents and remove skewers or other implements which could be used to self-harm.

Good

Wards for people with learning disabilities or autism

Safe	Good
Responsive	Good

Are Wards for people with learning disabilities or autism safe?

Good

Our rating of safe went up. We rated it as good.

Safe and clean care environments

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

Safety of the ward layout

Staff completed and regularly updated thorough risk assessments of all ward areas and removed or reduced any risks they identified. Ward staff completed an assessment of the ward environment each day. The service manager completed an assessment of the ward each month. A report of this assessment was circulated to staff and reviewed through the clinical governance process.

Staff could observe patients in all parts of the ward. The ward was set out along two corridors. The nurses' office was situated at the corner of the corridors allowing good visibility in both directions. The service had installed closed-circuit television throughout the communal areas of the ward. Images from the CCTV were displayed on a large screen in the nurses' office, enabling good visibility of all areas.

The ward complied with guidance and there was no mixed sex accommodation. The ward only admitted female patients.

Staff knew about any potential ligature anchor points and mitigated the risks to keep patients safe. The ward manager completed a comprehensive ligature audit with the maintenance manager. A senior nurse provided all new staff with a tour of the ward to highlight any potential ligature risks.

Staff had easy access to alarms and patients had easy access to nurse call systems. The service provided personal alarms to all staff. There were call buttons in all patients' bedrooms.

Maintenance, cleanliness and infection control

Ward areas were clean, well maintained, well furnished and fit for purpose. Although the nature of the building inevitably meant that the ward felt institutional, the environment was clean and bright. The ward provided good quality furniture.

Staff made sure cleaning records were up-to-date and the premises were clean. Cleaning staff were working on the ward throughout the inspection.

Staff followed infection control policy, including handwashing. The physical health lead nurse for the hospital completed infection control audits. The results of these audits were reported to the clinical governance meeting. Urgent infection control matters were reported to the daily meeting of senior staff. The most recent audit found the ward to be compliant with the required standards. Staff said that the hospital arrangements for infection, prevention and control during the Covid pandemic had been good and enabled them to feel safe at work.

Clinic room and equipment

Clinic rooms were fully equipped, with accessible resuscitation equipment and emergency drugs that staff checked regularly.

Staff checked, maintained, and cleaned equipment. Staff completed an audit of the clinic room each week. This included a check of resuscitation equipment and emergency medicine. All clinical equipment was kept clean.

Safe staffing

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

Nursing staff

The service had enough nursing and support staff to keep patients safe. The ward assigned two registered nurses and three health care assistants to each shift. If a patient required enhanced one-to-one observations, an additional health care assistant was assigned to the ward. Additional staff were also allocated to the ward to facilitate planned leave for patients. Patients said that the number of staff meant they felt safe on the ward.

The ward had low vacancy rates. The ward had no vacancies for registered nurses. The ward also employed sufficient numbers of health care assistants to cover its core establishment, although further recruitment was taking place for additional health care assistants to cover enhanced observations.

The service had low and reducing rates of bank and agency staff usage. During October 2021, the ward used agency staff to cover 19% of total staff hours. This fell to 14% in November 2021. The ward did not use any agency staff in December 2021. In the first week of January 2022, agency staff had covered 7% of total staff hours.

Managers limited their use of bank and agency staff and requested staff familiar with the service. The service used one registered nurse employed by an agency on a regular basis. The ward manager sought to anticipate when agency staff would be required. This meant they could book agency staff familiar with the ward in advance.

Managers made sure all bank and agency staff had a full induction and understood the service before starting their shift. Staff could only work on the ward if they had attended the nursing handover to discuss any risks, plans for the shift and patients' current presentations. If a member of staff arrived late, they would receive an individual handover from the nurse in charge. All new staff completed a tour of the ward with a senior nurse to ensure they were aware of any risks. Whenever possible, the speech and language therapist spent time with all staff who were new to the ward to ensure they were familiar with patients' needs and preferences for communication.

The service had high turnover rates. During 2021, 13 permanent staff had left the ward. Twenty-two new staff had started work on the ward. This amounted to an overall turnover rate of 25.7%. This data does not include the turnover of temporary staff. Some staff were concerned that high turnover rates led to constant changes on the ward and a lack of stability.

Managers supported staff who needed time off for ill health. For example, managers maintained contact with staff who were off sick to provide support. When staff were injured during incidents at work, managers provided assurance that they could take time off if they needed to.

Levels of sickness were low. During 2021, the average level of sickness each month was 1.3%.

Patients had regular one-to-one sessions with their named nurse. The completion of nurses' one-to-one sessions with patients was audited and reported as part of the ward's clinical governance process.

Patients rarely had their escorted leave or activities cancelled, even when the service was short staffed. The ward planned leave and activities in advance. Additional staff were assigned to the ward to facilitate these activities.

The service had enough staff on each shift to carry out any physical interventions safely. Nurses and health care assistants said there were always enough staff on the ward to support patients. Records of incidents showed that sufficient numbers of staff attended incidents to carry out restraint safely.

Staff shared key information to keep patients safe when handing over their care to others. Staff held a nursing handover at the start of each shift and a multidisciplinary team handover each weekday. Staff said the nursing handover formed a crucial part of the ward routines. They said staff discussed all patients thoroughly, especially if the patient had been unsettled.

Medical staff

The service had enough daytime and night-time medical cover and a doctor available to go to the ward quickly in an emergency. The ward employed a consultant psychiatrist and a ward doctor. Medical cover outside office hours was provided through an on-call duty rota. Duty doctors were not based on site but could usually attend the hospital within half an hour. A GP regularly visited the hospital. If patients needed urgent attention for physical illnesses, the staff took them to the emergency department at the nearby hospital.

Mandatory training

Staff had completed and kept up-to-date with their mandatory training. Overall compliance with mandatory training for permanent staff on Hansa Ward was 94%. The ward provided 26 training courses that some or all of the staff were required to complete. The ward had achieved a compliance rate of over 85% for 23 of these courses and a compliance rate above 75% for all courses.

The mandatory training programme was comprehensive and met the needs of patients and staff. The ward provided an extensive programme of 84 training courses, most of which were completed by staff online. The programme included courses on patient safety, security and the prevention and management of violence and aggression. All permanent staff had completed training on supporting people with learning disabilities or autism, communication skills and positive behaviour support plans.

Managers monitored mandatory training and alerted staff when they needed to update their training. Managers kept up to date records of the training that staff had completed. When the record showed that staff compliance with training was below 100%, manager usually noted the forthcoming dates on which training would be completed by the remaining staff.

Good

Wards for people with learning disabilities or autism

Assessing and managing risk to patients and staff

Staff assessed and managed risks to patients and themselves well. They achieved the right balance between maintaining safety and providing the least restrictive environment possible to support patients' recovery. Staff had the skills to develop and implement good positive behaviour support plans and followed best practice in anticipating, de-escalating and managing challenging behaviour. As a result, they used restraint and seclusion only after attempts at de-escalation had failed. The ward staff participated in the provider's restrictive interventions reduction programme.

Assessment of patient risk

Staff completed risk assessments for each patient on admission, using a recognised tool, and reviewed this regularly, including after any incident. The ward admitted patients experiencing mild or moderate learning disabilities along with some form of mental illness such as emotionally unstable personality disorder or schizo-affective disorder. Patients typically presented risks of self-harm and at times, risks to others. Some patients presented unpredictable behaviour when they were distressed. During the inspection we reviewed the risk assessments and risk management plans for all seven patients. Staff completed a risk assessment of all patients within 48 hours of admission. Risk assessments were routinely updated during a multi-disciplinary ward round once a month. The multi-disciplinary team also updated risk assessments at their daily handover meeting if the patient had been involved in an incident.

Staff used a recognised risk assessment tool. Staff completed a standard risk assessment form on the electronic patient record.

Management of patient risk

Staff knew about any risks to each patient and acted to prevent or reduce risks. All staff had access to a folder that contained patients' risk assessments, personal behaviour support plans and care plans. These documents were summarised into a communication 'grab sheet' that had been developed in collaboration with the speech and language therapist. The 'grab sheet' included details of the patient's diagnosis, the patient's likes and dislikes, potential triggers to distress and instructions of how to respond to distress. Staff also produced a version of the risk assessment set out in the form of 'traffic lights', setting out triggers, behaviours and responses for patients based on whether their level of agitation or distress was at a red (high), amber (medium) or green (low) level. Staff said they found these plans useful and they helped them to maintain patients at a 'green' level, as well as de-escalating patients from the higher levels. Plans had been created collaboratively with patients and included patients' preferences about how they would like staff to respond when they became distressed or agitated. The manager actively encouraged staff to ensure they read patients' risk assessments and care plans. The manager scheduled time into each shift for staff to do this. During our interviews with staff, they all showed an understanding of patients and demonstrated a good awareness of their needs. For example, staff were aware that one of the patients did not like to be asked direct questions when they were agitated. Staff assessed and managed risks to patients' physical health by monitoring patients' pulse, blood pressure, temperature and oxygen saturation. Staff recorded these observations on charts that clearly indicated when the results should be escalated to a doctor.

Staff identified and responded to any changes in risks to, or posed by, patients. All staff attended a handover meeting at the start of each shift. The handover meeting included a discussion about each patient's presentation and risks. The multidisciplinary team reviewed each patient at their daily handover meeting.

Staff could observe patients in all areas. The service had installed CCTV in all communal areas of the ward. Images from CCTV were displayed in the nurses' office. This enabled staff to view all areas. When patients presented a heightened level of risk, staff were assigned to one-to-one observations of the patient, either within eyesight or at arms-length. When patients required enhanced observations, staff provided this in the least restrictive manner. For example, staff limited enhanced observations of some patients to the times of the day when the patient presented the most risk.

Staff followed the service's policies and procedures when they needed to search patients or their bedrooms to keep them safe from harm although this was rarely required. At the time of the inspection, staff escorted patients on leave. This minimised the possibility of patients bringing contraband items onto the ward. However, in January 2022, a security breach by a member of staff led to a patient self-harming with an empty drink can. In this instance, staff searched the patient's bedroom for any other items that could be used to self-harm. The hospital carried out appropriate action to address the security breach.

Use of restrictive interventions

Levels of restrictive interventions were low. Between June 2021 and January 2022, there were 45 incidents of restraint. Thirty-five of these incidents were in response to violence or aggression. Nine incidents related to self-harm and one incident was classified as a security incident. When situations arose, staff used light-touch restraints. Most restraints were either precautionary or for de-escalation, involving forearm holds whilst the patient was standing or seated. The ward had not used prone restraint during this period. The service had not used rapid tranquilisation since before the last inspection in May 2021. The ward did not place patients in seclusion or long-term segregation.

Staff participated in the provider's restrictive interventions reduction programme, which met best practice standards. The ward completed a least restrictive practice audit each month. The ward had appointed a member of staff as the least restrictive practice champion and a patient as the least restrictive practice representative. They were involved in reviewing restrictive interventions. The audit of least restrictive practice was discussed in monthly clinical governance meetings and community meetings.

Staff made every attempt to avoid using restraint by using de-escalation techniques and restrained patients only when these failed and when necessary to keep the patient or others safe. All staff received training in the prevention and management of violence and aggression. This model takes a pro-active, person centred approach to the management of conflict, emphasising the use of physical intervention and restraint as a last resort. The reports of incidents shows that, on each occasion, staff attempted to resolve the situation using verbal de-escalation before they used restraint. When staff did use restraint, they used the least restrictive intervention, such as forearm holds.

Safeguarding

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

Staff received training on how to recognise and report abuse, appropriate for their role. All permanent staff had completed safeguarding training to level three, as well as an additional mandatory course on safeguarding individuals at risk. The ward also assigned the role of safeguarding champion to a member of staff. As part of this role, they attended monthly hospital-wide safeguarding meetings and supported the hospital's safeguarding lead in providing support and information to staff on safeguarding matters.

Good

Wards for people with learning disabilities or autism

Staff knew how to recognise adults and children at risk of or suffering harm and worked with other agencies to protect them. For example, staff recognised that a patient was vulnerable to sexual exploitation and had also made a number of allegations against staff. The ward had created a care plan to manage this, ensuring that the patient was accompanied by a male and female member of staff when on leave and always assigning a member of staff they were familiar with to support them during night shifts.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. All safeguarding concerns were escalated to the multidisciplinary team. The safeguarding lead for the hospital notified the local authority and Care Quality Commission when appropriate.

Managers took part in serious case reviews and made changes based on the outcomes. Staff from the local authority said that the hospital always responded to safeguarding concerns, shared information and attended meetings to discuss safeguarding matters.

Staff access to essential information

Staff had easy access to clinical information and it was easy for them to maintain high quality clinical records – whether paper-based or electronic.

Patient notes were comprehensive and all staff could access them easily. Although the service used a combination of electronic and paper records, staff made sure they were up-to-date and complete. Staff recorded daily progress notes for each patient on the electronic patient record. Additional documents, such as summaries of patients' risk assessments and personal behaviour support plans were stored in the nurses' office.

Records were stored securely. Staff accessed the electronic patient record using a personal user-name and password. Paper records were stored in locked filing cabinets in the nurses' office.

Medicines management

The service used systems and processes to safely prescribe, administer, record and store medicines. Staff regularly reviewed the effects of medications on each patient's mental and physical health. They knew about and worked towards achieving the aims of campaigns to stop the over-medication of people with a learning disability, autism or both.

Staff followed systems and processes to prescribe and administer medicines safely. All medicines were kept securely in the clinic room.

Staff reviewed each patient's medicines regularly and provided advice to patients and carers about their medicines. Doctors formally reviewed patients' medication at their monthly ward round. Additional reviews took place at the daily multidisciplinary team meeting if patients had been involved in incidents or if they displayed any adverse side effects. Patients prescribed Lithium, a medicine that requires regular monitoring through blood tests, had a care plan to ensure the tests were completed.

Staff completed medicines records accurately and kept them up-to-date. Nurses completed and signed medicines administration records. Any medication errors were reported and discussed in the hospital's monthly clinical governance meeting. The ward completed an audit of medication each month. In December 2021, Hansa Ward scored 100% in this audit.

Good

Wards for people with learning disabilities or autism

The service ensured people's behaviour was not controlled by excessive and inappropriate use of medicines. During the inspection we reviewed the prescription charts for three patients. One patient was receiving the maximum dose of a mood stabilizing medicine along with medicine for treatment resistant schizophrenia. Although the doses were high, the use of these medicines was consistent with the patient's diagnosis and presentation. The patient's doctor explained that their medication had reduced over the past year.

The service worked towards achieving the aims of campaigns to stop the over-medication of people with a learning disability, autism or both. The ward had assigned a nurse as a 'champion' in preventing over medication. The multidisciplinary team had plans to reduce the number of medicines that two patients were prescribed.

Staff reviewed the effects of each patient's medication on their physical health according to NICE guidance. When patients began taking a new medicine, staff took baseline physical health observations and recorded these at the front of the medicines administration record. The staff recorded patients' pulse, blood pressure, temperature and oxygen saturation and compared these to the baseline observations in order to check for any adverse side-effects of medication. Staff carried out these checks either daily or weekly depending on the needs of the patient.

Track record on safety

The service had a reasonable track record on safety. There were frequent safety incidents on the ward, such as low-level violence and aggression. Staff responded promptly to incidents in order to keep patients safe.

Reporting incidents and learning from when things go wrong

The service managed patient safety incidents well.Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

Staff knew what incidents to report and how to report them. For example, in December 2021, staff reported 17 incidents. Eight of these incidents involved violence and aggression, including five instances of actual physical violence to staff. There were seven incidents involving self-harm, one accident involving a fall from height and one security breach.

Staff raised concerns and reported incidents and near misses in line with the service's policy. Staff recorded incidents on an electronic incident record. The forms used within this record ensured that staff reported incidents in accordance with the policy. For example, when an incident involved the physical restraint of a patient, the form required staff to include details of the staff involved in the restraint and how long the restraint lasted.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong. For example, staff told us about situations when they had apologised to patients for minor medicines errors. Staff also apologised to a patient when there was a delay in identifying a fracture to their hand.

Managers debriefed and supported staff after any serious incident. All incident records showed there was a de-briefing session with staff after the incident. When a patient did not want to engage in a debrief immediately after an incident, staff spoke to them about the matter later when they felt more able to engage.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations. Staff completed investigations using a standard procedure. The procedure involved discussions with patients about what had happened and the outcomes they were seeking from the investigation. Investigations were thorough. They routinely involved interviews with staff, interviews with patients and reviews of CCTV footage.

Good

Wards for people with learning disabilities or autism

Staff received feedback from investigations of incidents, both internal and external to the service. Staff discussed incidents at team meetings and clinical governance meetings. Staff received emails from the director of operations for Cygnet Healthcare providing details of lessons learned from incidents at other hospitals.

Are Wards for people with learning disabilities or autism responsive?

Good

Our rating of responsive went up. We rated it as good

Access and discharge

Staff planned and managed discharge well. They liaised well with services that would provide aftercare and were assertive in managing the discharge care pathway. As a result, patients did not have excessive lengths of stay and discharge was rarely delayed for other than a clinical reason.

Bed management

Managers made sure bed occupancy did not go above 85%. Overall capacity of the ward was for 13 patients. However, at the time of the inspection the CQC had imposed a restriction on the registration of the hospital, limiting the capacity of the ward to eight patients.

Managers regularly reviewed length of stay for patients to ensure they did not stay longer than they needed to. One patient had been at the hospital for almost five years, two had been there over three years, two patients had been there for around one year and one patient had been admitted three months before the inspection. Staff were working towards discharge for all the patients, except the patient most recently admitted. For example, one patient had extended overnight leave to their family home with the support of their family and mental health services in their own area. For other patients, commissioners were in the process of identifying appropriate placements. All discharge plans were developed collaboratively with patients, commissioners and each patient's family.

Managers and staff worked to make sure they did not discharge patients before they were ready. The multidisciplinary team only considered patients for discharge when the patient had achieved an appropriate level of stability.

When patients went on leave there was always a bed available when they returned. Furthermore, the ward recognised that moving to new placements was difficult for many patients. One patient had to return to the ward four days after leaving due to the new placement breaking down. The ward was able to accommodate this.

Staff did not move or discharge patients at night or very early in the morning. All discharges took place over a number of days.

Discharge and transfers of care

The service had no delayed discharges in the past year.

Staff carefully planned patients' discharge and worked with care managers and coordinators to make sure this went well. Identifying new placements often took place over many months. The service arranged for patients to visit any proposed placements to familiarise themselves with their new environment prior to their move and help commissioners ascertain whether the new placement was right for them. When patients were ready to move, staff worked with care managers to develop transition care plans setting out how best to support the patient to prepare for the move, manage

their routines during the transition and how to support them to become familiar with the new placement. Usually, staff from the new placement regularly visited the patient to get to know them. Patients were supported by an advocate who supported the patient to express both their preferences and their views on whether they felt ready to move. When patients had their own property, occupational therapists assessed whether the premises were appropriate and made recommendations for improvements if necessary.

Facilities that promote comfort, dignity and privacy

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

Staff used a full range of rooms and equipment to support treatment and care. The ward was spacious. Each patient had their own bedroom with an en-suite toilet and sink. There was a dining room, lounge, activity room, quiet room, sensory room and a de-escalation room. Patients had unrestricted access to the garden. Patients also had access to a gym within the hospital.

The service had quiet areas and a room where patients could meet with visitors in private. For example, patients could meet with visitors in the quiet room or the garden.

Patients could make phone calls in private. Patient could use their own mobile telephones or make calls in private in the nurses' office.

The service had an outside space that patients could access easily. Patients had unrestricted access to the ward's garden.

Patients could make their own hot drinks and snacks and were not dependent on staff.

The service offered a variety of good quality food. The service provided a choice of meals for patients. This included healthy food options and vegetarian meals.

Patients' engagement with the wider community

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

Staff made sure patients had access to opportunities for education and work, and supported patients to engage in these opportunities. The occupational therapist provided a programme of educational and recreational activities for patients. Short courses were offered by the hospital's recovery college. The occupational therapy programme was agreed collaboratively with patients to incorporate the things that patients were interested in. Patients engaged in some work activities such as being on interview panels for new staff and being on the patients' council for the hospital.

Staff helped patients to stay in contact with families and carers. The ward welcomed visitors. Staff ensured that families were involved in discussions about patients' care and treatment, and involved in plans for discharge. During the Covid pandemic, when visitors were not permitted on the ward, staff made arrangements for patients to contact their families using video conferencing facilities.

Good

Wards for people with learning disabilities or autism

Meeting the needs of all people who use the service

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

The service could support and make adjustments for disabled people and those with communication needs or other specific needs. The ward was situated on the ground floor with step-free access from the front door. The ward provided a bedroom and bathroom that were adapted to meet the needs of people using a wheelchair. The service employed a speech and language therapist to assist with patients' communication needs. The speech and language therapist had introduced tools such as communication 'grab sheets' for each patient that provided staff with a summary of the best communication approach for that patient. Communication passports provided more detailed information, such as details of things patients liked to talk about and the patient's likes and dislikes. Staff used 'talking mats' to help patients communicate their choices and decisions through pictures. Each patient's communication plan explained the level that communication should be pitched at. For example, some patients were able to understand sentences with two or three key words. Other patients preferred the 'talking mats' approach. The speech and language therapist also provided personalised communication resources to support and reassure patients. For example, they had produced visual discharge plans and personalised, accessible information to help patients understand forthcoming appointments for cervical screening and dental check-ups.

The ward was clean, bright and included displays and signage that was appropriate for people with mild and moderate learning disabilities. At the time of the inspection, the capacity of the ward was limited to eight patients which meant there was plenty of room for patients and the ward was reasonably quiet. However, the lighting was very bright in all communal areas which may have been uncomfortable for some people with autism.

Staff made sure patients could access information on treatment, local services, their rights and how to complain. This information was displayed in communal corridors in picture and written formats.

The service had information leaflets available in languages spoken by the patients and local community. Patients could also access interpreters or signers when needed. The speech and language therapist considered all aspects of each patient's communication needs, including their preferred language, when developing communication plans.

The service provided a variety of food to meet the dietary and cultural needs of individual patients. A choice of food was provided for patients including options for Halal, Kosher, vegetarian, vegan and gluten-free meals.

Patients had access to spiritual, religious and cultural support. For example, one patient regularly met with an Iman. The service had previously supported a patient to attend a local church.

Listening to and learning from concerns and complaints

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

Patients, relatives and carers knew how to complain or raise concerns. However, there had been no formal complaints since the last inspection. When patients raised informal concerns, they were discussed in the multidisciplinary team handover.

The service clearly displayed information about how to raise a concern in patient areas. Information was displayed in words and pictures.

Good

Wards for people with learning disabilities or autism

Staff understood the policy on complaints and knew how to handle them. The hospital responded to complaints within 20 working days, as required by its complaints policy.

Managers investigated complaints and identified themes. Complaints made to the hospital were discussed by the senior multidisciplinary team at monthly clinical governance meetings.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing The service did not deploy sufficient staff to ensure safe and consistent care was provided to patients.