

The Views

Quality Report

22 Wellington Street
Matlock
Derbyshire
DE4 3JP
Tel: 01629831004
Website: www.cygnethealth.co.uk

Date of inspection visit: 29th August 2018
Date of publication: 24/10/2018

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

Ratings

Overall rating for this location		Good	
Are services safe?	Requires improvement 		
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

We rated Cygnet Views as good because:.

- There were sufficient numbers of staff to deliver care and treatment. Staff were well supported by managers and supervised regularly; 90% of staff were up to date with their supervision. Staff compliance with mandatory training was high at 94%.
- Patients had up to date detailed risk assessments. Staff knew and understood patient risk and met to discuss these. Care plans were holistic, individualised and recovery focused and staff updated these regularly. Patients were involved in care planning and risk management and were invited to meetings to discuss their care.
- We observed staff were kind, respectful and responsive when they interacted with patients. Staff understood the individual needs of patients and ensured their care was individualised. Staff assessed patients' communication needs and met these individual needs; each patient had a communication file to support this.
- Staff ensured patients received good physical health care. Staff monitored physical health and patients had access to annual health screening and specialists as required. There was good practice in relation to medicines management. Medicines were organised well, stored safely and recorded correctly. Medicines management processes were overseen by a commissioned pharmacist.
- Staff were involved in local audits and there was a robust audit cycle that provided the service with assurance about how care and treatment was delivered. There was a clear hospital dashboard to monitor and manage hospital performance and this was accessible to all staff.
- Managers understood the hospital well; they were visible and engaged in improving care. There was a healthy and supportive culture within the team and staff supported each other well.

- Staff demonstrated that they were committed to reducing restrictive practice, listened to patients' feedback and gave examples of where they had made changes. Staff were involved in quality improvement projects relating to patient admissions and discharges.
- Staff reported incidents and learning from incidents and complaints and incidents was shared. Changes were made following learning and when required both patients and staff received debriefs after incidents.
- Care and treatment was in line with National Institute of Health and Care Excellence guidance for patients with learning disabilities. There was a range of interventions to aid patients' psychological interventions, activities and a group programme.

However:

- We saw that some staff wore nail varnish and gel nails. This was not in line with policy as it was a potential infection control risk and a potential safety risk for staff carrying out restraints as it could potentially cause patient harm.
- At the time of our inspection staff were not offered sepsis training, this meant that they were not trained to notice signs of sepsis in patients. The organisation did not have a sepsis policy for staff to access for guidance. The hospital manager immediately responded to our concerns regarding this, after our inspection posters about sepsis were displayed on the ward, a policy was developed and there was a plan for local staff training.
- Patients gave us mixed feedback about staff. Some feedback related to a safeguarding concern that patients raised about a member of staff but there was also negative feedback that concerned staff attitudes towards patients.

Summary of findings

Contents

Summary of this inspection

	Page
Background to The Views	5
Our inspection team	5
Why we carried out this inspection	5
How we carried out this inspection	5
What people who use the service say	6
The five questions we ask about services and what we found	7

Detailed findings from this inspection

Mental Health Act responsibilities	11
Mental Capacity Act and Deprivation of Liberty Safeguards	11
Overview of ratings	11
Outstanding practice	25
Areas for improvement	25
Action we have told the provider to take	26

Good 

Cygnnet Views

Services we looked at

Wards for people with learning disabilities

Summary of this inspection

Background to The Views

The Views is an independent hospital situated near the centre of Matlock in Derbyshire. The hospital provides care and support for up to ten women with learning disabilities, challenging behaviour and complex mental health needs. At the time of our inspection there were ten patients who were all detained under the Mental Health Act.

At the time of our inspection, there was a registered manager who is a person who had registered with the Care Quality Commission to manage the service. They have a legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated regulations.

The Views are registered with the CQC for:

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

The service was last inspected in October 2015 and was rated as good overall all and in each of the five domains.

A Mental Health Act monitoring visit was carried out in November 2016 and there were no concerns identified at this visit

Our inspection team

Team leader: Liz Millet

The team that inspected the service comprised of two CQC inspectors, a specialist advisor who was a mental health nurse who had experience of working in learning disability services and an expert by experience, who had experience of using learning disability services.

Why we carried out this inspection

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

How we carried out this inspection

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

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

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

During the inspection visit, the inspection team:

- visited the hospital, looked at the quality of the ward environment and observed how staff were caring for patients
- spoke with four patients who were using the service
- spoke with four carers
- spoke with the registered manager, who was the hospital manager and the regional operational director
- spoke with seven other staff members; including a doctor, a nurse, an occupational therapist, assistant psychologist, support workers and the cook

Summary of this inspection

- received feedback about the service from four care co-ordinators or commissioners;
- spoke with an independent advocate
- attended and observed a multi-disciplinary morning meeting
- looked at six care and treatment records of patients
- carried out a specific check of the medication management
- looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the service say

During the inspection, three patients raised a safeguarding concern about a member of staff. We raised this with the hospital immediately. The hospital manager responded to this appropriately to ensure the safeguarding of patients; they raised a safeguarding alert and communicated with key stakeholders in a transparent way.

We spoke to four carers, three of the four carers were happy with the service that their family member received and felt that they were involved in their family's care. Carers told us they thought the hospital was clean and well maintained. They said there was a good level of activity for their family member and that staff were kind and worked hard for good outcomes for patients. One carer was unhappy as her daughter was living a long way from her and did not speak to her enough. The commissioner involved in this case provided an explanation for this that did not relate to care and treatment on the ward.

Patients gave us a mixed response about the care they received. Staff accompanied them when they spoke with us and patients were happy to speak openly about any concerns.

We spoke to four patients; each of the patients gave us some negative feedback about the service. One patient

said she did not want to be in the hospital. Two patients were not positive about staff attitudes and the way that staff spoke to them. One of these patients said bank staff were not as responsive when they asked for support as permanent staff. Another patient said staff did not help her and that she was not able to contribute fully to ward round. One patient said staff were often too busy to deal with them.

However, there were positive statements made as well such as that family were involved in care, that staff had supported them to reduce self-harming behaviour and that most staff were kind. One patient said there was a good choice of food and that complaints were handled quickly.

The four commissioners we spoke with were very positive about the service and said that the hospital communicated very effectively and regularly with them, that there were a wide range of activities and that they were satisfied that patients made very good progress. Commissioners told us that staff were dedicated and worked hard with patients. Some of these patients had struggled to make progress in other services in the past, but had done well at this hospital.

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 requires improvement because:

- We saw that some staff wore nail varnish and gel nails. This was not in line with policy as it was a potential infection control risk and a potential safety risk for staff carrying out restraints as it could potentially cause patient harm
- Staff were not offered sepsis training, this meant that they were not trained to notice signs of sepsis in patients. At the time of our inspection the organisation did not have a sepsis policy for staff to access so there was guidance about sepsis. A national study has demonstrated that deaths from sepsis for patients with learning disabilities are of concern. The hospital manager did immediately responded to our concerns regarding this. After our inspection sepsis posters were displayed, a policy developed and a plan made for local training.

However:

- Staff compliance with mandatory training was high at 93.5%, there were no areas where this had fallen below 87.5%.
- All patients had an up to date risk assessment and these were thorough and updated after incidents. Staff knew and understood patient risk. Staff met daily and discussed patient risk at meetings and handovers.
- Staff were committed to reducing restrictive practice and listened to patients' feedback. There were examples of how restrictive practice had been reduced and evidence that staff supported patients to take some therapeutic risks.
- Staff had implemented the Stop Over Medicating People with Learning Disabilities approach on the ward. Staff regularly reviewed patients' medication and a sensory box had been introduced to help patients to reduce levels of anxiety and behaviour that challenges.
- Staff reported incidents and learning from incidents was shared. There was evidence that changes had been made in response to incidents following adverse events. Patients and staff received debriefs following incidents.

Requires improvement



Are services effective?

We rated effective as good because:

- Staff created care plans that were holistic and individualised. Care plans were recovery orientated and set out achievable goals. Staff updated care plans regularly.

Good



Summary of this inspection

- Patients had good physical health care. The service worked closely with a local GP to ensure that patients had good access to physical health care including physical health monitoring and annual health screening.
- Staff were involved in quality improvement projects to improve understanding of team roles and to improve the discharge experience and process for patients, this was being designed and developed with patient participation.
- Staff received supervision and support; 90% of staff had received regular supervision and this took place every six weeks. There were regular team and nurses' meetings for staff to meet and discuss relevant issues.
- There was a range of care and treatment options for patients that were in line with National Institute of Health and Care Excellence guidance for patients with learning disabilities. There was a range of interventions to aid patients' recovery that were offered by the multidisciplinary team including psychological interventions, activities and a group programme.

Are services caring?

We rated caring as good because:

- We observed that staff were kind, respectful and really responsive when they interacted with patients.
- Staff understood the individual needs of patients including religious and cultural needs.
- Patients' care was individualised and patients planned their own activities. Patients were supported well during the admission process and spent a day on the ward in preparation for admission.
- Patients were involved in care planning and risk management and were invited to multidisciplinary team ward round. Care plans were accessible and staff wrote these in easy read with symbols so that they were accessible for patients.
- The speech and language therapist assessed patients' communication needs and staff communicated with patients in a way that suited them. All patients had a communication file where staff recorded patients' chosen communication methods.

However:

- Patients gave us mixed feedback about staff. Some feedback related to a safeguarding concern that patients raised about a member of staff but there was also negative feedback that concerned staff attitudes towards patients.

Good



Summary of this inspection

Are services responsive?

We rated responsive as good:

- Staff planned well for discharges, patients were prepared sufficiently. Staff ran a 'moving on group' to help patients prepare for discharge.
- Patients were able to personalise their rooms and we saw this on the day of our inspection. Patients were able to choose the colour of paint for their bedroom walls before they were admitted to the ward.
- Patients had access to well-maintained gardens and they had been involved in creating a separated 'secret' sensory garden. The garden was well-used and provided patients with quiet space.
- Staff encouraged patients to develop relationships with people that mattered to them. They supported patients to develop social skills and manage relationships. Patients accessed community activities and groups and made contact with people outside the hospital.
- Staff demonstrated they understood how to manage complaints and were responsive to complaints. Staff gave feedback on the outcome of complaints to patients and professionals. They ensured that they dealt with complaints fairly.

Good



Are services well-led?

We rated well-led as good because:

- Managers had a good understanding of all aspects of the hospital and were able to explain how the hospital was working to improve care to ensure it was high quality. Managers were visible and were accessible to patients and staff.
- Staff told us that the culture amongst staff within the team was healthy; where there were challenges staff supported each other well.
- There was a clear framework of what should be discussed at meetings. Information discussed was shared upwards from the ward to the most senior managers and from senior managers to the ward.
- Staff were involved in local audits and there was a robust audit cycle that provided the service with assurance about how care and treatment was delivered.
- Staff had positive relationships with providers that supported patients being safe and achieving positive outcomes. External stakeholders were happy with the way that the hospital worked with them.

Good



Summary of this inspection

- A hospital dashboard system was used to manage performance and was clear and accessible managers in the organisation and staff. The dashboard contained relevant information to improve performance.

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 completed training in the Mental Health Act.
- Staff could access support from the Mental Health Act administrator who visited the ward on a weekly basis.
- Patients had access to information about mental health advocacy and staff displayed this information throughout the ward and in the reception area. This was in easy read format to ensure it was accessible.
- Mental Health Act paperwork was organised well and stored correctly. Consent to treatment forms were attached to patients' medicine cards.
- The Mental Health Act administrator completed regular audits to ensure that staff applied the Mental Health Act correctly.

Mental Capacity Act and Deprivation of Liberty Safeguards

- All staff had completed training in the Mental Capacity Act.
- Staff demonstrated a good understanding of the Mental Capacity Act and the five statutory principles. Staff could give examples about how they applied this in their work.
- Staff assessed patient's capacity for individual, significant decisions and staff recorded this correctly.
- The Mental Health Act Administrator and nurse regularly reviewed capacity assessments to ensure they were completed and recorded properly.

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Wards for people with learning disabilities or autism	Requires improvement	Good	Good	Good	Good	Good
Overall	Requires improvement	Good	Good	Good	Good	Good

Wards for people with learning disabilities or autism

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

Are wards for people with learning disabilities or autism safe?

Requires improvement 

Safe and clean environment

Safety of the ward layout

- Staff completed monthly risk assessments of the care environment. A general risk assessment of the building was carried out annually. We reviewed these and saw staff completed actions promptly.
- The ward did not allow staff to observe all parts of the ward. The ward was spread across three levels and there were narrow corridors. There were no clear lines of sight. Staff managed risk by being positioned throughout the ward and observation levels were increased where risk was identified.
- There were reduced ligature fittings on the ward; however, there were some ligature anchor points. A ligature point is anything that patients could attach a cord, rope or other material for the purpose of hanging or strangulation. For example, there were ligature risks from door handles in corridors and taps in patients' bathrooms. However, ligature assessments were completed annually and there was an up to date ligature risk assessment available, this was completed in April 2018. The ligature risk assessment described clearly how risk was mitigated. For example, patient bathrooms could be locked off if a patient was a risk of

ligature tying. Staff positioned themselves throughout the ward and increased observations if a patient's risk had increased. Staff were aware of environmental ligature risks.

- The ward was for female patients only.
- Staff had easy access to alarms that they carried on their person. Patients had nurse call systems in their rooms. Staff checked alarms to ensure they worked properly.

Maintenance, cleanliness and infection control

- All ward areas were clean, had good furnishing and were well maintained. The hospital had received a food hygiene rating of five stars; this is the highest level that can be achieved.
- Cleaning records were up to date; we reviewed these and saw that domestic staff completed these and they were monitored by the domestic supervisor. Records demonstrated that staff cleaned the ward regularly. Domestic staff checked mattresses for signs of damage. Staff replaced mattresses when a new patient was admitted. The domestic supervisor took the lead in infection control.
- Staff adhered to some infection control principles including hand washing, there were hand sanitisers available throughout the ward for staff to use. However, some staff had nail varnish and gel nails, this was not in line with policy and an infection control risk.

Clinic room and equipment

- The clinic room was well equipped. Staff checked equipment to ensure it worked effectively. There was no examination couch; however, doctors used patient's

Wards for people with learning disabilities or autism

bedrooms if required. There was accessible resuscitation equipment, including a defibrillator and staff checked emergency equipment to ensure it was working properly.

- The clinic room and equipment stored in it was clean; staff recorded when they had cleaned the room and equipment.

Safe Staffing

Nursing Staff

- Nursing establishment levels were four whole time (WTE) equivalent nurses. There were two (WTE) vacancies at the time of our inspection. There was an ongoing recruitment programme for these posts and there was an interview organised for the day after our inspection. Bank nurses supported the hospital where there were vacancies.
- Support worker establishment levels were fourteen (WTE) support workers. There were no vacancies for support staff. One of the support staff had the role of therapeutic co-ordinator and was responsible for working with patients to plan activities.
- Between 1 April 2018 and 1 July 2018 there had been 109 shifts filled by bank staff to cover sickness, absence or vacancies. This accounted for 58% of shifts. In the same period, there had been eight shifts that were unfilled to optimum staffing levels. No shifts had fallen below the service's minimum numbers.
- The staff sickness rate was at 1.5%, the hospital manager told us this was below the organisational average of 3.55%.
- There had been seven staff leave in the 12 months prior to our inspection. There were a variety of reasons for staff leaving; there was no specific theme for staff turnover gathered from staff exit interviews.
- The hospital manager had calculated the number and grade of nurses and health assistants required and this was reviewed regularly.
- The number of nurses and support workers matched the number on all shifts. On day shifts there was at least one nurse and four support workers and at night one nurse and three support workers. These numbers were

above recommended staffing levels for the ward to be safe. On the day of our inspection, there was one nurse and seven support workers. This was due to enhanced observation levels required for patients.

- The hospital manager and nurse in charge could adjust staffing levels and were supported by the organisation to do this. Staffing was increased when there was an increased level of patient risk and therefore increased support needs on the ward.
- The ward only used staff from their own bank to ensure they maintained safe staffing levels.
- All bank staff received an induction and they were familiar with the ward before they commenced their duties. Most bank staff worked regularly on the ward and knew the patients well.
- There was one qualified nurse available on the ward at all times.
- Patients were able to have 1:1 time with their named nurse and this happened at least once a week.
- Staff told us that ward activities and escorted leave were rarely cancelled. We were given an example of staff working flexibly and starting their shift early in order that a patient could go on leave.
- There were enough staff to carry out physical interventions, both enhanced observations and restraint. All staff completed Management of Actual or Potential Aggression training and all of staff were up to date with this.

Medical Staff

- There was adequate medical cover day and night and a doctor could attend the ward in an emergency. A consultant psychiatrist and a junior doctor provided cover throughout the week. A regional consultant provided cover out of hours and at weekends. The consultant could reach the hospital, if called out within 45 minutes.

Mandatory training

- Staff had received and were up to date with mandatory training. Mandatory training included courses such as safeguarding, infection control, food safety, equality and diversity and information governance.

Wards for people with learning disabilities or autism

- Overall staff compliance with mandatory training was at 93.5%. Where training had expired this had been booked. The lowest level of training compliance had not fallen below 87.5% in any specific training courses.

Assessing and managing risk to patients and staff

Assessment of patient risk

- Our inspection team reviewed six care records in detail on the day of our inspection.
- Staff completed a risk assessment of every patient before the patient was admitted to the ward and these were updated and discussed on a daily basis. All risk assessments were up to date and updated after any incidents.
- The ward used Short Term Assessment of Risks and Treatability (START) risk assessment. We also saw historical risk management 20 (HCR 20) risk assessments in some patients' care records. These tools were recognised risk assessments.

Management of patient risk

- Staff assessed specific issues such as falls, epilepsy and choking risks. However, staff were not trained in assessing the risk of sepsis. The organisation did not have a sepsis policy for staff to access for guidance. The findings from LeDeR (Learning from deaths of people with a learning disability) show that nationally there are concerns about the number of deaths linked to sepsis. After the inspection, the hospital manager immediately displayed posters about sepsis throughout the ward, developed an organisational sepsis policy and planned staff training.
- Staff met daily and discussed patient risk at the two handovers and the morning meeting. We observed staff talking about each patient's risk at the multidisciplinary team morning meeting, attended by an assistant psychologist, consultant psychiatrist and nurse in charge. Risk was RAG rated (red, amber, green). The staff at these meetings also checked that care plans and positive behaviour support plans were up to date.
- There was a white board in the nursing office where information including patient risk, observation levels,

whether patients were on a section, physical health, allergies and identified named nurse was recorded. Staff updated this daily. This was only visible to staff who should have had access to this information.

- Staff followed policy in regard to observations and searches. Staff demonstrated they understood processes for searches and observations and care records showed that staff only carried out searches if an individual risk assessment justified this action.
- Blanket restrictions were only used when justified. The ward and the wider organisation did not allow plastic bags on the ward; this was due to incidents that had taken place in the organisation previously and was a requested action from the coroner. The ward provided hessian bags as a replacement for plastic bags.
- Patients were able to smoke in the garden. Smoking cessation was available to patients.
- There were no informal patients at the time of our inspection. There was information displayed explaining that informal patients could leave the ward and how to do so.

Use of restrictive interventions

- The ward did not use long-term segregation.
- Staff had carried out 102 restraints on patients in the period between July 2017 and July 2018. There had been a significant increase in restraints in the four months prior to our inspection. Staff explained this was due to the presentation of a patient on the ward. Of these restraints, one had been in prone position.
- There were low levels of rapid tranquillisation. Staff had used rapid tranquillisation on 11 occasions in the year before our inspection. When this took place, staff completed physical health observations as per policy. Staff followed National Institute of Health and Care Excellence guidance when they offered rapid tranquillisation. There was an up to date policy that was in line with up to date National Institute of Health and Care Excellence guidance.
- Staff worked to reduce restrictive practice and they audited blanket restrictions. Staff took carefully considered therapeutic risks. For example, staff had reviewed the policy of restricting access to the therapy kitchen where patients made drinks and snacks.

Wards for people with learning disabilities or autism

Recently, patients had been individually risk assessed; this had resulted in two patients having door fobs so that they could access the kitchen. Staff had also reviewed access to the garden and 'secret' sensory garden; they had listened to feedback from patients and made changes so that patients could access outside space without having to ask staff to unlock the door.

- Staff only used restraint after they had attempted to deescalate. We reviewed data for August 2018, 43% of incidents that could have resulted in staff using restraint were successfully de-escalated. Positive behaviour support plans contained clear information from patients that outlined coping strategies and interventions that worked best for them. Staff were able to describe how they distracted and de-escalate patients. Restraint was used as a last resort.
- We saw staff with long nails and gel nails, this was not in line with Cygnet's dress code and personal appearance policy. The policy outlined that this was a risk in regard to safety when carrying out restraints; gel nails could injure patients.
- Staff demonstrated an understanding of the Mental Capacity Act definition of restraint.

Safeguarding

- Staff were trained in safeguarding, 96% of staff were up to date with safeguarding training. Staff were trained in safeguarding both children and adults. The hospital manager was the safeguarding lead for the ward. Staff knew how to raise a safeguarding alert and did so when required.
- Staff were able to give examples of how they had protected patients from abuse and harassment. Staff ensured that they updated all relevant professionals when there were concerns to ensure communication was shared effectively.
- Staff were able to identify adults and children at risk of abuse and worked with external partners to ensure their safety. Staff gave examples of how this had taken place in practice. Staff attended safeguarding meetings when this was required.
- Children could visit patients; staff assessed whether there were safeguarding issues before this took place. There was a suitable room for patients to meet with children.

Staff access to essential information

- Staff used electronic records, but staff printed of key documents such as care plans and risk assessments and kept them in files so that they were easily accessible. These were accessible for external professionals where patients had given the consent to view their records. This was updated when there were changes to risk assessments or care plans for example. Paper records were stored securely and the electronic record system was password protected. All staff had access to electronic records.
- All relevant information was available to staff including bank staff.
- Staff were able to record information on the electronic note keeping system.

Medicines management

- Staff demonstrated good practice in medicines management. Medicines were well organised and stored safely. Staff monitored temperatures effectively of the refrigerator and the clinic room. Medicines were stored safely and staff checked that medicines were in date and in use. We looked at six patients' medicine cards. We found one medicine card where one prescription had not been signed for or dated; however, in all other cases staff had completed medicine cards correctly including recording patients' allergy status. A commissioned pharmacist monitored and audited medicines related activity and staff followed correct protocols for the administration and reviews of pro re nata (PRN) medication. This means medication given as required. At the time of our inspection, there was one patient who was preparing for discharge and administered their own medication.
- Staff reviewed the effects of medication on patients' physical health and followed relevant National Institute of Care Excellence National Institute of Health and Care Excellence guidelines. Staff ensured that patients prescribed anti-psychotics were monitored appropriately with regular blood tests and referred patients for electrocardiograms to monitor cardiac health. Where patients were prescribed a high level of anti-psychotic medication staff used the Glasgow

Wards for people with learning disabilities or autism

Anti-psychotic Side-effect Rating Scale to monitor side effects. Staff carried out weekly physical health observations at the well woman's clinic and these were recorded appropriately.

- Staff had implemented the Stop Over Medicating People with Learning Disabilities (STOMP) approach on the ward and patients' medication was regularly reviewed. The staff had introduced the use of a sensory relaxation box containing items to help patients to reduce levels of anxiety and behaviour that challenges.

Track record on safety

- Two serious incidents had taken place in the 12 months prior to our inspection.
- The adverse events that had taken place related to a patient who had barricaded themselves in a room and set a small fire. A robust review of procedure and environmental risk had taken place in response to the incidents. Staff had made appropriate changes and learning had been shared.

Reporting incidents and learning from when things go wrong

- All staff knew what to report and how to report. All staff including bank staff reported incidents. Staff were required to discuss all incidents with the nurse in charge, including those that were less serious, to ensure all incidents that needed to be recorded were recorded.
- We reviewed incident data; staff reported a range of incidents. In the six months prior to our inspection, there were 203 incidents reported. The most frequently reported was self-harm, staff recorded 67 incidents of self-harm. These incidents also included lower levels of self-harm that did not lead to injury.
- Staff understood duty of candour. The ward shared information about patient harm or safeguarding with commissioners and families where appropriate. Staff had open and transparent relationships with commissioners and communicated where there were concerns about a patient's placement.
- Staff received feedback from the investigation of incidents and met to discuss this. Staff discussed feedback in team meetings, handovers and morning

multi-disciplinary team meetings. Incidents that took place at other locations within the organisation where learning had been identified were shared with staff by email or fed back via the hospital manager

- There was evidence that changes had been made following incidents and that staff had also sought the advice of other external professionals regarding changes to security to ensure that patients were safe.
- Staff received debriefs after incidents took place. The nurse or team leader usually facilitated these. Patients received debriefs after incidents including restraints. Staff gathered patient's feedback about how an incident had been managed and if anything could be done differently in the future.

Are wards for people with learning disabilities or autism effective? (for example, treatment is effective)

Good 

Assessment of needs and planning of care

- Our inspection team reviewed six care records in detail on the day of our inspection.
- Staff completed a comprehensive mental health assessment prior to admission as part of the assessment process.
- Staff assessed patients' physical health at admission. We saw that staff had completed this for all patients. The service worked closely with a local GP who ensured that patients accessed annual health screening and facilitated blood tests and electrocardiograms.
- Staff created care plans that developed the needs identified in patient's assessments. Care plans reflected the needs of patients that were recorded in other documents contained in care records.
- All care plans were holistic and staff considered the wider needs of patients and were genuinely individualised. They were consistently recovery orientated and focused on achievable goals.

Wards for people with learning disabilities or autism

- Care plans were updated at least every three months, but more frequently when staff and patients identified that there was a change needed to be made.

Best practice in treatment and care

- We saw a range of care and treatment options for patients that were in line with National Institute of Health and Care Excellence guidance for patients with learning disabilities, including those with behaviour that challenges. Staff provided a range of psychosocial interventions. There was a range of interventions from speech and language therapy, occupational therapy and psychology who worked closely together. All patients completed a psychological, speech and language and occupational therapy assessment after admission. Care records demonstrated that patients were engaged in psychological interventions. Patients could access therapy including cognitive behaviour therapy for people with learning disabilities, trauma based therapy and building coping strategies. Most patients engaged in psychological therapy once a week.
- There were groups to develop new skills and improve daily living skills. Each patient had their own personalised activity programme. Staff monitored activity patients were involved in. Patients aimed to complete 25 hours of activity a week and they normally achieved this.
- Patients had good access to physical health care. Each patient had a specific physical health care folder where all information about physical health was stored including a hospital passport and staff could access this easily. The ward worked closely with the local GP and practice nurse and patients had access to an annual physical health review. We saw evidence that this took place and that patients saw specialists, including diabetes care.
- Staff supported patients to live healthier lives and supported patients to access comprehensive annual screening through their GP. There was a regular wellbeing group and staff talked to patients about healthy lifestyles. Staff gave us examples about how they encouraged patients to eat healthier food and get active. The ward had 'Active Fridays' where patients planned and chose their desired 'active' activity and patients could access free gym membership.
- Staff used a variety of rating scales to assess and support patients' progress. These included the Health of the Nation Outcome Scale for learning disabilities Model of Occupational screening tool Behaviour Problems Inventory Assessment of Motor and Processing Skills.
- Staff participated in clinical audits. Nurses and the pharmacist completed a weekly medication audit. The occupational therapist audited the environment for any specific equipment patients required and reviewed whether there was a suitable sensory environment. There were quarterly audits of patients' physical health files. The organisation's Quality Lead audited care records and verified whether care and treatment was in line with National Institute of Health and Care Excellence guidance.
- Staff were involved in quality improvement projects, one of these projects was being developed at the time of our inspection by psychology staff and the occupational therapist. They worked with patient participation to develop an in-depth preparation programme for discharge, this started as soon as patients came into the unit. The hospital had also introduced an initiative where staff 'buddied up' with other staff with an aim to understand each other's roles better and improve team work.

Skilled staff to deliver care

- Staff who worked with patients were from a range of disciplines including an occupational therapist, an assistant psychologist and speech and language therapist. Staff included support workers including a therapy coordinator, nurses and a consultant psychiatrist and junior doctor. In addition to this, the service commissioned a pharmacist.
- Staff were experience and qualified. None of the nurses were specialist learning disability nurses. The hospital had been unable to recruit nurses who had completed nursing training in this specialism. All staff were able to access specialist training about learning disabilities, autism and related issues. Out of the 30 staff who worked in the team 26 had completed training in autism and 27 had completed training about learning disabilities and a separate course about personality disorders.
- New staff received an induction. This included mandatory training, Managing Actual and Potential

Wards for people with learning disabilities or autism

Aggression training. Staff had at least one week on the ward before they were counted in staff numbers. All new support workers completed the care certificate and team leaders supported this.

- Staff received supervision; 90% of staff had received regular supervision. Supervision usually took place every six weeks. Professional staff all received supervision from staff within their specific discipline.
- Regular team meetings took place and we reviewed minutes from these and observed there was a structured agenda that included a review of recent incidents. There were also monthly nurses' meetings.
- Staff completed an appraisal, 87% of staff had completed this. Appraisal completion levels were monitored at bi-monthly meetings with the organisation's human resources department.
- Staff had accessed a range of specialist training for their role including positive behaviour support, diabetes management, phlebotomy, suicide awareness and carrying out electrocardiograms.
- Managers dealt with poor staff performance and absence effectively and both managers and staff gave examples of this having taken place.

Multidisciplinary and interagency team work

- Staff held regular and effective multidisciplinary team meetings. There were daily morning meetings where staff met and discussed patients and risk. The multidisciplinary meeting ward round was held each week and patients were reviewed monthly at this.
- Handovers took place twice daily in addition to the morning meeting.
- The hospital had good relationships with external professionals including commissioners and care coordinators. Staff also had relationships in the local community with community groups and places of worship that patients used. They worked closely with a local GP and practice nurse who reported positive working relationships with hospital staff.

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

- Staff had completed training in the Mental Health Act; training compliance was at 100%. Staff had a good understanding of the Mental Health Act and the Code of Practice.
- Staff had access to the Mental Health Act administrator. The Mental Health Act administrator was contactable by phone and visited the ward on a weekly basis.
- Policies and procedures concerning the Mental Health Act were up to date and relevant. Staff could access these easily. All relevant policies were accessible on the intranet.
- Patients had access to information about mental health advocacy. Staff displayed information about this in easy read format.
- Staff explained patient's rights to them; they did this at a minimum of every three months. This was in an accessible format, in easy read for patients who required this. Staff recorded when they had done this and the Mental Health Act administrator monitored this.
- Staff ensured that patients could take section 17 leave and patients and carers received a copy of these.
- We observed that staff requested an opinion from a second opinion doctor for patients who were not able to or had not consented to treatment.
- Staff kept copies of patients' detention papers in care records. Records were well organised and stored correctly. Staff attached patient's consent to treatment forms to medicine cards.
- Staff displayed information to tell informal patients that they could leave the ward freely.
- Section 117 aftercare information was contained in patient's care plans when they were entitled to this.
- The Mental Health Act administrator completed audits every six months to ensure staff applied the Mental Health Act correctly.

Good practice in applying the Mental Capacity Act

- Staff had completed training in the Mental Capacity Act; training compliance was at 100%.
- Staff demonstrated a good understanding of the Mental Capacity Act and the five statutory principles. Staff talked about how they applied this in their daily work.

Wards for people with learning disabilities or autism

- There had been no deprivation of liberty safeguards applications in the last 12 months.
- There was a policy on the Mental Capacity Act and staff knew how to access this.
- Staff could access support about the Mental Capacity Act from the multidisciplinary team and Mental Health Act administrator.
- Staff could give examples of how they supported patients to make specific decisions.
- We saw staff assessed patients' capacity for specific, significant decisions where appropriate and this was recorded in patients' care records.
- Staff ensured that where patients did not have capacity for a specific decision that they made decisions that were in their best interests. Staff used a best interest assessor where appropriate. Staff considered the patient's wishes, feelings and values and involved family where possible.
- Staff could make deprivation of liberty safeguarding applications when required and these applications were monitored.
- Nurses and the Mental Health Act administrator reviewed capacity assessments regularly to ensure staff completed them correctly.
- Staff supported patients to access health services when required and encouraged participation in community services an example of this was the local dance that patients attended.
- Patients gave us a mixed response when asked about how staff treated them and some of their feedback was negative. Two patients were not positive about staff attitudes or about the way staff spoke to them. A patient told us most staff were kind and there were other positive statements made about staff having supported patients well.
- Staff demonstrated that they understood the individual needs of patients and all elements of patients' care were highly individualised. Staff ensured patients made choices and planned their own activities. Staff understood patients' personal likes and dislikes and different cultural and religious needs. We saw this in patients' individualised activity programme.
- Staff were happy to raise concerns about disrespectful attitudes of other staff towards patients. They were confident to raise concerns without fear of consequences for doing so.
- Staff provided us with examples of how they had protected the confidentiality of patients where the patients had not wanted certain information shared with family.

Are wards for people with learning disabilities or autism caring?

Good 

Kindness, privacy, dignity, respect, compassion and support

- We observed that staff were consistently kind, respectful and highly responsive when they interacted with patients. Staff gave emotional support and advice and responded to patients' needs and requests.
- Staff supported patients to understand and manage their care, treatment and condition. We saw evidence of this in patients' care records and when we talked to staff about patients' care.
- We saw evidence that patients were involved in care planning and risk management. Patients were involved in their own care planning and the patients' voice was evident in care plans. Staff wrote care plans in accessible language with symbols so that they were accessible for patients to understand. Patients were involved in multidisciplinary team ward round and offered a copy of their care plan. Patients contributed to their positive behaviour support plans and staff updated information after incidents had taken place.

Wards for people with learning disabilities or autism

- Staff communicated with patients in a way that suited them. There was evidence of this throughout the ward. The speech and language therapist assessed all patients' communication needs and then staff ensured they met these in the care and treatment they provided. Staff used 'talking mats' to support patients' communication. All patients had a communication file where staff clearly recorded patients' chosen communication methods.
- Staff involved patients in the recruitment of staff. A patient was included on the interview panel for new staff. Patients were encouraged to feedback on services in the weekly patient meeting, attended by the advocate. There were comments cards and a comments box available for patients to provide feedback.
- There were no advance decisions in place, aside from those relating to managing incidents.
- Staff ensured patients could access advocacy and an Independent Mental Health Advocate spent one day a week on the ward. We spoke to the advocacy service and they were very positive about the way that the hospital worked with them to ensure the protection of patient's rights.

Involvement of families and carers

- Staff involved families and carers, and invited them to meetings including multidisciplinary ward round and community treatment reviews. There were families who lived a long way from the service who used conference calling to take part in meetings if they could not attend. Most carers felt included in patient care. Care records demonstrated that carers were involved in patient care.
- There were no carers' meetings for carers to give feedback. Staff said this was because many carers lived far away. However, staff encouraged carers to feedback with comments cards. There had been a recent carer's survey, however; only one carer had given feedback, we looked at this and feedback was positive.
- Patients fed back on the service they received at their community meetings. Managers reviewed this feedback was reviewed at regional governance meetings.
- All carers were offered a carers assessment. Carers, staff and care records confirmed this.

Are wards for people with learning disabilities or autism responsive to people's needs? (for example, to feedback?)

Good 

Access and discharge

Bed management

- Bed occupancy over the 12 months prior to our inspection was 90%.
- The average length of stay was 18 months, however in the 12 months prior to our inspection the average length of stay was 215 days.
- The service worked to deliver on strategy set out in NHS England's 'Transforming Care programme.' Patients had individualised programmes of care and treatment with a wide range of activities to prepare them to live more independently in the community and staff worked with patients to achieve successful discharges.
- Beds were available for patients who lived locally, however the service took referrals from a wide geographical area.
- The provider ensured there was always a bed available for patients when they returned from leave.
- When patients were moved or discharged this happened between 9am and 5pm. Staff planned for discharges, so that patients were prepared. The hospital and the new care provider completed discharge care plans jointly.
- There had been no recent cases of patients who had required a move to a local psychiatric intensive care unit.

Discharge and transfers of care

- Delayed discharges were rare, where there were delays the ward worked to manage these efficiently. When delays came about these were normally due to a lack of availability of community placements.

Wards for people with learning disabilities or autism

- Staff supported patients during transfers and discharges and ensured that patients were supported. Staff ran a 'moving on group' that helped patients to manage their discharge.

Facilities that promote comfort, dignity and privacy

- Patients had their own bedrooms; all bedrooms had an en-suite bathroom.
- We saw patients had personalised their rooms with photos and possessions. Before patients were admitted to the ward, they could choose the colour of paint for their bedroom walls.
- Patients could store their possessions in their bedrooms and they had keys for their rooms. Where a patient had been individually risk assessed as being unsuitable to have keys they were given a suitable alternative to store their possessions.
- Staff and patients had full access to a range of rooms to support treatment and care. This included a clinic room, lounge, dining room, faith room, therapy kitchen, beauty salon and computer room. At the time of our inspection the therapy kitchen did not have a cooker this was due to a local health and safety assessment that had identified that it could be a potential fire risk due to where its location. The manager had reviewed this and there were plans to move the therapy kitchen and include a cooker.
- There were areas on the ward where patients could be quiet if they did not want to go to their room. Visitors used the faith room or could, if risk assessed as appropriate, visit patients on the ward or in the garden.
- Patients could make a phone call in private. Most patients had mobile phones, but if a patient did not have mobile phone, they could use the pay phone or office phone if they wanted to.
- Patients had access to well-maintained gardens; patients had been involved in creating a separated 'secret' sensory garden. Patients used this well and staff supported patients to use this space for quiet time and emotion management.
- Food was of a good quality. It was cooked and baked on site. We spoke to the cook who explained the choices on offer and tasted the food.

- Patients were able to make hot drinks and snacks if their risk assessment allowed. Otherwise, staff accompanied them.

Patients' engagement with the wider community

- We were given examples where patients had accessed education. Patients made use of opportunities both internal and external to the service to do this. There were weekly maths and English sessions offered by a tutor.
- Staff supported patients to have contact with their families and carers. Patients made regular home visits which staff actively supported.
- Staff encouraged patients to develop relationships with people that mattered to them. Developing social skills and managing friendships and relationships was part of the social community skills group programme. Staff supported patients to access community groups and make meaningful relationships. Patients attended community activities and groups including a local afro Caribbean centre and community dances.

Meeting the needs of all people who use the service

- The hospital was accessible to wheel chair users and there were ramps, a wheel chair lift for patients and an adapted communal bathroom.
- Staff ensured that there was a wide range of information for patients and this information was presented in easy read. There was easy read information displayed throughout the ward about a range of issues including patients' rights, how to complain, the staff team, healthy eating and treatments. This information was displayed in an engaging and accessible way throughout the ward.
- At the time of our inspection, there were no patients that required leaflets in languages other than English. However, staff knew where they could access these if the need arose.
- There had been no need to request interpreting/ signing in the last year, but staff knew how this could be accessed if required.
- Patients had a choice of food to meet their dietary needs and individual likes and dislikes. There were examples of how this had been facilitated including the preparation of Afro Caribbean food and a diabetic diet. Patients had a choice. The chef carefully considered

Wards for people with learning disabilities or autism

how they could provide patients with a balanced diet and balanced health needs with patient choice. Patients could request different foods they liked and the chef responded to these individually. Hot meals were offered twice a day and on the day of our inspection, we saw that the chef was cooking different meals for different patients.

- Staff ensured that patients had access to spiritual support and were able to give examples of patients who had attended a local church. There was evidence in the faith room of patients work displayed that explored faith and beliefs.

Listening to and learning from concerns and complaints

- There had been four complaints and three compliments made in the 12 months prior to our inspection. Of the four complaints, one had been upheld and another partially upheld. One complaint was still in the process of being investigated.
- Patients knew how to raise a complaint or a concern and staff gave them accessible information so that they knew how to do this.
- Patients received feedback from their complaints, staff gave this to them in an accessible format that matched their communication style. For example, a patient had recently complained, the outcome of the investigation into complaint was fed back to them and they were unhappy with this. The hospital manager had requested that a second investigation to be completed by another manager from another Cygnet hospital to ensure fairness.
- Staff ensured that patients who made a complaint were protected from discrimination or harassment and were able to describe how they did this.
- Staff understood how to handle complaints and escalated these appropriately. The staff dealt with complaints in a responsive way. We spoke to a stakeholder who had made a complaint and who was happy with the outcome and changes that staff had made in response. Staff had improved their communication with the stakeholder as a result of the complaint.

- We reviewed complaints and saw staff had dealt with these in line with policy. Staff discussed learning from complaints at team meetings and in supervision.

Are wards for people with learning disabilities or autism well-led?

Good 

Leadership

- The hospital manager was a qualified nurse and had the knowledge and experience to carry out their role.
- The hospital manager and regional operational director had a good understanding of all aspects of the hospital and was able to explain how the hospital was working to improve care to ensure it was high quality. The regional operational director understood the service, was up to date with developments, and understood the challenges that the hospital faced.
- Both the hospital manager and regional operational director were visible for staff and patients. We observed patients approaching the hospital manager to ask questions when we carried out our inspection. The regional operational director visited the hospital at least once every two weeks and spent time talking to patients and staff, having recently worked a night shift. The most senior managers of the organisation visited the hospital annually.
- There were leadership development opportunities for the hospital manager, a leadership course had recently been made available. Support workers had the opportunity to become team leaders and they led the shift with the nurse in charge. There was evidence that managers had worked as support workers and nurses for the organisation and had been promoted.

Vision and Strategy

- Not all staff knew the vision and values of the organisation. These had been updated in April 2018 when the hospital and staff had been transferred from their previous employer to Cygnet.

Wards for people with learning disabilities or autism

- The values and vision of the organisation formed the structure of appraisal documents and the hospital manager was able to talk about how staff incorporated values and staff had been involved in designing the new values.
- Staff were able to talk about the strategy of the service at team meetings and feedback from staff was shared with managers. Staff also received email updates from senior managers about changes.
- Managers could explain how they delivered the service within the budget available and how they managed higher levels of acuity on the ward safely with these budgets. Managers were able to explain how they complied with the national Transforming Care programme aim of reducing hospital admissions for people with learning disabilities or autism.

Culture

- Staff told us that the culture within the team was healthy and supportive. The team had faced some recent challenges due to changes in patient's needs and risk. However, the team had supported each other with challenges.
- Staff were positive about who they worked for. Overall, they were happy about the changes that had taken place in the organisation when they had transferred to Cygnet.
- Staff consistently said they could raise concerns without fear of retribution and knew that they could do this with the most senior managers if they wanted to. There were bullying and harassment officers who worked across the organisation.
- Staff understood the whistle blowing process and said they would be comfortable to speak up if they needed to.
- Managers gave examples of how they had managed poor staff performance and the outcomes from this.
- The team worked well together and the hospital manager ensured that teams that worked on shift together were changed annually so that staff had the opportunity to change who they worked with.
- Staff appraisals took place, 87% of staff had completed an up to date with their appraisal. Appraisals included

conversations about staff career prospects and opportunities for development. For example, there were opportunities offered to unqualified support workers to complete their nursing training.

- Staff told us that the organisation promoted equality and diversity. For example, staff had attended recent training, facilitated by an external local lesbian, gay, bi-sexual, transgender (LGBT) charity. There were LGBT rainbow flags visible in the reception and around the hospital.
- The service's staff sickness level was 1.5% this was below that of the organisational average of 3.55%. Staff were entitled to organisational sick pay only at the managers discretion, otherwise they were entitled to statutory sick pay.
- Staff could access support from the occupational health service. In addition, there was a free phone support and counselling phone.
- The organisation had staff awards called Acts of Random Kindness (ARK). A member of staff from the hospital had recently been put forward for this.

Governance

- There was a clear framework of what should be discussed at meetings at ward, hospital and regional level. Staff shared information effectively and learning from incidents and complaints took place. There was a clear pathway from the ward to the top of the organisation for sharing information. Senior managers and hospital managers met regularly to discuss bed availability, blockages, patient progress, governance and best practice and updates from these meetings were shared with front line staff.
- We saw examples of how staff had made specific changes as a response to serious incidents and a complaint. Staff were responsive to complaints and incidents and made changes where they were needed.
- Staff were involved in local audits and there was a robust audit cycle that provided the service with assurance about medication, care records and Mental Health Act processes and patients' physical health.

Wards for people with learning disabilities or autism

- Staff worked with external providers to ensure that patients were safe and that their outcomes were positive. External stakeholders told us communication with the service was good and that the hospital worked well with them.

Management of risk, issues and performance

- Staff could escalate concerns to the risk register through the hospital manager who discussed these concerns at managers meetings.
- Staff concerns did match the items on the risk register. The risk register concerns were rated red, amber and green (RAG rated.) For example, staff talked to us about the requirement for more staff due to increased nursing observations and said that that had placed pressure on staffing. This was reflected in the risk register.
- The service had a business continuity plan. This was located in the reception area and was available for everyone to read. The business continuity plan clearly outlined the service plans for emergencies.
- Staff told us there were no cost improvement programmes in place.

Information management

- Staff had access to computer systems and a suitable patient information system
- The information governance systems ensured patient records were confidential.
- The hospital manager had the information that they required for their role. Data about quality of care, staffing and performance was accessible and the hospital manager was able to monitor the hospital's performance and to inform their weekly reporting to the regional manager.
- The dashboard system that the hospital manager used to manage, monitor and improve performance was clear and accessible to other managers and staff. A wide range of performance issues were reported on the system. This included staff supervision and training, restraints, patient activity and care plan progress.

- Staff made notifications to the Care Quality Commission when they were required to. Staff completed notifications effectively and promptly.

Engagement

- Staff received up to date information about the organisation and the service from their managers. The most senior managers in the organisation communicated with staff regularly by email and information from managers meetings was shared with staff at team meetings.
- We saw evidence that staff shared up to date information about the service at patients' community meetings. Updates were shared with carers at forums. Cygnet had an up to date website with information about their services.
- Patients and carers could give feedback about the service and they could do this in a way that met their needs. Patients and carers could feedback directly to senior managers by email.
- Staff had access to feedback and there was consistent evidence that staff had listened to this and reviewed elements of restrictive practice.
- Patients and carers views were considered when changes were made to the service. Patients were asked for their opinions about aspects of treatment and care.
- Patients were able to meet with the regional operations director when they visited the hospital.

Learning, continuous improvement and innovation

- Staff were encouraged to be involved in change and quality improvement and there was a culture of trying to improve.
- The occupational therapist was due to present a paper on autism as a professional conference later in the year.
- There were innovations taking place in the hospital including the projects about how the ward could improve discharge and admission processes.
- Staff did not take part in national audits.
- The hospital had not participated in an accreditation scheme relevant to their service.

Outstanding practice and areas for improvement

Outstanding practice

Staff had developed a training programme in the hospital to help staff to experience what it is like to be admitted and live at the hospital. Three support workers had completed this and further staff were booked in.

During this training staff 'walked in the shoes' of patients and went through the admission process as a patient would do. Staff spent six hours on the ward out of uniform. They were allocated a bedroom, attended the group programme and completed all relevant admission paperwork.

Staff members completed a questionnaire before and after the experience asking them what they expected of the experience beforehand and then what the reality was.

We reviewed staff feedback from this that demonstrated that staff had found the experience gave significant insight and empathy into the experience of patients.

The staff who had completed this had made suggestions about how they thought they should change the service to be more sensitive to the patients and to make the admission's process a better experience. The hospital manager was looking to make changes in response to staff comments.

Areas for improvement

Action the provider **MUST** take to improve

- The provider must ensure that staff comply with organisational dress code and personal appearance policy and do not wear gel nails and nail varnish.

Action the provider **SHOULD** take to improve

- The provider should ensure that there is a healthy ward culture and that patients' feedback about staff attitudes and responsiveness is addressed where required.
- The provider should ensure that staff are aware of the risk of sepsis, are trained to identify sepsis and that they can access the organisational policy for guidance.

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
Accommodation for persons who require nursing or personal care Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 12 Safe Care and Treatment The provider did not ensure that staff complied with dress code and personal appearance policy. This meant that there was some staffed posed a risk to infection control and patients' physical safety. This was a breach of regulation 2 (e) (h)