Cygnet Hospital Ealing

Quality Report

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Date of inspection visit: 24 May, 25 May and 2 June 2017
Date of publication: 10/08/2017

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

Ratings

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

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

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

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

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

Summary of findings

Overall summary

We rated Cygnet Hospital Ealing as **good** because:

- When the service was last inspected in March 2016, we made a number of recommendations. Most of these recommendations were met, although there were some outstanding issues. When the service was last inspected in March 2016, we found that the service had not ensured that all incidents where it is necessary to report directly to CQC had been reported. We found an improvement at this inspection.
- We also issued a number of recommendations for the service to consider improving. At this inspection we found that most of these recommendations were being met.
- Where there were ligature risks, these were identified in ligature risk assessments and managed depending on the individual risk presented by patients and their needs.
- The hospital had a comprehensive multi-disciplinary team which worked well together.
- The service had begun to look at specific ways to improve patient engagement including bringing in corporate experts by experience. This had had some success in developing user-led policies and input but needed to be further embedded.
- Medicines were managed safely.
- Members of staff on New Dawn had all undertaken training in dialectical behavioural therapy.

However:

- When the service was last inspected in March 2016, we recommended that the provider should continue to address poor staff attitude and ensure that patients were treated with dignity and respect. During this inspection, patient feedback from Sunrise ward raised concerns that some staff were not consistently respectful in their approaches to patients.
- Issues raised by patients during community meetings were not being addressed in a timely fashion.
- Some patients did not have sufficient access to activities at the weekends
- The staff team on Sunrise ward were not having the opportunity at team meetings to learn from incidents, complaints and audits.
- Supervision records for staff on Sunrise ward were not available for the hospital manager to review which meant the quality of supervision could not be audited.
- While there had been improvements in reducing restrictive practices in the service and some new initiatives had been rolled out, continued work needed to be done in this area.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Specialist eating disorders services	Good	We rated the eating disorder service as good because: • The service had begun work to look at the ward culture regarding restrictive practices and had started to make changes. Patients told us that they had noticed some improvements over the two weeks prior to the inspection visit. • The service had plans to extend patient engagement through the Cygnet expert by experience and bringing in an ex-patient to lead on this. • Patient care plans were clear and comprehensive and risk assessments were updated frequently. • Patients and family carers were positive about the ward consultants and their responsiveness. However, • We spoke with eight patients and received four feedback cards. All feedback we received from patients was negative of some aspects of empathy and thoughtfulness by staff. Although some patients told us that this was mixed. • While staff meetings took place on the ward, we saw in the minutes did not record discussion about incidents and performance across the hospital. • We checked patient community meeting minutes and it was not clear from the minutes what actions were taken following issues being raised or suggestions being made from patients. • Staff supervision records were not held centrally which meant that the quality of supervision could not be monitored by the hospital manager.
Tier 4 personality disorder services		We did not rate personality disorder services. We found that there were some areas where the service could improve. • Some patients raised concerns with us about some members of staff, discussing confidential information about other patients.

Summary of findings

- Some patients told us that they wanted to have access to more activities on the ward.
- We saw community meeting minutes and saw that patients repeatedly raised the same concerns over two months. It was not clear from the minutes what action had been taken when patients raised concerns and whose responsibilities these would be and how this information was fed back to patients.
- Patients were subject to a blanket restriction regarding searching patients when they returned from leave. This had not been determined based on individual patient risk.

However:

- Most patients and family members' feedback was positive about the service.
- The ward was clean and well-kept with quiet areas and communal areas for patients.
- Staffing was sufficient to meet the needs of the patient group.
- There were strong governance processes within the hospital. Information and data relating to ward performance was fed up to the hospital director by the ward manager and this fed into the wider governance within Cygnet. This meant that information about incidents, complaints and near misses could be analysed and evaluated so learning could be maximised.
- Staff told us that they felt supported.
- Patients' care plans and risk assessments were comprehensive and reflected the current situation of the patient.
- There was a strong multi-disciplinary team.

Summary of findings

Contents

Good

Cygnet Hospital Ealing

Services we looked at

Specialist eating disorders services; Personality disorder services

Summary of this inspection

Background to Cygnet Hospital Ealing

Cygnet Hospital, Ealing has two wards.

Sunrise ward is a ward for women over 18 who have eating disorders. It has 17 beds. The service offers psychological therapies as well as support and care relating to physical and mental health.

New Dawn ward is a specialist service for women over 18 who have diagnosed personality disorders. It has nine beds and offers predominantly dialectic behaviour therapy as a model for treatment.

The service is registered to undertake the following regulated activities:

- Care and treatment for persons detained under the Mental Health Act 1983
- Treatment for disease, disorder or injury

When the service was last inspected in March 2016, when both wards were inspected. We rated the hospital as good overall. At that inspection the service was issued with two requirement notices and recommendations of things which the hospital should consider improving. The service does not currently have a registered manager but the hospital manager who was newly in post at the time of our inspection, told us that they intended to apply to be the registered manager.

We have not rated the ward for patients with a diagnosis of personality disorder as we do not currently rate this specialist service.

Our inspection team

The team which inspected this service comprised of four CQC inspectors, one specialist advisor who was a nurse with specialist experience in eating disorders services and one expert by experience.

Why we carried out this inspection

We undertook this inspection to find out whether Cygnet Hospital Ealing had made improvements to its services since our last comprehensive inspection in March 2016. At that inspection, we rated the hospital as **good** overall. The hospital was rated as **requires improvement** for safe, and **good** for effective, caring, responsive and well led.

Following the March 2016 inspection, we told the provider it must take the following actions to improve its services:

- The provider must ensure that they submit all required statutory notifications to the CQC.

We also told the provider that it should consider taking the following action:

- The provider should ensure they actively work to reduce the use of prone restraint at the service and that restraint is conducted in a manner which upholds the dignity and privacy of patients.
- The provider should ensure that all ligature risks are adequately managed and mitigated.
- The provider should ensure that all information is fully completed on incident forms.
- The provider should ensure that all staff complete basic life support training and prescription writing and administration standards training.
- The provider should ensure that outstanding shortfalls identified following audits are followed up.
- The provider should ensure nursing staff fully understand their responsibilities in carrying out mental capacity assessments.

Summary of this inspection

- The provider should continue to ensure that poor staff attitude is addressed and that patients are treated with respect at all times.
- The provider should continue to address privacy and dignity concerns raised by patients in shared bedrooms.
- The provider should ensure that community meeting minutes are displayed in communal areas.
- The provider should ensure that care plans reflect what had been agreed in the ward rounds and updated in a timely manner.

We issued the provider with two requirement notices at the previous inspection. These related to the following regulations of the CQC (Registration) Regulations 2009.

- Regulation 18 Notification of other incidents
- Regulation 17 Notification of death or unauthorised absence of a person who is detained or liable to be detained under the Mental Health Act 1983.

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?
- Is it well-led?

Before visiting, we reviewed a range of information about Cygnet Hospital, Ealing. We carried out an announced inspection 24th and 25th May 2017 and returned with short notice to the hospital location on 2nd June 2017.

We looked at information provided to us beforehand by the provider as well as information given to us on site and we requested additional information from the provider following the inspection visit relating to the service.

We visited the specialist eating disorder ward and the specialist personality disorder ward. We did not rate the specialist personality disorder ward.

During the inspection visit, the inspection team:

- visited both wards of the hospital and looked at the quality of the ward environments as well as observing how staff cared for patients
- spoke with eleven patients who were using the service and three family carers of current patients and one family carer of a patient who had been recently discharged
- spoke with the ward managers, the clinical service manager, the hospital manager and the regional quality manager
- spoke with one ex-patient and one expert by experience lead for the provider
- spoke with 17 other staff members, including nurses, doctors, occupational therapists, social worker, psychologist and health care assistants and dietician
- spoke with the patients' advocate
- requested feedback from commissioners and reviewed feedback
- attended one ward round and one patients' community meeting
- looked at 11 care and treatment records of patients
- 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 we spoke with 11 patients. One patient contacted us outside the inspection and we also spoke with five family carers. We spoke with one ex-patient. We also received four comments cards.

Most patients we spoke with were negative about their experiences at Cygnet Hospital, Ealing. This was particularly the case on Sunrise ward which is the ward for women with eating disorders. The feedback which we received indicated that patients found the restrictive nature of their treatment regimens difficult to manage.

Summary of this inspection

Some patients told us that while there were some members of staff whom they felt treated them with care and respect, there were some other particular members of staff that had been less attentive.

Two patients raised concerns about staff members sleeping during the night shifts. We saw that this had been raised in patient community meetings particularly on Sunrise ward. We raised this with the service at the time of the inspection.

We checked the results of the family and friends test for the last quarter. There had been four responses relating to care and treatment provided at Cygnet Ealing. Two responses stated that they would not recommend the service, and they were from Sunrise ward, one response stated they would recommend the service from New Dawn ward and one stated they would neither recommend nor not recommend the service, from Sunrise ward.

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?

Good

We rated safe as **good** because

- When the service was last inspected in March 2016, we recommended that the service actively work to reduce the use of prone restraint and should ensure that restraint was conducted in a way that upholds the privacy and dignity of patients. At this inspection, we saw that the service had continued to work on reducing restrictive practice including the use of prone restraint and we saw that patients were involved in preparing restraint care plans.
- When the service was last inspected in March 2016, we had also identified that the service should ensure that ligature risks were adequately managed and mitigated. During this inspection, we found that ligature risk assessments were comprehensive and staff were aware of the key risk areas.
- The wards were clean and regular infection control audits took place.
- Patients' risk assessments were comprehensive and up to date.
- Staff had a good understanding of how to report incidents and the provider had a robust incident reporting system. When the service was last inspected in March 2016, we identified that staff should complete incident forms comprehensively. We found that this was an improvement during this inspection.
- Staff had a good understanding of safeguarding procedures. There was a dedicated safeguarding lead in the hospital who was the social worker and the service had also established regular meetings with the local authority safeguarding team with a police presence in order to coordinate safeguarding concerns and referrals.
- Staffing was sufficient to meet the needs of patients in the service and additional staff were available when it was necessary.
- Staff had completed relevant mandatory training. When the service was last inspected in March 2016, we recommended that staff complete basic life support training. At this inspection, this had been actioned.

However:

- Team meeting minutes on Sunrise ward did not clearly indicate how information following incidents was shared with the team and there was no documented discussion around learning from incidents within team meetings

Summary of this inspection

- While work had been done to reduce restrictive practices on Sunrise ward including blanket restrictions and the use of physical restraint, there was scope for further work in this area

Are services effective?

Good

We rated effective as **good** because :

- When the service was last inspected in March 2016, we recommended that the service should consider how they manage, record and archive patients' care plans. During this inspection, we found that patients' care plans were comprehensive and up to date, including feedback from patients. Patients were given copies of their care plans. There had been an improvement in this area.
- Medication was prescribed in line with best practice guidance and psychological therapies including dialectical behavioural therapy (DBT) and cognitive behavioural therapy (CBT) were offered. Patients also had access to family therapy.
- A dietician was employed to work with patients and although primarily based in the eating disorders service, did work across both wards.
- Staff had access to regular supervision and team meetings where information about the service was shared on New Dawn ward.
- Staff had a good understanding of the Mental Health Act.
- When the service was last inspected in March 2016, we recommended that nursing staff fully understand their responsibilities in carrying out mental capacity assessments. At this inspection, we found that staff were able to explain how they used the Mental Capacity Act in the context of their work and displayed a good understanding of this.

However:

- Supervision records on Sunrise ward did not always include a discussion about clinical practice and patient care
- Supervision records on Sunrise ward were not stored centrally. As records were not centrally held, it meant that they could not be audited by the hospital manager or ward manager.
- Staff meeting records from Sunrise ward were not immediately accessible on site during the inspection. We accessed these minutes after the inspection and it was not clear that every month, performance information including updates regarding incidents on the ward were discussed.

Are services caring?

Requires improvement

We rated caring as **requires improvement** because:

Summary of this inspection

- Feedback received from patients we spoke with on Sunrise ward was predominantly negative and raised issues relating to being treated by staff with a lack of dignity. In March 2016, we recommended that the provider should continue to ensure that poor staff attitude was addressed and that patients were treated with respect at all times. The feedback we received from patients did not reflect that significant changes had been made in this respect.
- On Sunrise ward, when patients were being cared for on a 1:1 close observation, there was a lack of engagement from staff that were carrying out the close observation.
- Issues and suggestions raised by patients in community meetings were not addressed in a timely manner. When the service was last inspected in March 2016, we recommended that the provider should ensure that community meeting minutes were displayed on communal areas in the ward. During this inspection, we found that community meeting minutes were available on wards but were not displayed in communal areas.

However:

- We observed one community meeting on Sunrise ward and saw that patients were encouraged to participate and raise concerns.
- The service had recently begun specific work on increasing patient involvement including having patient representatives on each ward and a patient representative who led on reducing restrictive practice to feed into the local work in these areas. There were also future plans to link in with a former patient to lead on patient involvement and some evidence of changes in practice as a result of increasing co-production through the development of guidelines initiated by patients for members of staff.
- When the service was last inspected in March 2016, we recommended that the provider continue to address privacy and dignity concerns raised by patients in shared bedrooms. During this inspection, we found that patients did not specifically raise concerns about shared bedrooms.
- Family members we spoke with were positive about the care that was delivered in the service.

Are services responsive?

Good

We rated responsive as **good** because:

- There were sufficient communal and quiet areas including a multi-faith room and garden with a balcony accessible to patients on the first floor.

Summary of this inspection

- There was a full therapeutic programme including plans to employ additional staff at the weekends to ensure that programmes could run over the weekends.
- Patients on New Dawn were positive about the food options available.
- Patients across the hospital told us that they were aware of the complaints procedure and we saw that information about how to make complaints was accessible on the wards.
- The service had access to interpretation and translation services for patients who did not speak English.

However:

- Some patients complained about the lack of activities during their time on the ward, particularly at weekends.

Are services well-led?

Good

We rated well-led as **good** because:

- The service had strong governance procedures whereby information from the service fed through information from the hospital manager into the regional and corporate leads within Cygnet. Information was available at the ward level to the ward manager and hospital level for the hospital manager to have an understanding of the performance of the service.
- Staff were positive about their experiences working for the provider and told us that they were able to raise concerns and felt heard by their management.
- The service had developed a coherent action plan based on a number of sources including family and friends' feedback, staff survey results as well as an analysis of incidents to improve the quality of care delivered in the hospital.
- Sunrise ward had achieved accreditation until 2017 from the Royal College of Psychiatrists Quality Network for Eating Disorders.
- The service was in the process of implementing "safe wards" programmes to further improve patient experience in the service.

However:

- When the service was last inspected in March 2016, we identified that the service had not made all notifications to CQC which it was required to do. During this inspection, we found that incidents had been notified to CQC but the service had not immediately notified CQC when the previous manager had been absent for over 28 days as they are required to do. They did complete this notification after the inspection visit.

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.

- Mental Health Act documentation was accurate and available.
- A Mental Health Act administrator working in the hospital who had oversight of the administration of the Mental Health Act.
- Staff had undertaken specific training related to the use of the Mental Health Act.
- Patients on the ward had access to an advocate who visited regularly
- Staff informed detained patients of their rights at regular intervals and this was correctly recorded.

Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff had undertaken specific training related to the Mental Capacity Act and Deprivation of Liberty Safeguards. At the time of our inspection, no patients were subject to authorisations of their deprivation of liberty.
- Staff we spoke with had a good understanding of the Mental Capacity Act and were able to give us examples of how it was used in practice.

Good

Specialist eating disorder services

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

Are specialist eating disorder services safe?

Good

Safe and clean environment

- The ward was set out with bedrooms and nurses offices on the first floor. Activity rooms were located on the ground floor. The service had installed convex mirrors to improve visibility at the corners of corridors. The service had also installed close circuit television (CCTV) cameras in corridors and communal areas. Staff could monitor CCTV footage in the nurses' office. Staff used recordings during investigations of incidents and complaints. Patients had signed a form to confirm they were aware that CCTV recordings were being made.
- At the previous inspection in March 2016, we recommended that the provider ensure that ligature risks be adequately managed and mitigated. We found there had been an improvement at this inspection.
- Although the service had installed anti-ligature features in patient's bathrooms, patients had unsupervised access to rooms with ligature points, such as the sensory room. The risk related to ligature risks present were mitigated through the use of patient observation and risk assessment which included assessing risk related to access to unsupervised areas in the ward. The estate manager completed a ligature audit in April 2017. The ward was in the process of replacing the fire alarms as the fittings had been identified as a ligature risk.
- Staff stored and dispensed medication from the clinic room. There was also a treatment room with a couch where staff weighed patients, took blood and inserted nasogastric tubes. A defibrillator, oxygen and a suction machine were kept in the clinic room. The first aid kit was complete and contained plasters and wound dressings. A comprehensive set of emergency drugs and equipment were stored in an emergency bag, including three epi-pens of adrenaline. The contents of this bag were checked each week and this was recorded. However, the bag did not have a security tag to show whether it had been opened or used since the last check. During the inspection we raised this and this was rectified during the inspection.
- The service had re-decorated the ward shortly before the inspection. Most areas were clean and well-maintained.
- The estate manager ensured that equipment was maintained and calibrated regularly as the hospital had a maintenance contract with an external company. This included the blood glucose monitoring machine and blood pressure machine. The electrocardiogram machine and weighing scales had been serviced. Staff had placed stickers on these machines to show they were due to be serviced again in August 2017. Staff recorded the temperature of the medicines fridge each day which was recorded.
- Housekeepers cleaned the ward each day. Patients received clean towels every two days and clean bed linen each week.
- Staff carried personal alarms. An electronic system indicated the location of an alarm that had been activated. This information was displayed in the nurses' office.

Safe staffing

- The ward had an establishment level of 12 nurses and 28 nursing assistants. There were three vacancies for nurses and four vacancies for nursing assistants.

- The sickness rate between 1 April 2016 and 30 March 2017 was 4.4%. This figure is slightly above the national average for health services. The turnover rate during this period was 21%.
- The number of staff allocated to the ward varied according to the needs of patients. Staffing levels were determined by the hospital management, using a bespoke tool which has been developed by the provider taking into account the needs and acuity of patients. The service used an e-rostering tool to ensure that shifts are covered up to three months in advance and so any gaps can be identified.
- Duty rotas showed that the number of staff required matched the number of staff allocated. The duty rota showed there were sufficient staff allocated to key tasks throughout the shift such as observations, supervision at meal times, and medication.
- Between 1 February 2017 and 30 April 2017, six shifts had been covered by bank staff and 38 shifts had been covered by agency staff. Staff were permitted to work up to 22 hours overtime per week. The ward manager monitored the number of hours staff worked overtime.
- Patients had regular one-to-one sessions with their named nurse.
- At the start of each shift, the shift co-ordinator allocated staff to specific tasks. Therapists facilitated most activities. These activities were rarely cancelled.
- The service allocated sufficient staff to each shift to ensure that physical interventions were carried out safely.
- A specialist doctor worked from 9.00am to 5.00pm from Monday to Friday. Outside these hours, there was an on call-rota of duty doctors. These doctors were associate specialists in mental health and had support from consultants who were eating disorders specialists. Consultants were available on-call out-of-hours.
- The service provided 32 mandatory training courses for staff, including intermediate life support, preventing and managing violence and aggression and safeguarding. In March 2017, compliance with mandatory training was 96%. When the service was last inspected in March 2016, we recommended that staff complete at least basic life support training. At this inspection, we found this had improved.

Assessing and managing risk to patients and staff

- There had been 24 incidents of restraint involving seven patients between 1 November 2016 and 30 March 2017. One incident involved staff restraining a patient in the prone position. This incident resulted in the patient receiving rapid tranquilisation. When the service was last inspected in March 2016, we recommended that the provider actively work to reduce the use of prone restraint and ensure that restraint was conducted in a manner which upholds the dignity and privacy of patients. At this inspection, we saw that prone restraint had reduced and patients had restraint care plans which they had been involved in developing.
- Staff completed a risk assessment of all patients on admission using a standard risk assessment tool known as the short-term assessment of risk and treatability (START). Risk assessments were updated after incidents. Risk assessments clearly identified trigger behaviours and ways that a patient should be provided with care and support regarding de-escalation, before considering other uses of restrictive practices such as restraint.
- Whilst all services for patients with eating disorders took place in a structured environment, the ward had tried to minimise blanket restrictions on patients. For example, medication times had become more flexible and patients were able to have mobile telephones unless these phones presented a specific risk to the patient. The times at which patients went to bed had recently become more flexible and patients could use the ward facilities, such as the patient lounge, whenever they wished to. However, patients raised concerns about restrictions on going out for walks and leave more generally. Prior to the inspection, the Cygnet reducing restrictive practice lead had spent a week on the ward to look at the practice and culture and to look at specific ways that this could be improved. The service had delivered workshops for staff particularly around looking at reducing restrictive practices and this was work which was continuing.
- The service used enhanced observations to reduce risks to patients. Staff placed patients on observation levels that required checks every 15 minutes if the risk levels determined that it was appropriate for specific patients. Staff could increase this to constant observation if necessary. Nurses reviewed enhanced observations at each handover meeting. The full multidisciplinary team reviewed observation levels at the ward round. Staff

searched patients when they returned from unescorted leave. Staff also carried out room searches if they thought patients had items that could present a risk to themselves or others. The provider had an established observation protocol which this linked to and staff were aware of this.

- Staff received training on de-escalation techniques. Restraint was only used after attempts to de-escalate situations failed. Staff recorded incidents of restraint on a standard form and this included all the necessary information.
- Staff recorded the use of rapid tranquilisation on a standard form. Records included the type of medication, the dose and the route. We checked two incidents of rapid tranquillisation which had happened in the six months prior to our inspection visit. We saw that while one incident recorded appropriate physical health checks after the rapid tranquillisation had been administered, one other incident did not indicate that the necessary physical health checks had been completed. This meant that there was a risk that when patients were administered with rapid tranquillisation there was not a clear way of evidencing that all physical health checks had been completed.
- We checked the medication audits between 1 January 2017 and 1 May 2017 there had been four significant interventions when stock medication had not been administered because it was out of stock. We followed this up during the inspection and the service told us that improvements had taken place including additional training for staff but that they were aware of this issue and were taking action to address it and included changing protocols about when medication was ordered. Medication was managed by a pharmacist who visited regularly and the storage and dispensing of medication was carried out appropriately.
- All staff received training in safeguarding and knew how to raise concerns. The hospital had appointed a safeguarding lead who reported concerns to the local authorities. When staff identified safeguarding concerns, they created a safeguarding plan to ensure the immediate safety of the patient, reported the incident to the appropriate agencies and conduct a more thorough investigation if necessary. The hospital safeguarding lead kept a tracker document which ensured that any safeguarding referrals made were followed up in a timely manner. The service had developed a link with an individual social worker in the London Borough of Ealing adult safeguarding team which meant that information, advice and follow up was readily available. The hospital had set up monthly safeguarding meetings with the local authority and these were also attended by a representative of the local community police team. This meant that there were extensive opportunities for information to be shared and discussed relating to safeguarding at the hospital.
- Patients could arrange for children to visit. The service required children to be accompanied by an adult at all times. Visits took place in rooms adjacent to the reception area of the hospital. Children did not visit patients on the ward.

Track record on safety

- Between 1 April 2016 and 30 April 2017, the ward had eight serious incidents which had been reported. Three of these related to patients who had been absent without leave. Two of these incidents related to self-harm and one was an error by the service where a nasogastric tube had been incorrectly inserted.
- The service took action to address the causes of incidents. For example, a patient had recently absconded from the hospital by climbing through a window. The hospital had installed restrictors on the window opening mechanism to prevent this from happening again.

Reporting incidents and learning from when things go wrong

- When the service was last inspected in March 2016, we recommended that the provider should ensure that information was fully completed in incident forms. At this inspection, we found that incident forms we checked were comprehensively completed.
- Staff knew how to report incidents on an electronic record. The initial record included a description of the incident and details of immediate action taken. Incident reports were passed to the clinical services manager who completed an initial investigation.
- This initial incident report included details of any action in relation to the hospital's duty of candour, such as a debriefing with the patient and informing the family.

Good

Specialist eating disorder services

- Staff discussed all incidents in handover meetings. Staff held specific debriefing meetings to identify the triggers to the incident and create plan to manage similar incidents effectively if they occurred again.
- Staff told us that they discussed serious incidents at team meetings. However, we asked for staff meeting minutes during the inspection and they were not immediately available as the ward manager was not available. We were sent minutes from the recent staff meetings following the inspection and saw that since the beginning of 2017, there were only two sets of recorded minutes for January 2017 and March 2017. These meetings did not have a clear discussion of incidents and complaints across the ward, hospital and provider which meant that it was not clear how information from the board was shared with staff and that there was a risk that staff on the ward may not receive all the information about learning from incidents, audits and complaints that was available in order to improve their practice.

Are specialist eating disorder services effective?

(for example, treatment is effective)

Good

Assessment of needs and planning of care

- Initial assessments were comprehensive, holistic and included patients' perceptions of their needs on admission. This included an assessment of the presenting complaint, a review of the patient's psychiatric and physical history, a mental state examination and a review of the patient's medicines. An initial management plan was prepared on the basis of these assessments.
- A full physical examination of the patient took place when they were admitted and was updated regularly. This included an assessment of skin integrity. Staff completed physical health checks on patients four times each day in the period shortly after admission. This reduced to twice a day and daily and was reviewed according to patient need.
- When the service was last inspected in March 2016, we recommended that the service ensure that care plans reflected discussions which had been agreed at ward rounds and that they were updated in a timely manner. At this inspection, we found that there had been an improvement in this area.
- Care records were up to date, personalised and holistic. All members of the multidisciplinary team made entries in the care record. Patients had different care plans for different aspects of their care and treatment. For example, one patient had personal care plans entitled "Understanding my mental health", "My safety planning", "Learning more about myself", "Staying healthy" and "My life skills." Patients met with a nurse each week to update their "My Shared Pathway" workbook. This provided a review of the progress the patient had made during the week. We saw that patients had access to a range of therapies including occupational therapy groups and psychology. We found that where it was relevant, patients had specific care plans which reflected physical health care needs or a need for female staff only to undertake 1:1 observations.
- When the service was last inspected in March 2016, we recommended that the service consider how they manage recording and archiving patient care plans and risk assessments. At this inspection, we found that patient records were stored appropriately.
- Patient records were held on paper files and stored in the nurses' office. The service held some information electronically. Staff were required to input a personal user name and password to access electronic information

Best practice in treatment and care

- Doctors prescribed medicine in accordance with guidance from the National Institute for Health and Care Excellence (NICE). Medicine was not offered as the sole treatment for anorexia, although low doses of medicine were used for the treatment of mental illness, including anti-depressants, anti-psychotics and anxiolytics. These medicines were often prescribed to manage the symptoms of comorbidities such as personality disorder, post-traumatic stress disorder and obsessive-compulsive disorders.
- The service offered psychological therapies including psychotherapy, drama therapy, dialectical behavioural therapy and cognitive behavioural therapy**.** One member of staff was also qualified to provide sand play

therapy. While psychological input was usually not offered to patients who had a body mass index (BMI) under 15, this decision was made on an individual basis, and each patients needs were reviewed individually.

- The ward provided care and treatment within a structured environment with a therapeutic programme. This involved three phases of treatment according to the patient's BMI. For patients with a BMI of less than 15, the aim of treatment was to improve physical health and restore the patient's weight. For patients with a BMI greater than 15, treatment focused on psychological therapies. Patients with a BMI above 18 began a rehabilitation programme that supported the patient to become more independent and take more responsibility for their eating.
- All patients were registered with a local GP. The ward doctor worked closely with the GP when necessary.
- The ward doctor worked closely with the GP and local hospital to ensure that patients had access to physical healthcare, including access to specialists. For example, the doctor liaised with the neurologist at the local hospital to agree appropriate prescribing, and management of side effects, for patients with epilepsy.
- The service employed a full time dietician. The dietician worked within the multidisciplinary team with the aim of restoring patients back to a healthy metabolic rate as quickly and safely as possible. The dietician assessed patients for the risk of refeeding syndrome on admission. This assessment involved an electrocardiogram and blood tests. A flowchart was used to indicate which meal plan should be used. Staff expected patients to eat in their bedrooms for the first few days. This allowed staff to assess patients eating behaviours. The multidisciplinary team would review any patients who did not complete their meals. In these circumstances, the team would consider nasogastric feeding, depending on the patient's legal status, physical health and risks. The consultant psychiatrist, ward doctor, dietician and ward manager met to oversee the implementation of national guidance on eating disorders. This group reviewed any incidents relating to nutritional risk and incorporated national guidance into a local policy.
- The service used the health of the nation outcome scales (HoNOS) to measure patients' progress. The service also weighed patients twice a week. Psychology staff also used a standard outcome measure for patients with eating disorders like the eating disorders examination questionnaire (EDE-Q) as well as using structured clinical interviews for diagnostic purposes (SCID – 5) and to interpret information from patients.
- The clinical team leader and senior nurses carried out regular audits. An audit of the use of nasogastric feeding and one-to-one observations was carried out each week in order to monitor its use. Patients' records were audited each month to check that quality was adequate. Assessments of capacity to consent to treatment were audited every three months.
- There was an occupational therapy team which had input onto the ward and offered a variety of programmes, including group work and creative work. The occupational therapists worked toward specific identified models such as using remotivation processes and vocational questionnaires.

Skilled staff to deliver care

- The multidisciplinary team included a consultant psychiatrist, a junior doctor, a social worker, occupational therapists, psychologists, a dietician, nurses and nursing assistants.
- Many of the staff had worked at the hospital for a number of years and were experienced in working with people with eating disorders.
- New staff received a standard induction that took place over four weeks. During the induction period, new staff completed a workbook covering the values and behaviours expected by the organisation, as well as key areas of policy and practice. New staff were allocated an 'induction buddy' who they shadowed for two or three days before starting work in their designated role.
- The organisation's policy stated that staff were expected to access supervision on a monthly basis. The ward manager did not have access to supervision records which staff had completed following supervision sessions. The supervisor kept the notes and classified them as confidential. This meant that there was a risk that the managers within the service were unable to audit the quality of supervision. We checked three supervision records provided by one supervisor and saw that, for example, issues relating to the management of patient care was not consistently discussed. This meant that there was a risk that supervision was not used to promote or develop clinical practice and skills.
- Reflective practice meetings took place once a month.

- The ward manager told us that the service had team meetings monthly. Staff meeting minutes were handwritten and it was not clear how staff who were not present could access this information or ensure that the minutes were available for all staff, including agency and bank staff.
- At the start of April 2017, 96% of staff had completed an annual appraisal. Both doctors' revalidation was up to date.
- Staff received specialist training for their role. For example, in February 2017 ten staff had completed training in nasogastric feeding. This training involved learning about the theory and practice on a dummy, shadowing a colleague who was inserting a tube and then carrying out the procedure under supervision. Staff had also completed training on the recovery star, smoking cessation and infection prevention and control.
- The service suspended staff, or moved them to administrative duties, if any patients made an allegation against them. Managers investigated all allegations and took further action if necessary.

Multi-disciplinary and inter-agency team work

- Each patient attended a multidisciplinary ward round each week. The consultant psychiatrist chaired the meeting. All staff contributed to the discussions. During the meetings staff and the patient reviewed their progress, updated risk assessments and reviewed arrangements for leave.
- Staff held a handover meeting twice a day, at the start and end of each shift. Notes from these meetings included background information about each patient, and current information about risks and observation levels.

Adherence to the MHA and the MHA Code of Practice

- On the day of our inspection, 11 out of 16 patients were detained under section three of the Mental Health Act.
- A MHA administrator provided support in following the requirements of the Act.
- The responsible clinician's authorisations of leave for detained patients were kept in a folder in the nurses' office. The responsible clinician completed an authorisation form providing full details of leave, such as the times of leave, frequency, where the patient could go and who they could go with. Staff stored these forms alongside risk assessments and a record of leave that patients had taken.
- In March 2017, 95% of staff had completed mandatory training on the MHA Code of Practice.
- When patients were detained under the MHA, staff attached certificates to their medicine charts to confirm that the patient was consenting to treatment. The responsible clinician completed an assessment of the patient's capacity to consent to treatment. Copies of these assessments were also attached to the medicine chart. Medicine charts included details of medication that could be used when it was required. On one patient record, medication given in an emergency was authorised by the doctor using the appropriate part of the MHA.
- Staff recorded discussions they had with detained patients about their rights and how the MHA applied to them.
- The service took steps to ensure that informal patients were aware of their right to leave the ward. The service displayed notices next to the ward exit advising informal patients that they could leave. Records showed that staff spoke to informal patients about their rights and provided written information about this. We checked the records of the informal patients and saw that clear capacity assessments had been undertaken to establish that they had capacity to consent to their admission on the ward.
- Staff could access advice about the MHA through the MHA administrator.
- Staff had correctly completed the statutory paperwork relating to the MHA. Documents were up to date and stored appropriately.
- A clinical team leader completed audits of documents relating to consent to treatment and mental capacity every three months.
- An Independent Mental Health Advocate (IMHA) visited the ward once a week. The IMHA attended ward rounds with patients, supported patients to understand how the MHA applied to them and assisted patients in making complaints

Good practice in applying the MCA

Good

Specialist eating disorder services

- In March 2017, 98% of staff had completed mandatory training on the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards.
- When the service was last inspected in March 2016, we recommended that nursing staff should fully understand their responsibilities in carrying out assessments of mental capacity. At this inspection, we found this had improved.
- Staff had an understanding of the MCA. We saw that one patient who had been admitted informally under the Mental Health Act, had a clearly documented assessment of capacity and agreement to proceed with the treatment regime. This evidenced that they had capacity to consent to treatment and had consented to their admission and some of the restrictions which had been introduced. This was a good example of understanding of the Mental Capacity Act and the way it was used on an eating disorders ward in respect to some of the restrictive treatment regimes.

Are specialist eating disorder services caring?

Requires improvement

Kindness, dignity, respect and support

- We observed staff responding to patients with care and kindness. Within community meetings, staff and patients chatted together in a friendly and pleasant manner. However, during our time on the ward, we also observed that some staff carrying out one-to-one observations of patients were not engaging with the patients. This reflected some of the feedback which we received from patients which included staff who were involved in one to one were not fully attentive when observing patients.
- When the service was last inspected in March 2016, we recommended that the provider should continue to ensure that poor staff attitude is addressed and that patients are treated with respect at all times. At this inspection, we found patients reported concerns about not being treated with respect consistently by all staff members. So this continued to be a concern.
- We interviewed eight out of 16 patients and received comment cards from three patients. We also received feedback from a former patient prior to the inspection. Feedback from patients was about the way staff treat them was consistently negative. Three patients specifically said they had not been treated with dignity or respect. For example, one patient said they had felt belittled by things staff said. Some patients said the psychiatrist was caring and helpful, and one patient acknowledged that many of the permanent staff were very good. Patients who were not detained under the Mental Health Act and who had agreed to their admission told us that it felt as if they were detained due to the restrictions on the wards. We checked the records of these patients and saw that there were capacity assessments in place to indicate that they had consented to their admissions and to the rules that were in place resulting from the admission as they wished to recover.
- At our previous inspection in March 2016, we recommended that the service should continue to address privacy and dignity concerns raised by patients in shared bedrooms. During this inspection, this was not raised by patients as a specific concern.
- Some patients also said there had been improvements on the ward in the weeks prior to the inspection. Feedback from two family carers that we spoke to was very positive, particularly concerning the ward consultant and feeling that they were listened to and that the care provided was of a good standard. However, the feedback of the patients meant that there was a risk that their voices were not being heard and that they did not feel listened to.
- Staff were familiar with patients and had a good understanding of their needs. Within the ward round, staff demonstrated a good understanding of patients' histories, their relationships with their families, the things they found most challenging and their aspirations for the future.
- Patient feedback was also received through the regular friends and family test at the hospital. The most recent family and friends information which was held by the hospital which was gathered between 1 March 2017 and 30 April 2017 was completed by three patients who were on Sunrise ward. Two of these indicated that they would be unlikely to recommend the hospital and one indicated that they would neither recommend nor not recommend the service to others.

Good

Specialist eating disorder services

The involvement of people in the care they receive

- When patients were admitted to the ward, they were given an induction to the service. This induction involved being shown around the ward and being introduced to staff and patients. Patients received a 'Service User Handbook' that gave details of the rules and routines of the ward, as well as explaining the roles and responsibilities of each member of staff.
- Some patients said they were not involved in decisions about their care and treatment. However, care plans included patient's views and progress notes showed that patients had one-to-one meetings with staff. Within the ward round, the consultant psychiatrist made most decisions after a lengthy discussion with the patient.
- Patients had access to an advocate who visited each week. During our inspection, the advocate was supporting six patients. The advocate often supported patients with complaints. These complaints often involved small concerns such as patients being told to wait for things, appointments not being made on time, leave not being facilitated and staff not responding to patients requests. The advocate escalated concerns to senior managers.
- Some patients asked for their families and carers to be involved in their care and treatment. When patients requested this, family members were invited to ward rounds where they could contribute to decisions about care and treatment.
- The service had started to increase co-production work which was led by a Cygnet expert by experience lead. There had been some actions and progress on specific issues. For example, we saw that patients had established a contract whereby two members of staff would be identified every shift to prioritise assistance and access to the locked toilet and bathroom for patients. This was so that patients knew who to ask and staff would always be available to do this. This meant that there were some initiatives in place to increase involvement. The service also had plans to engage a former patient to lead on patient experience work in the hospital.
- Community meetings were held once a week at which patients could give feedback about the way the service was run. However, when we asked for meeting minutes, these were not consistently recorded. For example, while there was a standard agenda, on some meeting minutes, this was blank meaning it was not clear whether the issues had been discussed or not. There was no clear place on the ward where minutes were displayed for patients as they were kept in a file. These meetings were well attended by staff and patients but minutes did not consistently document who attended the meetings. Patients had raised concerns about there being low staff numbers and night staff sleeping on duty. In the minutes where patients had raised concerns about night staff sleeping, they had been told initially that no action was to be taken because they could not provide the ward manager with the names of the staff that they were making allegations regarding. It was only after subsequent meetings and a further complaint that there was an agreement for managers to conduct night time checks.
- When the service was last inspected in March 2016, we recommended that community meeting minutes be displayed in communal areas on the ward. That was not the case when we visited although they were present on the ward and available on request, they were not clearly displayed.
- We attended one community meeting where we saw that patients were encouraged to speak up and share feedback and concerns with staff in an open manner and where minutes from the previous meeting were read. However, It was not clear from the meeting minutes reviewed that issues raised by patients were responded to with clarity and in a timely manner. For example, in April patients raised issues concerning mugs on the wards and access to pets such as therapy dogs. The minutes stated that a member of staff would look into this but it was not clear from the subsequent meeting what had happened and whether these issues had been actioned or were still pending. This meant that there was a risk that the lack of clear actions and responsibilities in the community meeting minutes could mean that significant issues raised by patients within this forum were not being addressed appropriately.

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

Good

Specialist eating disorder services

Good

Access and discharge

- Between 1 November 2016 and 30 April 2017, bed occupancy was 95%. The average length of stay for patients discharged between 1 April 2016 and 30 March 2017 was nine months. This reflected the treatment pathway.
- The ward provided a national service. Patients came to the ward from across England.
- The service only transferred patients to other wards or hospitals if they required treatment or investigation for their physical health.
- The service only admitted patients to the ward on the days that ward rounds took place, usually a Tuesday or Wednesday. This meant that all the multidisciplinary team would be available to carry out assessments as soon as possible. Discharges were planned in advance and took place during the day.
- The service transferred patients to psychiatric intensive care units if patients required more intensive care.
- Between 1 November 2016 and 30 April 2017, the discharge of one patient had been delayed for non-clinical reasons. No patients had been readmitted within 90 days of discharge.

The facilities promote recovery, comfort, dignity and confidentiality

- The ward had a full range of rooms, including a clinic room, treatment room, dining room, lounge, activity rooms and meeting rooms. There were three single bedrooms. All other bedrooms were shared by two patients. Sleeping areas were divided by a curtain. All bedrooms had ensuite facilities.
- There were quiet areas where patients could meet with visitors.
- All patients had mobile telephones and were able to make calls in private.
- Patients had access to a large balcony. The service facilitated short walks for patients each day.
- Patients' access to hot drinks and snacks was strictly regulated by their treatment plans.
- Patients could personalise their bedrooms, and most chose to do so.
- Patients could securely store their possessions.
- The service provided a comprehensive range of therapeutic and recreational activities during the week. However, patients reported to us that there was a very limited choice of activities at weekends. The service had employed assistant psychologists who worked at the weekend but this was a new initiative.

Meeting the needs of all people who use the service

- The ward had a lift to allow access for people with disabilities. The service provided medical bed and supportive mattresses for patients who needed them.
- Information leaflets could be translated into different languages and staff were aware how to access information in other languages.
- The service could access interpreters and signers if required.
- Food was prepared on site. This meant the service could provide meals to meet the specific dietary needs of patients.
- Patients could access spiritual support if requested. There was a multi-faith room within the service on the ground floor which could be accessed by patients on the ward.

Listening to and learning from concerns and complaints

- The service had received 12 complaints in the past 12 months. The service had upheld four of these complaints. None of these complaints had been referred to the ombudsman. Complaints related to the functioning of appliances, the quality of care, staffing and medication.
- Patients knew how to complain. Two patients told us they had made complaints but were dissatisfied with the outcome. However, their complaints had been investigated in line with the provider's policy.
- The ward did not have a system of recording informal concerns raised by patients. This meant that there was a risk that learning and outcomes from more informal complaints may not be captured.

Are specialist eating disorder services well-led?

Good

Specialist eating disorder services

Good

Vision and values

- Staff were familiar with the organisation's values of helpful, responsible, respectful, honest and empathic.
- The team's main objectives were to improve the quality of care through reducing the use of agency staff and reducing the restrictions placed on patients. Both these objectives reflected the values and objectives of the hospital.
- The Cygnet Hospital Ealing was a small hospital with only two wards. All the staff knew who the senior managers were and these managers frequently visited the ward.

Good governance

- The hospital had a robust governance system in place which involved information being shared from the ward level by the ward manager through monthly reports to the hospital manager and at monthly hospital-wide integrated governance meetings. These meetings were attended by a regional quality assurance manager and the information was fed up to the Cygnet board so that there was oversight of issues at Cygnet Ealing.
- Staff meeting minutes on Sunrise ward, which we saw, did not clearly establish that information about incidents was discussed in the context of improvement and that performance information from the integrated governance meetings and from the provider's board was being picked up on a ward level.
- The service had recently appointed a new hospital manager and had developed an action plan based on feedback from quality visits, audits and learning from incidents and complaints. This action plan was updated and monitored regularly to ensure that improvements were on course.
- At the beginning of the inspection, the hospital manager identified key areas of improvement within the hospital and actions were in place to address these areas.
- However the hospital had not submitted a notification of absence of a registered manager. When registered managers are absent for a service for over 28 days, there is a requirement that the service notifies the Care Quality Commission formally. When we arrived at the inspection, we found that the registered manager had been absent for over 28 days as they had left the service to take another job. There had been an interim manager and the new manager had come into post but no notification had been made to CQC regarding the absence of a registered manager. We discussed this with the service during the inspection and the notification was made following the inspection. However, this meant that there was a gap in understanding regarding the legal requirements about notifying CQC in specific incidents.
- Information available to the hospital director was extensive. They were able to analyse incidents and key performance indicators at a ward and service level as well as comparing their service with other services run by the provider. This meant that the manager was able to establish themes regarding incidents, sick leave and other information points to ensure the effective running of the service.

Leadership, morale and staff engagement

- None of the staff raised concerns about bullying or harassment. Staff knew how to raise concerns and told us that they felt able to do so without fear of victimisation.
- Morale was good. Staff described the ward as being a nice place to work and positive about the focus on reducing restrictive practices on the ward which was a relatively new initiative within the service.
- There were opportunities for leadership development. The managers had recently promoted some healthcare assistants to being senior healthcare assistants. Managers within Cygnet also had a leadership development programme.
- Staff valued the support they received from their colleagues. Staff discussed any concerns in handover meetings. Annually the service undertook a staff survey. The outcomes of the staff survey fed into the hospital action plan.

Commitment to quality improvement and innovation

- The ward had achieved accreditation as part of the Quality Network for Eating Disorders. This accreditation was awarded by the Royal College of Psychiatrists and was valid until 2017.

Tier 4 personality disorder services

Safe	
Effective	
Caring	
Responsive	
Well-led	

Are tier 4 personality disorder services safe?

Safe and clean environment

- The ward layout meant there were some blind spots that staff could not observe. Examples of blind sports included areas on the corridor near the entrance of the ward and near the shower room. The ward mitigated this through the use of convex mirrors to increase visibility of corridors for staff and closed circuit television (CCTV). Staff could monitor CCTV from the nursing office.
- When the service was last inspected in March 2016, we recommended that the provider ensure that ligature risks be adequately managed and mitigated. We found there had been an improvement at this inspection.
- The ward had ligature anchor points on the ward, for example the fire alarm in the corridor. Staff mitigated the risk presented by ligatures through the use of a ligature risk assessment and an environmental risk assessment. The ligature risk assessment was last updated in April 2017. We identified that the ligature risk assessment provided a detailed and descriptive assessment of all ligature anchor points across the ward. The ligature risk assessment included photos of the ligature, information regarding the risk rating as well as the location and how staff address and managed these risks. The ward manager kept the ligature risk assessment on the ward.
- The clinic room was small but clean and tidy. Staff checked and recorded fridge temperatures each day. Clinic rooms were small and there was no room for examination couches. This meant that physical examinations took place in patients' bedrooms to maintain privacy and dignity. Staff were aware of the location of ligature cutters which in addition to the first aid box were located in the nursing office.
- Emergency equipment included a blood pressure machine, resuscitation equipment, pulse oximeter machines and scales. Staff checked the resuscitation bag on a daily basis. The facilities department was responsible for the maintenance of equipment. We checked maintenance records and saw that this was up to date. Records showed that staff calibrated equipment and contractors carried out portable appliance tests.
- The ward was clean and furniture was well maintained.
- The ward conducted an infection control audit every other month. Guidance and information about handwashing techniques was clearly visible throughout the ward. An annual infection control audit was also carried out across the hospital which identified areas where improvements could be made.
- A health and safety manager conducted a monthly environmental risk assessment. The ward manager allocated the role of security to a member of staff on each shift. The member of staff conducted an environmental check on each shift.
- The hospital issued personal alarms to all staff. The hospital carried out reviews of the alarm system to ensure it worked correctly. There were no alarms in patients' bedrooms.

Safe staffing

- The service allocated five full time nurses and nine nursing assistants to the ward. There was one vacancy for a nurse. Two of the five nurses were team leaders and two of the nine support workers were designated senior support workers. Between 1 April 2016 and 30 March 2017, the staff turnover rate was 8% and the sickness rate was 1.5%.
- Staffing levels were determined using a bespoke tool which had been developed by the provider taking into

account the needs and acuity of patients. The service used an e-rostering tool to ensure that shifts are covered up to three months in advance and so any gaps could be identified.

- The service operated two shifts a day. During the day, the service allocated four staff to the ward, including two qualified nurses. At night, the service allocated three staff, including one qualified nurse.
- Between 1 February 2017 and 30 April 2017, the service used agency staff to cover six shifts. The service had used bank staff to cover 38 shifts. Bank staff were familiar with the ward and patient group which promoted continuity of care
- Ward staff were able to book additional bank staff from the service's pool of workers if the ward needed more staff, for example, to conduct enhanced observations or if there was an increased level of risk on the ward. The ward manager approved additional agency staff for the ward as necessary.
- A member of staff was present in communal areas at all times.
- Staff we spoke with were able to provide time to meet with patients for one to one sessions. However patients told us that they felt staff could sometimes be too busy to escort them for leave or to the garden and that the ward sometimes felt short staffed.
- The consultant psychiatrist for the ward was also the medical director at the hospital. The consultant psychiatrist attended the ward on Wednesdays for a ward round and consultations on Fridays. The ward also had a permanent ward doctor who worked 9-5 Monday to Friday. Out of hours cover was provided by a range of duty doctors.
- Staff received mandatory training. The average mandatory training rate for staff was 94% as at April 2017. This Included safeguarding adults and children, equality and diversity training, basic life support and additional courses as indicated by the provider. When the service was last inspected in March 2016, we recommended that staff complete at least basic life support training. At this inspection, we found this had improved. Basic life support training was conducted in person with trainers and included use of simulation with artificial models to increase staff confidence in using CPR.
- Between 1 November 2016 and 30 April 2017, there were 27 incidents of staff using restraint on patients. Five patients were involved in these incidents. One restraint was in the prone position and one of these restraints had resulted in the use of rapid tranquillisation. When the service was last inspected in March 2016, we recommended that the provider actively work to reduce the use of prone restraint and ensure that restraint was conducted in a manner which upholds the dignity and privacy of patients. At this inspection, we saw that prone restraint had reduced and patients had restraint care plans which they had been involved in developing.
- The provider had implemented a strategy to minimise the use of restrictive practices on the ward. This aimed to reduce the use of restraint. The ward had a lead member of staff who took an interest in reducing restrictive practice including restraint and blanket restrictions. They with the ward manager reported on the use of restraint and promoted learning on how to reduce the use of restraint and other restrictive practices.
- Staff undertook a risk assessment of patients when they arrived on the ward using a recognised tool which was the START risk assessment tool. Staff met the target of completing this assessment within 72 hours following admission. Staff reviewed this risk assessment this every three months or after incidents. The risk assessments had identified areas of risk such as social skills, medication adherence, violence, self-neglect and insight. Staff had regularly updated risk assessments after incidents to ensure that current information was available.
- The service displayed a notice on the door to the ward advising informal patients of their right to leave. We spoke with one informal patient who understood their rights as an informal patient.
- The service placed patients who presented a heightened level of risk on enhanced observations. This was in line with an observation policy and there were different levels of observation depending on the needs of individual patients and their associated risk. Enhanced observation levels could be every 15 minutes, constant one-to-one observation within eyesight, constant one-to-one observation within arms-length or two-to-one observation. If someone arrived at the ward having been on one-to-one observations at the previous

Assessing and managing risk to patients and staff

hospital, this was continued. Staff reviewed observation levels at handovers and MDT meetings. Staff could only reduce the level of observation after a review by a doctor.

- The service did not permit patients to have items that could cause harm such as sharp objects, drugs, alcohol or cigarette lighters.
- Staff searched each patient's property when they were admitted and when they returned from leave. Patient could store some restricted items in their own personal storage box. Nurses stored these boxes in the nursing office. The service had a clear policy and protocol related to searching patients which included the need to search bags which patients returned with after having leave. A decision about personal searches was made by ward staff on the basis of risk.
- The provider had an agreement with an external pharmacy organisation to supply medication and pharmacy services to the hospital. The external organisation carried out audits of medicine, medicine charts and clinic rooms on a weekly basis. The organisation provided learning to staff around medication management. The ward stored medicines securely in clinic rooms and recorded temperatures for fridges and the clinic room.
- The ward conducted a monthly prescription chart audit. The audit checked patient details such as weight and height, correct signatures and dates, names recorded, boxes signed off following administration, discontinued drugs clearly marked, correct coding and T2 forms were correctly completed. From this audit we observed that in March and April there were some drug omissions identified. However these were not indicated to have a significant impact on patient health and safety and related to medication being out of stock. We spoke with the hospital about this concern and were told that this happened when ward rounds advised changes in medication and medication needed to be ordered before 10am to be delivered on the same day. The service is looking at changes in the procedures which will ensure that this does not happen in the future. Patients also raised the issue of medication sometimes being out of stock in their community meetings. The ward manager's monthly report had also documented two medication management incidents in March 2017 that related to delivery of medicines to the wrong unit and prescribing and administration actions leading to doses being exceeded. Staff were aware of these incidents and the consultant psychiatrist had recorded an action to supervise staff when dispensing medicines and the external pharmacist provided additional medicines management training. All staff who supervised medication were required to undertake e-learning which was renewed annually.
- We saw that four patients had incidents recorded where medication had not been administered due to the medication being out of stock. This had been identified on the pharmacy audit. However, it was not clear what action had been taken to minimise future impact. This meant that there was a risk that this practice may continue.
- When children visited patients, they met in a specifically designated room in the hospital.
- Staff had a good understanding of safeguarding and there was a safeguarding lead in the hospital who was the hospital's lead social worker. There was a clear log of all incidents which had been referred to the local safeguarding team and staff were aware that they could access advice and support relating to safeguarding issues. The hospital had an identified link with a specific social worker in the Ealing safeguarding adults team. This ensured that feedback could be tracked and protection plans for individual patients were discussed in multidisciplinary team meetings. The hospital had set up monthly safeguarding meetings with the local authority and these were also attended by a representative of the local community police team. This meant that there were extensive opportunities for information to be shared and discussed relating to safeguarding at the hospital.

Track record on safety

- The ward had two serious incidents from 1 April 2016 to 30 April 2017. One of these incidents involved a patient not returning from leave and an incident of self-harm.

Reporting incidents and learning from when things go wrong

- When the service was last inspected in March 2016, we recommended that the provider should ensure that information was fully completed in incident forms. At this inspection, we found that incident forms we checked were comprehensively completed.
- Staff knew how to complete an incident form. Incidents and accidents were reported using the provider's incident and accident reporting log book. Staff also

recorded incidents in patient's progress notes. The ward manager reviewed the incident form, signed off the form and sent it to the clinical manager for review. The clinical manager reviewed all incidents and accidents reports. The clinical manager reported the findings of all serious untoward incident investigations to the monthly integrated clinical governance meeting. Incident forms also went to the provider's safety team who reviewed the incidents. This meant that there were robust systems in place to ensure that information about current incidents and learning could be shared.

- Staff said they were open and transparent with patients when things went wrong. Staff informed the patient's nominated close relative if the patient was involved in a serious incident. The provider had a duty of candour policy which stated it was the ward manager or senior manager's responsibility to contact families or next of kin depending on the nature of an incident. The hospital manager was aware of this process.
- Learning from incidents was shared during debrief sessions and handovers. Ward managers completed monthly ward reports on governance of the ward which reflected and shared learning through analysis of incidents. The clinical manager produced a monthly summary of serious incidents that included outcomes and lessons. Staff team meeting minutes were recorded and documented so that staff could have access to them if they were not present. Staff discussed incidents, complaints and learning from incidents during staff meetings.
- The hospital debriefed staff after incidents and the provider had arrangements for staff to contact external psychologists confidentially. The ward had a debrief log which recorded debriefs and staffs reflection on the incident. The log recorded what staff did, what they could have done better, lessons learnt, how they can improve, what they felt and what was difficult.

Are tier 4 personality disorder services effective?

(for example, treatment is effective)

Assessment of needs and planning of care

- Admissions to the ward were planned. The ward admitted patients the day before the weekly ward round to ensure the availability of the multidisciplinary team. Staff completed a physical health assessment and risk assessment on admission.
- A comprehensive physical and mental health assessment was undertaken by the doctor and nurse within 24 hours of admission. This included a medical history and physical examination, blood tests, measuring vital signs, and assessing general health and lifestyle.
- When the service was last inspected in March 2016, we recommended that the service should ensure that care plans reflected what was agreed in ward rounds and that they were updated in a timely manner. At this inspection, we found that care plans were up to date.
- Care records were up to date, personalised and holistic. Care plans recorded the patient's perception of identified needs with interventions by the multidisciplinary team. Care plans were focused on outcomes, strengths and goals. Staff had recorded where patients had not agreed to goals or objectives with patient signatures.
- When the service was last inspected in March 2016, we recommended that the service consider how they manage recording and archiving patient care plans and risk assessments. At this inspection, we found that patient records were stored appropriately. Staff stored care plans securely in paper files on wards.

Best practice in treatment and care

- The psychiatrist prescribed medication in accordance with guidance published by the National Institute of Health and Care Excellence (NICE).
- The ward offered psychological therapies recommended by NICE. The majority of patients received therapy under the dialectical behavioural therapy (DBT) model. This included DBT orientated skills groups and individual sessions with psychologists. Patients also had access to creative and drama therapy as well as family therapy. One patient undertook sand therapy, which was a therapeutic technique that involved sand, water and miniature objects to create a free and protected space to express themselves.
- The ward had a ward doctor to meet the physical health needs of patients. All patients were encouraged to register with the local GP and staff supported them to make and attend appointments. The ward doctor

monitored patients' physical health once a week. The service did not have a standard process to record physical health monitoring checks which alerted nursing staff to specific concerns raised. However, information was shared between nursing staff and doctors.
- Staff used the health of the nation outcome scales (HoNOS) to measure outcomes. These scales covered 12 health and social domains and enabled the clinicians to build up a picture over time of their patients' responses to interventions. Psychologists also used additional scales and measures to report on effectiveness of their treatment.
- Staff participated in clinical audit. Audits included clinical records, risk assessments, mental health audits and physical health care.

Skilled staff to deliver care

- The multidisciplinary team had a full range of mental health disciplines to provide input to the ward. This included a consultant psychiatrist, nurses, support workers, psychologist and assistant psychologist, occupational therapist and sessional therapist. A pharmacist from an external organisation visited the ward once a week. The hospital had a social worker who also attended and was part of the team.
- Staff were required by the providers policy to receive supervision on a monthly basis. At the end of March 2017, 100% of staff had received supervision on a monthly basis over the previous three months. Supervision records were held centrally on the ward. We reviewed examples of supervision agendas and items for discussion included mandatory training, primary sessions with patients, care plan reviews, risk assessment reviews, punctuality, medication management, quality of recording and reading of rights. Staff we spoke with confirmed that they received regular monthly supervision.
- Appraisals were completed for 88% of the staff on the ward.
- Staff received specialist training for their role on the ward specifically working with patients with diagnoses of personality disorders. All staff were trained in DBT which enabled staff to work with patients in a way that was consistent with the therapeutic programme. A trainer from an external organisation visited the ward to provide refresher training. The ward was also looking to provide self-harm training for staff.

Multi-disciplinary and inter-agency team work

- The ward held regular and effective multi-disciplinary meetings. Staff attended operational meetings for the ward on a monthly basis. Ward rounds took place once a week. There was also a weekly reflective practice session. The ward held handovers meetings twice a day at the beginning of each shift.
- The ward had a good relationship with the eating disorders unit and ward managers spoke on a regular basis. A dietician visited the ward once a month to advise on healthy living and body image.
- The service linked in with community mental health services in the patients' referring areas and had regular contact with commissioners for the services. This was to ensure that information about patients' progress was fed back.

Adherence to the MHA and the MHA Code of Practice

- 98% of staff had completed training in the Mental Health Act (MHA) and the MHA Code of Practice. Seven of the nine patients on the ward were detained under the MHA.
- MHA documentation was stored in paper files. There were records of leave arrangements, relevant capacity assessments and detention paperwork. The ward had attached consent and authorisation certificates to patients' medicine charts.
- The ward displayed information about independent mental health advocates who attended the ward on a weekly basis.
- The hospital conducted regular audits of the MHA to ensure staff applied it appropriately. Relevant information following these audits was fed back on a ward level during meetings and during supervision where appropriate
- Staff informed patients of their rights and repeated this at regular intervals.

Good practice in applying the MCA

- When the service was last inspected in March 2016, we recommended that nursing staff should fully understand their responsibilities in carrying out assessments of mental capacity. At this inspection, we found this had improved.
- Across the hospital, 95% of staff had completed mandatory training on the Mental Capacity Act and Deprivation of Liberty Safeguards. Staff had a good understanding of the MCA and its principles.

Tier 4 personality disorder services

Are tier 4 personality disorder services caring?

Kindness, dignity, respect and support

- We observed positive interactions between patients and staff. Staff interacted in a respectful, caring and responsive manner. Staff showed a good understanding of patients' individual needs.
- We received mixed feedback from patients in regards to the care, treatment and support they received from staff. Patients were positive about the genuine compassion that staff displayed and found the majority of staff friendly, open and polite. Two patients raised concerns that on occasion staff would discuss confidential information about other patients in front of them. All patients we spoke with highlighted that restraint was rarely used and that this was a positive experience for them in comparison with other services. We received four comment cards from patients. All were positive about staff but highlighted that the ward could get hot and humid.

The involvement of people in the care they receive

- The service arranged for patients to view the ward before admission so they were familiar with the environment. The ward provided each patient with an orientation on the day after their admission. The ward gave patients the opportunity to meet other patients and provided them with a buddy. Staff provided an information booklet to patients on their admission. The information booklet was developed by the occupational therapist and patients we spoke with felt it was useful. The ward planned admissions on a Tuesday as the ward round was the following day.
- Patients attended a ward round with their consultant psychiatrist and multidisciplinary team each week. Patients were encouraged to engage in decisions about their care and about how staff could support them to manage their presenting risks. Patients met with their primary nurse each month to update their care plan. Records showed evidence of patients being involved in care planning. The service used the 'My Shared Pathway' workbooks to help patients identify the outcomes they wanted to achieve as part of their recovery.
- Information about how patients could access independent advocacy was displayed on the wards. An advocate attended the ward once a week. Patients we spoke with were positive about the support and availability of the advocate.
- Families and carers were actively involved if patients wanted them to be. The ward held a weekly carers day on Sundays which was run by a nurse and the psychologist. Staff actively encouraged families to attend ward rounds once a week with patient's permission.
- The ward held a community meeting each week and discussed issues such as meals, maintenance, medication and therapy. During our review of the meeting minutes we identified that patients had raised issues such as the bathroom not being fixed for three months and this had not been addressed. It was not evident in the minutes of community team meetings that feedback about issues raised in the community meetings was addressed within a specific timescale and with a member of staff or patient indicated as being responsible for following up items which were raised. For example, we saw that issues such as medication being out of stock had been discussed at a community meeting but the outcome of raising this issue and actions taken were not in any subsequent minutes. As the same issues were repeatedly raised with no actions identified or documented on the feedback to patients at their community meetings, this meant that there was a risk that informal complaints and concerns as well as patient feedback was not being responded to.
- Cygnet hospitals appointed a corporate expert by experience to facilitate user involvement across the organisation. The expert by experience explained that their role was to speak with patients and feedback their views to corporate leaders and hospital managers. This was a position which was new within the organisation and some of the impact was not immediately evident on New Dawn ward. A ward representative had been identified for future work in this area.
- Patients attended a daily planning meeting to discuss groups, therapy and leave for the day.

Tier 4 personality disorder services

Are tier 4 personality disorder services responsive to people's needs?
(for example, to feedback?)

Access and discharge

- The ward admitted patients from across the country. NHS trusts and Clinical Commissioning Groups across England referred patients to this specialist service. The ward aimed to respond to referrals within 24 hours to determine the patient's suitability for admission. Staff discussed referrals at multidisciplinary meetings.
- Average occupancy levels for the ward over the previous 6 months were 100%.
- At the time of our inspection the average length of stay for a patient was 388 days. This would not be unusual for the type of service provided where patients requiring specialist care and would have longer treatment pathways. From 1 November 2016 to April 30 2017 the service had experienced two delayed discharges. The delays in discharge were not due to clinical reasons but related to difficulties in support with funding panels and finding suitable accommodation.

The facilities promote recovery, comfort, dignity and confidentiality

- The ward had a communal lounge which contained sofas and a television with bright and modern décor. The environment was hot and windows did not open which left the ward humid. Patients we spoke with also felt the air conditioning created a smell on the ward.
- Patients did not have access to a quiet area on the ward. Quiet rooms were only available off the ward. For one to ones, patients spoke with staff in their bedrooms.
- Patients were allowed mobile phones if the risk was assessed as low. On the ward patients had access to the cordless phone in the nursing office.
- Patients could only access the garden with staff as the garden was downstairs. Patients we spoke with said that when staff were busy they would not have any access to the garden and were concerned by this.
- Patients were complimentary about the food and felt it was of good quality. Meals were adapted to meet cultural, religious or dietary requirements. Patients had access to hot drinks and snacks whenever they required. Patients did raise the issue of times for breakfast, lunch and dinner. Breakfast was 8:40-9am, lunch was from 12:00-12:45 and dinner was at 17.15-18:00. Patients felt the times for all meals were too early and wished to change the times. We did not see that this had been raised in patient meetings. However, the meal times reflected the needs of the other ward in the service.
- Patients were able to personalise their bedrooms. The bedrooms we viewed included personal items of patients such as photos on the walls and their own televisions.
- Patients did not have keys to their rooms but could request staff lock their rooms. All bedrooms had lockable safes for patients to store possessions.
- Patients we spoke with raised the lack of activities on the ward. Whilst those who were involved in the DBT programme had a very therapeutic based programme throughout the day, those not on DBT felt it could be boring. Patients also raised the lack of physical activities available to them, citing a 45 minute yoga group once a week as the only physical activity. Patients also felt the lack of activities on the day of ward rounds could lead to anxiety. However, we checked the activities programme and saw that there were therapeutic activities available most days. There were fewer activities at the weekend although the service was addressing this by employing assistant psychologists to work at the weekend and facilitate additional groups.

Meeting the needs of all people who use the service

- The ward was located on the first floor of the building. Patients with mobility issues could access the lift to get to the ground floor and bathrooms had disabled access.
- There was a multi-faith room on the ground floor of the hospital. Patients who wished to access specific religious services were facilitated to do so.
- Staff were aware of the process to book interpreters if necessary.

Listening to and learning from concerns and complaints

- Patients we spoke with said they knew how to make complaints and would feel confident in doing so.
- The ward had not had any complaints in the previous 12 months. We reviewed the complaints log book and saw that recording forms included details of the complaint, dates and acknowledgement letter templates for 5 day responses and 20 day responses. The service had a

robust corporate complaints policy. However, informal complaints were not routinely recorded. This meant that there was a risk that information which could lead to learning and improvements may be lost.

Are tier 4 personality disorder services well-led?

Vision and values

- Staff were familiar with the organisations values of being helpful, responsible, respectful, honest and empathetic. Staff we spoke with reflected the organisational values in their attitude towards their job and patients on the ward.
- Staff knew who the senior managers were within the hospital. Staff said that senior managers at the hospital frequently visited the ward. The Cygnet board met at different hospitals throughout the year including Cygnet Ealing.

Good governance

- The ward had access to a robust governance system that reviewed mandatory training, appraisals and supervision to ensure it was up to date.
- The ward manager submitted a monthly ward manager report to the hospital manager. The monthly report covered incidents, restraints, rapid tranquilisation, blanket rules, safeguarding, medicines management, complaints and compliments, supervision, appraisals, training, audits and areas for improvement.
- The human resource department informed the ward manager of upcoming appraisal dates, including ensuring that the ward manager knew when they were due.
- The ward manager identified training needs and other support with the clinical manager. A training co-ordinator provided statistics around training that informed the ward manager of areas needing improvement.
- The clinical manager and two ward managers had a shared risk register that they updated monthly.
- The ward manager attended a regular integrated governance meeting where information was reviewed about key performance indicators, incidents, complaints and learning from these both across the hospital but also across the region and the organisation. This ensured that there was a flow of information through the organisation.

Leadership, morale and staff engagement

- At the time of our inspection, the service did not have a registered manager. The previous registered manager had left in March 2017 and although a new hospital manager was in post and had been since April 2017, at the time of the inspection they had not applied to become registered manager.
- Staff felt morale was good and staff we spoke with told us that they felt the management was supportive. They enjoyed working in the team. The ward manager told us that they felt supported in their role and had authority to request additional resources if necessary.
- Staff told us they were aware of the whistleblowing process and they knew how to use this. Staff said they could raise concerns without fear of victimisation.
- Staff brought feedback to the head of department meeting and received suggestions from the hospital manager on how to improve services.
- The provider carried out an annual staff survey and used the results of the staff survey to input into the hospital's action plan.

Commitment to quality improvement and innovation

- The service had undertaken a number of organisation-wide initiatives to work on reducing restrictive practice including appointing service user representatives who were able to feed back to the management about particular areas of concern in this area.

Outstanding practice and areas for improvement

Outstanding practice

- All staff on New Dawn had accessed specialist DBT skills training which meant that patients received a consistent approach from all staff members, aiding their recovery.
- The service had started to initiate more user-led focus on reducing restrictive practices with the input of experts by experience including co-producing guidelines for staff according to patient preferences. This work was still at early stages but intended to develop user voice in the service.
- Patients on New Dawn ward were involved in the development of their own restraint care plans.

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that patients are treated with care, dignity and empathy by staff and that this is reflected in the feedback which patients provide and any concerns raised by patients are addressed. The provider must ensure that patient community meetings are documented with actions and outcomes and that feedback is given to patients about concerns that they raise.
- The provider must ensure that staff on Sunrise ward receive feedback about incidents, complaints and concerns raised by patients and that team meetings are regularly held with clear minutes which reflect the conversations about learning from incidents and feedback from other services.

Action the provider SHOULD take to improve

- The provider should ensure that all notifications which they are required to make to CQC are made in a timely manner.
- The provider should ensure that staff working on Sunrise ward engage with patients during one to one observations.
- The provider should ensure that all incidents of rapid tranquillisation are followed with appropriate physical health checks which are documented.
- The provider should continue to focus on reducing restrictive practices.
- The provider should ensure that patients have access to a variety of activities including at weekends.
- The provider must ensure that supervision records from Sunrise ward are available to the appropriate hospital managers rather than just to individual supervisors so the quality of the supervision can be monitored.

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 10 HSCA (RA) Regulations 2014 Dignity and respect The provider had not ensured that service users were treated with dignity and respect because feedback we had received from 8 service users on Sunrise ward as well as three comments cards reflected that patients did not experience care which was delivered by staff in a constantly respectful way. This is a breach of regulation 10 (1)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance The service had not ensured that there were systems and processes in place to assess, monitor and improve the quality and safety of services provided in the carrying on of the regulated activity (including the quality of the experience of service users in receiving those services). This was because the quality of staff meeting minutes on Sunrise and patient community meeting minutes on Sunrise and New Dawn meant that it was not clear to establish how feedback to and from staff and patients was used to drive improvement and responded to in a timely fashion.