

Cygnnet Health Care Limited

Cygnnet Hospital Bierley

Inspection report

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

Ratings

Overall rating for this location

Requires Improvement



Are services safe?

Requires Improvement



Are services effective?

Requires Improvement



Are services caring?

Requires Improvement



Are services responsive to people's needs?

Good



Are services well-led?

Requires Improvement



Summary of findings

Overall summary

Our rating of this service stayed the same. We rated it as requires improvement because:

- Although we found the service largely performed well, it did not meet legal requirements relating to the below points, meaning we could not give it a rating higher than requires improvement.
- The service did not always use systems and processes to safely prescribe, administer, record and store medicines. Staff did not always regularly review the effects of medications on each patient's mental and physical health.
- Staff did not always have easy access to clinical information, and it was not easy for them to maintain high quality clinical records – whether paper-based or electronic. On the low secure forensic wards, admission assessment documents were not always available for review and care records were not always updated as needed. Care plans did not always reflect patients' assessed needs, or were always personalised, holistic and recovery oriented.
- Staff did not always document the assessed and managed risks to patients and themselves.
- On the low secure forensic wards, the clinic rooms were not always checked and maintained regularly.
- Patients who required easy read documentation did not always have this need met. Staff did not always involve patients in care planning and risk assessments.
- The ward teams did not always have access to the full range of specialists required to meet the needs of patients on the wards.

However,

- All wards were safe, clean, well equipped, well furnished, well maintained and fit for purpose. The design, layout, and furnishings of the ward supported patients' treatment, privacy and dignity. Each patient had their own bedroom with an en-suite bathroom and could keep their personal belongings safe. There were quiet areas for privacy. The food was of good quality and patients could make hot drinks and snacks at any time.
- The service had enough nursing and medical staff who had received basic training to keep people safe from avoidable harm. Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.
- Managers made sure they had staff with the range of skills needed to provide high quality care. They supported staff with appraisals, supervision and opportunities to update and further develop their skills. Managers provided an induction programme for new staff.
- Staff understood and discharged their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005.

Summary of findings

Our judgements about each of the main services

Service

**Forensic
inpatient or
secure wards**

Requires Improvement

Rating



Summary of each main service

Our rating of this service stayed the same. We rated it as requires improvement because:

- Staff did not have easy access to clinical information, and it was not easy for them to maintain high quality clinical records – whether paper-based or electronic.
- Admission assessment documents were not always available for review and care records were not always updated as needed. Care plans did not always reflect patients' assessed needs, or were not always personalised, holistic and recovery oriented.
- Clinic rooms were not always checked and maintained regularly.
- Patient information was not readily available for agency staff to access.
- Patients who required easy read documentation did not always have this need met.
- The ward teams did not always have access to the full range of specialists required to meet the needs of patients on the wards.
- Staff did not always document the assessed and managed risks to patients and themselves.

However,

- All wards were safe, clean, well equipped, well furnished, well maintained and fit for purpose.
- The service had enough nursing and medical staff who had received basic training to keep people safe from avoidable harm. Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.
- Managers made sure they had staff with the range of skills needed to provide high quality care. They supported staff with appraisals, supervision and opportunities to update and further develop their skills. Managers provided an induction programme for new staff.

Summary of findings

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

Good



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

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

- The service provided safe care. The ward environments were safe and clean. The wards had enough nurses and doctors to keep people safe. Staff assessed and managed risk well. They minimised the use of restrictive practices and followed good practice with respect to safeguarding.
- Staff developed holistic, recovery-oriented care plans informed by a comprehensive assessment. They provided a range of treatments suitable to the needs of the patients and in line with national guidance about best practice. Staff engaged in clinical audit to evaluate the quality of care they provided.
- Managers ensured that these staff received training, supervision and appraisal. The ward staff worked well together as a multidisciplinary team and with those outside the ward who would have a role in providing aftercare.
- Staff understood and discharged their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, and understood the individual needs of patients. They actively involved patients and families and carers in care decisions.
- The service managed beds well so that a bed was always available locally to a person who would benefit from admission and patients were discharged promptly once their condition warranted this.

Summary of findings

- The service was well led and the governance processes ensured that ward procedures ran smoothly.

However:

- The service did not always use systems and processes to safely prescribe, administer, record and store medicines. Staff did not always regularly review the effects of medications on each patient's mental and physical health.
 - Staff did not have easy access to clinical information, and it was not easy for them to maintain high quality clinical records – whether paper-based or electronic.
 - The ward teams did not always have access to the full range of specialists required to meet the needs of patients on the wards.
 - Staff did not always involve patients in care planning and risk assessments.
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Summary of findings

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Summary of this inspection

Background to Cygnet Hospital Bierley

Cygnet Hospital Bierley is an independent mental health hospital provided by Cygnet Health Care Ltd situated in West Yorkshire.

The hospital is registered to provide care for up to 56 male and female patients across four different inpatient wards:

- Bronte ward is a 12-bed forensic low secure service for women
- Shelley ward is a 16-bed forensic low secure service for men
- Denholme ward is a 12-bed psychiatric intensive care unit for women
- Bowling ward is a 16-bed specialist personality disorder service for women

The hospital has been registered with the Care Quality Commission since April 2009 to carry out the following regulated activities:

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

The hospital had a registered manager and an accountable controlled drugs officer.

The Care Quality Commission last carried out a comprehensive inspection in November 2019. As a result of that inspection, we rated the hospital as good overall, with requires improvement in safe.

As a result of concerns received about the safety and culture of the service, the Care Quality Commission carried out a focussed inspection of the hospital in August 2020. At that inspection we rated the service as 'Requires Improvement' overall, with requires improvement in safe and well led. The hospital was in breach of three regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Regulation 12 Safe care and treatment
- Regulation 13 Safeguarding
- Regulation 17 Governance

At this inspection, we inspected all the five key questions in the forensic low secure wards and the psychiatric intensive care unit. We did not review the specialist personality disorder service as there were no concerns at the time of inspection.

What people who use the service say

We spoke to six carers and 11 patients whilst on inspection. We also reviewed the 2020/2021 friends and family survey and the 2020 service user survey. Most patients and carers were happy with the care being given by the staff at the service. However, some patients were not happy with high use of agency staff and the lack of activities available seven days a week.

Summary of this inspection

How we carried out this inspection

The team that inspected the service comprised of four on site CQC inspectors, two off site CQC inspectors, a Mental Health Act reviewer, one off site expert by experience and three mental health nurse specialist advisors.

During the inspection, the inspection team:

- visited both low secure forensic wards and the psychiatric intensive care unit;
- spoke to 11 patients who were using the service;
- spoke with the registered manager, clinical manager and medical director;
- Spoke with three ward managers;
- spoke with six carers/relatives;
- spoke with 27 staff members including nurses, support workers, occupational therapists, safeguarding lead, and psychologists;
- spoke with 6 external agencies;
- looked at 17 care and treatment records for patients;
- attended 6 meetings specific to patient care;
- looked at a range of policies, procedures, and other documents relating to the running of the service.

Visits were unannounced and took place on 11 May 2021 and 12 May 2021 during the day shifts.

You can find information about how we carry out our inspections on our website: <https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection>.

Areas for improvement

Action the service **MUST** take is necessary to comply with its legal obligations. Action a provider **SHOULD** take is because it was not doing something required by a regulation but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the service **MUST** take to improve:

Low Secure Forensic Wards

We told the service that it must take action to bring services into line with 3 regulations.

- The provider must ensure that systems and processes are established and operated effectively to ensure that accurate, complete, and contemporaneous records are being maintained and updated in respect of each patient, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided. (Regulations 17(1)(2)(c)(f))
- The provider must ensure that all staff are aware of the clinic room record keeping processes and complete audits to ensure records are being kept up to date. (Regulations 17(1)(2)(d)(ii))
- The provider must re-assess establishment levels and ensure the current permanent staffing levels match the needs of the service and work to reduce the amount of agency staff used. (Regulations 18(1))

Summary of this inspection

- The provider must ensure that care records are easily accessible for patients and staff. Ensuring that agency staff can access patient information quickly and that care records are written in a way that patients can understand. (Regulations 9(1)(c)(3)(a)(b)(c)(d)(e)(f)(g)(h))

Psychiatric Intensive Care Unit

We told the service that it must take action to bring services into line with 1 regulation.

- The provider must ensure that all medicines are administered in accordance with hospital policy and that the policy is fit for purpose. (Regulation 12)

Action the service SHOULD take to improve:

We told the service that it should take action because it was not doing something required by a regulation, but it would be disproportionate to find a breach of the regulation overall.

Low Secure Forensic Wards

- The provider should continue to ensure that monitoring and observations following the use of rapid tranquilisation are fully completed in line with the provider's policy and guidance from the National Institute for Health and Care Excellence.
- The provider should ensure that when patients are required to open mail in front of staff that this is individually risk assessed and the relevant decision documented and regularly reviewed.
- The provider should ensure that they continue with the recruitment of activity coordinators so that activity is available to patients seven days a week.
- The provider should ensure that care plans include a comprehensive individualised strategy for the use of routine and 'when required' medicines in people who are at risk of violence and aggression.

Psychiatric Intensive Care Unit

- The provider should ensure that when patients are required to open mail in front of staff that this is individually risk assessed and the relevant decision documented and regularly reviewed.
- The provider should ensure that care records are easily accessed and navigated for all staff working on the ward.
- The provider should continue to re-assess establishment levels and ensure the current permanent staffing levels match the needs of the service and work to reduce the amount of agency staff used.
- The provider should ensure that there are enough staff available 7 days a week to be able to offer patients a more varied range of activities.






Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Forensic inpatient or secure wards	Requires Improvement	Requires Improvement	Requires Improvement	Good	Requires Improvement	Requires Improvement
Acute wards for adults of working age and psychiatric intensive care units	Requires Improvement	Good	Good	Good	Good	Good
Overall	Requires Improvement	Requires Improvement	Requires Improvement	Good	Requires Improvement	Requires Improvement

Forensic inpatient or secure wards

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

Are Forensic inpatient or secure wards safe?

Requires Improvement 

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

Safe and clean care environments

All wards were safe, clean, well equipped, well furnished, well maintained and fit for purpose. However, the clinic rooms were not always checked and maintained regularly by staff.

Safety of the ward layout

Staff completed and regularly updated thorough risk assessments of all ward areas. Ligature audits were completed regularly. However, some of the actions, such as the removal or replacement of curtain rails and trunking, from the September 2020 audits had not been completed.

Staff could observe patients in all parts of the wards. The service had CCTV in all communal areas of the wards and security mirrors and staff mitigated against any blind spots.

There was no mixed sex accommodation. Bronte ward was a female ward and Shelley ward was a male ward.

Staff knew about any potential ligature anchor points and mitigated the risks to keep patients safe. There were ligature maps on the wall of each ward office, and these were regularly reviewed and updated.

Staff had easy access to alarms and patients had easy access to nurse call systems. All staff members had alarms provided on entry to the building and there were nurse call alarms in all patient bedrooms, visitor areas and communal areas.

Maintenance, cleanliness and infection control

Ward areas were clean, well maintained, well-furnished and fit for purpose. Staff made sure cleaning records were up-to-date and the premises were clean. The wards were in good repair and the maintenance and staff team completed regular cleaning and maintenance checks.

Forensic inpatient or secure wards

Staff followed infection control policy, including handwashing. All infection prevention control procedures were followed, and personal protective equipment was always worn. The service also completed quarterly infection control audits and monthly personal protective equipment audits.

Seclusion room

The Seclusion room on Shelley ward allowed clear observation and provided two-way communication. It had a toilet and a clock that was visible through a glass panel. Bronte ward did not have a seclusion room.

Clinic room and equipment

Clinic rooms were fully equipped, with accessible resuscitation equipment and emergency drugs, however, staff did not always check, maintain, and clean equipment regularly. The cleaning records for the clinic room on Bronte ward had not been completed 11 times in March 2021 and five times in February 2021. The clinic room temperature on Bronte ward had not been checked four times in March 2021. Resuscitation equipment on Bronte ward had been checked late four times in April 2021 and one check in April 2021 had not been signed. The defibrillator on Bronte ward had not been checked three times in March 2021, two times in April 2021, and one time in May 2021. The wards completed weekly clinic room audits, however, there was no recorded audit date since 30 March 2021 for Bronte ward and 27 March 2021 for Shelley ward.

Safe staffing

The service had enough nursing and medical staff who had received basic training to keep people safe from avoidable harm. However, not all staff knew the patients due to the high use of agency staff.

Nursing staff

Managers calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants for each shift and the ward manager could adjust staffing levels according to the needs of the patients. The service had enough nursing and support staff to keep patients safe and the service had low vacancy rates. There were two vacancies for qualified nurses on Shelley ward and no vacancies on Bronte ward. At the time of the inspection the provider had recruited into one of the vacant qualified nurse positions on Shelley ward. However, the service had high rates of agency nurses and support workers. Between May 2020 and April 2021 Bronte ward used nurse agency staff for 459 12-hour shifts and support agency staff for 1509 12-hour shifts. Shelley ward used nurse agency staff for 178 12-hour shifts and support agency staff for 1136 12-hour shifts.

Managers tried to request staff familiar with the service and ensured they had a full induction and understood the service before starting their shift. Regular staff supported agency staff with understanding patient needs, however, documentation about the patient needs was not always available to agency staff due to their limited access to certain systems. It was not always possible to get agency staff who were fully aware of the patient needs.

The service did not have low turnover rates. Turnover across all three core services was 30.99% across 12 months. The service was not able to give specific turnover rates for the forensic core service.

Managers supported staff who needed time off for ill health and levels of sickness were reducing. Sickness across all three core services was 5.19% from May 2020 to April 2021. The service was not able to give specific sickness rates for the forensic core service.

Patients had a one to one session with their named nurse twice a week. Although this was not always documented, patients and staff told us this did happen.

Forensic inpatient or secure wards

Patients sometimes had their escorted leave or activities cancelled, when the service was short staffed. However, most staff and patients told us the escorted leave or activity would be re-scheduled rather than cancelled and that the ongoing recruitment of weekend activity coordinators would prevent any further cancellations.

The service had enough staff on each shift to carry out any physical interventions safely. The wards had a service wide response team allocated each day to support with physical interventions. On Bronte ward some staff were concerned that there may not be enough staff able to complete physical interventions. However, rotas were created to ensure there were enough trained staff on shift each day and management were working with the occupational therapy team and human resources team to ensure staff were fully supported to complete their role.

Staff shared key information to keep patients safe when handing over their care to others. The service had regular meetings to ensure patients most up to date information was shared and doctors received a handover e-mail each morning with any updates.

Medical staff

The service had enough daytime and night-time medical cover and a doctor available to go to the ward quickly in an emergency and managers could call locums when they needed additional medical cover.

Mandatory training

Staff had completed and kept up to date with their mandatory training. The overall training compliance rate on Bronte ward was 94% and on Shelley ward it was 97%. The mandatory training programme was comprehensive and met the needs of patients and staff.

Managers monitored mandatory training and alerted staff when they needed to update their training.

Assessing and managing risk to patients and staff

Staff did not always document the assessed and managed risks to patients and themselves. Staff mostly achieved the right balance between maintaining safety and providing the least restrictive environment possible to support patients' recovery, however the opening of mail in front of staff was not individually risk assessed in line with best practice. Staff followed best practice in anticipating, de-escalating and managing challenging behaviour. As a result, they used restraint and seclusion only after attempts at de-escalation had failed. The ward staff participated in the provider's restrictive interventions reduction programme.

Assessment of patient risk

Staff told us that they completed risk assessments for each patient on admission, using a recognised tool. However, on inspection we were unable to locate an initial risk assessment for one patient on Shelley ward and one patient on Bronte ward due to documents being filed away. This meant that the initial assessment could not be reviewed regularly or updated after any incident.

Management of patient risk

Most staff knew about any risks to each patient and acted to prevent or reduce risks and staff identified and responded to any changes in risks to, or posed by, patients. Regular twice daily handover meetings ensured staff were aware of patient risks that day. However, agency staff did not have full access to patient records or to an overview of documented patient risks which could impact on their ability to protect patients

Staff followed procedures to minimise risks where they could not easily observe patients and staff followed provider policies and procedures when they needed to search patients or their bedrooms to keep them safe from harm.

Forensic inpatient or secure wards

Use of restrictive interventions

Levels of restrictive interventions were low, and staff participated in the provider's restrictive interventions reduction programme, which met best practice standards. However, most staff told us that patients had to open their mail with staff, and this was listed as a restriction for parcels on most patients care records that we looked at. There was no individual patient risk assessment for the opening of mail to be monitored.

Staff made every attempt to avoid using restraint by using de-escalation techniques and restrained patients only when these failed and when necessary to keep the patient or others safe. Staff understood the Mental Capacity Act definition of restraint and worked within it.

Staff followed NICE guidance when using rapid tranquilisation. At the previous inspection in 2020, the provider received a requirement notice to ensure that the monitoring and observations following the use of rapid tranquilisation were fully completed in line with the providers policy and national guidance. There had been improvement to this, however, on Bronte ward there were 2 records that had no respiratory rates recorded in March 2021.

When a patient was placed in seclusion, staff kept clear records and followed best practice guidelines and staff followed best practice, including guidance in the Mental Health Act Code of Practice, if a patient was put in long-term segregation. One of our roles as a regulator is to keep the use of the Mental Health Act (MHA) under review and check it is being used properly. A mental health act reviewer had reviewed the long-term segregation on Bronte ward prior to the onsite inspection and had found it followed the Mental Health Act Code of Practice.

Safeguarding

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

Staff received training on how to recognise and report abuse, appropriate for their role and staff were kept up to date with their safeguarding training. Staff could give clear examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. Both wards had a notice board in the ward office that highlighted any current safeguarding concerns.

Staff knew how to recognise adults and children at risk of or suffering harm and worked with other agencies to protect them.

Staff followed clear procedures to keep children visiting the ward safe. Children did not visit the wards but could use the patient visiting rooms after confirmation from a social worker.

Staff knew how to make a safeguarding referral and who to inform if they had concerns.

Managers took part in serious case reviews and made changes based on the outcomes.

Staff access to essential information

Staff did not have easy access to clinical information, and it was not easy for them to maintain high quality paper or electronic clinical records.

Patient records were stored securely, however, notes were not always comprehensive and not all staff could access them easily. The service used a combination of electronic and paper records and staff did not always make sure they were up-to-date and complete. The service used three different systems, one paper based and two electronic, to keep

Forensic inpatient or secure wards

patient records. The drive based electronic system was not accessible by agency staff or student nurses. The electronic care record system had limited functionality and restrictions. Patients rated as being a high risk due to an increase in incidents and flagged as being red could not have the rating colour changed on the system for 7 days even if their presentation had changed. However, the service was able to update the rating scores each day.”

Medicines management

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

The service had systems and processes in place to safely store, administer and record medicines use. A pharmacist reviewed the prescription charts and associated Mental Health Act authorities every two weeks and records were generally clearly completed. Patients were supported to self-administer medicines where possible; this was kept under review to help ensure medicines were handled safely.

Staff reviewed the effects of medicines on patient’s physical health. The prescribing of high dose antipsychotics was kept under review and baseline physical health checks were completed. A self-rating tool was used to monitor for potential side effects of antipsychotic medicines. Physical health monitoring following Rapid Tranquilisation was audited by the hospital and results shared at ward level to support learning and improvement. The records we viewed showed that monitoring was completed for the required period. However, care plans did not include a comprehensive individualised strategy for the use of routine and ‘when required’ medicines in people who are at risk of violence and aggression. There were plans to hold regular monthly MDT reviews of patient’s physical health needs. The hospital was enrolled in a national clozapine bench marking audit to support effective and safe prescribing.

Where peoples routine blood tests showed a low vitamin D, supplements were prescribed in line with current guidance (Public Health England). Nicotine replacement therapy was prescribed if required by patients who smoked prior to admission.

Track record on safety

The service had a good track record on safety.

Reporting incidents and learning from when things go wrong

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

Staff knew what incidents to report and how to report them. Staff raised concerns and reported incidents and near misses in line with provider policy. Staff reported serious incidents clearly and in line with provider policy. We looked at a number of incident reports and saw evidence of clear documentation and that the appropriate people had been involved in reviewing of incidents.

The service had not had any never events on any wards in the last 12 months.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong.

Forensic inpatient or secure wards

Managers debriefed and supported staff after any serious incident. Both wards had debrief books that were filled in daily by staff and the staff had the opportunity to attend regular reflective practice sessions. However, some staff told us that there was sometimes limited uptake of these sessions due to there not being enough staff on the wards.

Managers investigated incidents thoroughly and staff received feedback from investigation of incidents, both internal and external to the service. Staff met to discuss the feedback and look at improvements to patient care. The service also had a monthly quality newsletter which highlighted all incidents and any improvements that could be made. We saw evidence of daily risk meetings and regular MDT's where changes to care were discussed in relation to changing risks and needs. There was evidence that changes had been made as a result of feedback

Managers shared learning with their staff about never events that happened elsewhere. The services monthly quality newsletter highlighted lessons learned from other health and social care services.

Are Forensic inpatient or secure wards effective?

Requires Improvement 

Our rating of effective went down. We rated it as requires improvement.

Assessment of needs and planning of care

Staff told us they always assessed the physical and mental health of all patients on admission and developed individual care plans which were reviewed regularly. However, the assessment documents were not always available and care records were not always updated as needed. Care plans did not always reflect patients' assessed needs, or were not always personalised, holistic and recovery oriented.

Staff told us that they completed a comprehensive mental health assessment of each patient either on admission or soon after and that all patients had their physical health assessed soon after admission and regularly reviewed during their time on the ward. However, due to the filing system for paper records we were unable to locate an initial risk assessment for one patient on Shelley ward and one patient on Bronte ward.

Staff did not always develop a comprehensive care plan for each patient that met their mental and physical health needs and staff did not regularly review and update care plans when patients' needs changed. Care plans were not always personalised, holistic and recovery orientated. We reviewed 13 care records across Bronte and Shelley ward. We found eight records did not always show patient involvement in the creation of the care plans or if their views and preferences had been considered.

Staff did not always develop care plans that were accessible for patients. We found one patient on Shelley ward and one patient on Bronte ward who required easy read documentation, but this was not available. The service did advise us that they were in the process of creating easy read documents in partnership with the independent health advocacy service.

Best practice in treatment and care

Staff provided a range of treatment and care for patients based on national guidance and best practice. They ensured that patients had good access to physical healthcare and supported them to live healthier lives. Staff sometimes used recognised rating scales to assess and record severity and outcomes. They also participated in clinical audit and quality improvement initiatives.

Forensic inpatient or secure wards

Staff provided a range of care and treatment suitable for the patients in the service.

Staff delivered care in line with best practice and national guidance.

Staff identified patients' physical health needs and recorded them in their care plans.

Staff made sure patients had access to physical health care, including specialists as required.

Staff met patients' dietary needs and assessed those needing specialist care for nutrition and hydration.

Staff helped patients live healthier lives by supporting them to take part in programmes or giving advice.

Staff sometimes used recognised rating scales to assess and record the severity of patients' conditions and care and treatment outcomes. We reviewed 13 care records across Bronte and Shelley wards and found that that five patients had rating tool documents that were not fully completed. This included not being dated, no scores being listed, or not being completed when expected.

Staff used technology to support patients. External agencies and carers had been able to talk to patients and attend patient meetings during the COVID pandemic with the use of teleconferencing. External agencies told us that when this was requested it had been set up quickly.

Staff took part in clinical audits, benchmarking and quality improvement initiatives. Bronte and Shelley wards participated in a quality improvement network for low secure forensic mental health services in March 2021 and received accreditation from the network.

Managers used results from audits to make improvements. Clinical outcomes were discussed in the providers regular clinical governance meetings and shared with external teams and organisations. Ward managers shared the audits at local staff meetings and any feedback from the governance meetings. The service also shared learning from these audits in the monthly quality newsletter.

Skilled staff to deliver care

The ward teams did not always have access to the full range of specialists required to meet the needs of patients on the wards. Managers made sure they had staff with the range of skills needed to provide high quality care. They supported staff with appraisals, supervision and opportunities to update and further develop their skills. Managers provided an induction programme for new staff.

The service did not always have access to a full range of specialists to meet the needs of the patients on the ward. There were not enough activity coordinators on the wards to ensure activities were available to the patients 7 days a week.

Managers ensured staff had the right skills, qualifications and experience to meet the needs of the patients in their care, including bank and agency staff.

Managers gave each new member of staff a full induction to the service before they started work. The service provided the new member of staff with an induction booklet which they had 3 months to complete.

Managers supported staff through regular, constructive clinical supervision and appraisals of their work. Supervision and appraisal rates were at 100% across both Bronte and Shelley ward.

Forensic inpatient or secure wards

Managers made sure staff attended regular team meetings or gave information from those they could not attend. Staff could raise items for discussion on a notice board in the ward nursing offices. We reviewed a sample of team meeting notes from previous months and meetings were well attended, detailed discussion took place and notes from the meetings were made available on the ward.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge.

Managers made sure staff received any specialist training for their role.

Managers recognised poor performance, could identify the reasons and dealt with these.

Multi-disciplinary and interagency teamwork

Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care. The ward teams had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation and engaged with them early in the patient's admission to plan discharge.

Staff held regular multidisciplinary meetings to discuss patients and improve their care.

Staff made sure they shared clear information about patients and any changes in their care, including during handover meetings.

Ward teams had effective working relationships with other teams in the organisation.

Ward teams had effective working relationships with external teams and organisations. We spoke with three specialised commissioning teams, NHSE and the local authority. We were told the service was generally responsive to requests, however, there had been times when information had taken longer than expected to be received.

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

Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice and discharged these well. Managers made sure that staff could explain patients' rights to them.

Staff received, and kept up to date, with training on the Mental Health Act and the Mental Health Act Code of Practice and could describe the Code of Practice guiding principles.

Staff knew who their Mental Health Act administrators were and when to ask them for support and could access the team for support and advice on implementing the Mental Health Act and its Code of Practice.

The service had clear, accessible, relevant and up-to-date policies and procedures that reflected all relevant legislation and the Mental Health Act Code of Practice.

Patients had easy access to information about independent mental health advocacy and patients who lacked capacity were automatically referred to the service. The independent mental health advocate visited the site on a weekly basis. During the COVID pandemic these visits had been done through teleconference. Information on how to contact the advocate was available on boards in both wards' communal areas.

Forensic inpatient or secure wards

Staff explained to each patient their rights under the Mental Health Act in a way that they could understand, repeated as necessary and recorded it clearly in the patient's notes each time.

Staff made sure patients could take section 17 leave (permission to leave the hospital) when this was agreed with the Responsible Clinician and with the Ministry of Justice.

Staff requested an opinion from a Second Opinion Appointed Doctor (SOAD) when they needed to.

Staff stored copies of patients' detention papers and associated records correctly and staff could access them when needed.

Care plans included information about after-care services available for those patients who qualified for it under section 117 of the Mental Health Act.

Managers and staff made sure the service applied the Mental Health Act correctly by completing regular audits and discussing the findings. The latest Mental Health Act audit was completed in April 2021 and received a compliance rate of 100% on both wards.

Good practice in applying the Mental Capacity Act

Staff supported patients to make decisions on their care for themselves. They understood the providers policy on the Mental Capacity Act 2005 and assessed and recorded capacity clearly for patients who might have impaired mental capacity.

Staff received, and were consistently up to date, with training in the Mental Capacity Act and had a good understanding of at least the five principles. There was a clear policy on Mental Capacity Act which staff could describe and knew how to access.

Staff knew where to get accurate advice on the Mental Capacity Act and staff gave patients all possible support to make specific decisions for themselves before deciding a patient did not have the capacity to do so.

Staff assessed and recorded capacity to consent clearly each time a patient needed to make an important decision. Staff assumed capacity as per the Mental Capacity Act, however, when it was needed a capacity to consent form was completed.

When staff assessed patients as not having capacity, they made decisions in the best interest of patients and considered the patient's wishes, feelings, culture and history.

The service monitored how well it followed the Mental Capacity Act and made changes to practice when necessary.

Staff audited how they applied the Mental Capacity Act and identified and acted when they needed to make changes to improve. The last Mental Capacity Act audit for the whole service was completed in November 2020 by the Mental Health Act administrator with a 96% compliance percentage reported.

Are Forensic inpatient or secure wards caring?

Forensic inpatient or secure wards

Our rating of caring went down. We rated it as requires improvement.

Kindness, privacy, dignity, respect, compassion and support

Some staff did not always understand the individual needs of patients and were not always able to support patients to understand and manage their care, treatment or condition due to the high use of agency staff who did not have access to the appropriate records and systems. However, staff treated patients with compassion and kindness, and they respected patients' privacy and dignity.

Staff were discreet, respectful, and responsive when caring for patients and gave patients help, emotional support and advice when they needed it. Patients said staff treated them well and behaved kindly. We spoke to nine patients and five carers across Bronte and Shelley ward. Seven patients and all the carers were happy with the support provided to them by staff.

Staff supported patients to understand and manage their own care treatment or condition and directed patients to other services and supported them to access those services if they needed help. The wards gave patients the option to work towards self-medication and supported each stage of the process. Care records showed input from many other services, especially physical health professionals.

Staff respected the individual needs of each patient and staff followed policy to keep patient information confidential. However, agency staff were not able to access electronic patient information to fully understand the patient needs. Each bedroom door on both wards had a sign that told staff how patients would prefer to be observed.

Staff felt that they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards patients.

Involvement in care

Staff did not always involve patients in care planning and risk assessments; however, they did actively seek their feedback on the quality of care provided. They ensured that patients had easy access to independent advocates.

Involvement of patients

Staff introduced patients to the ward and the services as part of their admission. Staff and patients told us the process for being admitted to the ward, however, there was no formal admission checklist.

Staff did not always involve patients and give them access to their care planning and risk assessments. We reviewed 13 care records across Bronte and Shelley ward. We found eight records did not always show that a patient had been involved in the creation of care plans or risk assessments and documents were not always signed to show whether the patient had been given a copy of these documents.

Staff did not always make sure patients understood their care and treatment or find ways to communicate with patients who had communication difficulties. There were some patients who required easy read documentation, but this had not been produced. Some patients told us that they had difficulty understanding the language used in their care records.

Forensic inpatient or secure wards

Staff involved patients in decisions about the service, when appropriate. The patients could take part in staff interviews and attend governance meetings.

Patients could give feedback on the service and their treatment and staff supported them to do this. The patients could attend a daily morning meeting, regular community meetings and the regular people's council. There was also a You Said, We Did board on both wards.

Staff made sure patients could access advocacy services. A contracted advocacy service visited the ward on a weekly basis and was well known by all patients and staff.

Involvement of families and carers

Staff informed and involved families and carers appropriately.

Staff supported, informed and involved families or carers. Both wards provided a carers pack and carers leaflet to families and carers on patient admission, if the patient had consented, which had been developed with the patients. This pack included information on the day to day running of the service and available outside resources that carers could access. Staff supported, informed and involved families or carers of patients despite the complexities that COVID 19 caused. Staff helped patients keep in touch with families and carers by telephone and video calls. Staff supported families and carers to attend meetings so that they could input into the treatment of their family member.

Staff helped families to give feedback on the service. The carers pack and carers leaflet gave information on how families and carers could give feedback.

Staff did not give carers information on how to find the carer's assessment. Three out of the five carers we spoke to said they did not know what the carers assessment was, and one carer was aware of it but was not aware of how to complete one.

Are Forensic inpatient or secure wards responsive?

Good 

Our rating of responsive stayed the same. We rated it as good.

Access and discharge

Staff liaised well with services that would provide aftercare and were assertive in managing care pathways for patients who were making the transition to another inpatient service or to prison. As a result, discharge was rarely delayed.

Bed management

Managers regularly reviewed length of stay for patients. The average length of stay was 311.3 days on Bronte ward and 330.5 days on Shelley ward. The service had out-of-area placements with patients coming from other locations outside of West Yorkshire. The service kept in regular contact with clinical commissioning groups and care coordinators by inviting them to all meetings online and sending them meeting minutes.

Managers and staff worked to make sure they did not discharge patients before they were ready.

Forensic inpatient or secure wards

When patients went on leave there was always a bed available when they returned. When patients were on extended leave the service kept the bed free for the patients return.

Patients were very rarely moved between wards and if it did happen, it was only when there were clear clinical reasons, or it was in the best interest of the patient. Staff did not move or discharge patients at night or very early in the morning.

Discharge and transfers of care

Managers monitored the number of delayed discharges. The service had low numbers of delayed discharges in the past year. There had been no delayed discharges on Shelley ward and one on Bronte ward in the previous 12 months. Staff carefully planned patients' discharge and worked with care managers and coordinators to make sure this went well. However, this was not always documented on patient care plans. Of the 13 care records we reviewed, one patient on Shelley ward and one patient on Bronte ward had no evidence of discharge planning.

Staff supported patients when they were referred or transferred between services and the service followed national standards for transfer.

Facilities that promote comfort, dignity and privacy

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

Each patient had their own bedroom, which they could personalise. This included painting the bedroom walls and signs were on the bedroom doors with patient preferences for observation when needed.

Patients had a secure place to store personal possessions. There was lockable storage in each bedroom and patients were individually risk assessed for a door key to their own bedroom.

The service had a full range of rooms and equipment to support treatment and care. Staff and patients could access the rooms. There were multiple communal rooms on the wards to meet all patient needs and there was a therapy corridor that included a gym.

The service had quiet areas and a room where patients could meet with visitors in private. There was a quiet room on each ward and visitor rooms off the ward in the hospital.

Patients could make phone calls in private. Patients could use their bedrooms, or the wards designated quiet rooms.

The service had an outside space that patients could access easily. Both wards had a courtyard attached that patients could access with support from staff members.

Patients could make their own hot drinks and snacks and were not dependent on staff. There was access to cold and hot drinks and snacks in the dining rooms.

The service offered a variety of good quality food. Individual food preferences were considered, and a variety of different dietary and religious requirements could be met. Patients had the opportunity to raise any issues with the menu at daily morning meetings and with the staff at the service.

Forensic inpatient or secure wards

Patients' engagement with the wider community

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

Staff made sure patients had access to opportunities for education and work. The service's recovery college gave patients access to in house educational courses. The service also provided volunteer work opportunities at a local charity shop; however, this had been temporarily stopped due to the COVID pandemic.

Staff helped patients to stay in contact with families and carers and encouraged patients to develop and maintain relationships both in the service and the wider community. During the COVID pandemic lockdown, patients could use electronic devices. The service also facilitated visits through the fence in the main courtyard and sometimes supported outdoor socially distanced visits.

Meeting the needs of all people who use the service

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

The service could support and make adjustments for disabled people and those with communication needs or other specific needs. However, care records were not always in an accessible format for patients who required easy read documentation.

Staff made sure patients could access information on treatment, local service, their rights and how to complain. The service had information leaflets available in languages spoken by the patients and local community. These could be requested from the provider and printed off the computer when needed.

Managers made sure staff and patients could get help from interpreters or signers when needed. Some staff on the wards were bilingual and could support patients and carers who did not speak English as a first language. The service could also request support from interpreters or signers when needed.

The service provided a variety of food to meet the dietary and cultural needs of individual patients and patients had access to spiritual, religious and cultural support. The hospital had a multi-faith room within the hospital and could use rooms on the ward for spiritual reflection.

Listening to and learning from concerns and complaints

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

Patients, relatives and carers knew how to complain or raise concerns. The five carers we spoke to said they knew how to give feedback on the service including service questionnaires and video calls.

The service clearly displayed information about how to raise a concern in patient areas.

Staff understood the policy on complaints and knew how to handle them.

Managers investigated complaints and identified themes.

Staff protected patients who raised concerns or complaints from discrimination and harassment and staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint.

Forensic inpatient or secure wards

Managers shared feedback from complaints with staff and learning was used to improve the service. All staff we spoke to were aware of the any previous concerns and whistleblowings that had been raised and the response from the service to those concerns.

The service used compliments to learn, celebrate success and improve the quality of care. From 2 November 2020 until 6 May 2021 the whole service had received 74 compliments. Fourteen compliments were specific to the low secure forensic wards. with the majority being about the staff members and the quality of care provided. The regular quality newsletter recognised staff members who had prevented serious incidents from happening and shared the learning from these.

Are Forensic inpatient or secure wards well-led?

Requires Improvement 

Our rating of well-led stayed the same. We rated it as requires improvement.

Leadership

Leaders had the skills, knowledge and experience to perform their roles. They had a good understanding of the services they managed and were visible in the service and approachable for patients and staff. Management ensured they regularly visited the wards and were available for staff questions. Most staff could identify the senior management at the service.

Vision and strategy

Staff knew and understood the provider's vision and values and how they were applied to the work of their team.

Culture

Most staff felt respected, supported and valued. They said the provider promoted equality and diversity in daily work and provided opportunities for development and career progression. They could raise any concerns without fear.

Governance

Our findings from the other key questions demonstrated that governance processes did not always operate effectively at team level and that performance and risk were not always managed well. The service used three different platforms across paper and electronic formats to keep patient care records. Some paper documents had been archived and were not easily accessible. The electronic drive database could not be accessed by agency staff or student nurses. Some staff told us that the electronic records system frequently crashed or froze. The electronic records system would not allow staff to change the colour rating of a patient presentation until seven days had passed, however, the rating scores could be updated daily.

Ward managers were not fully aware of the clinic room processes and procedures and regular checks and audits were not always completed.

There was a high use of agency nurse and agency support staff with patient information not easily accessible. Some patients presented as needing easy read documentation, but this had not been implemented. However, we were told that the service was in the process of creating one-page profiles and easy read documentation.

Forensic inpatient or secure wards

Management of risk, issues and performance

Teams did not always have access to the information they needed to provide safe and effective care. Due to the three records systems, it was not always clear where patient information was stored and it was not always easily accessible. The service had a risk register that was regularly reviewed and updated. The risk register was accessible by all staff who had access to the shared drive. The service held regular team meetings and there were regular regional governance meetings to share learning. There were daily risk assessment meetings. The service had created a regular quality newsletter which highlighted safety issues and lessons learnt from within the service and from external services, that was available for all staff to read in the staff rooms.






Information management

Staff collected and analysed data about outcomes and performance and engaged actively in local and national quality improvement activities. Bronte and Shelley wards participated in a quality improvement network for low secure forensic mental health services in March 2021 and received accreditation from the network. Clinical outcomes were discussed in the providers regular clinical governance meetings and shared with external teams and organisations. Ward managers shared the audits at local staff meetings and any feedback from the governance meetings. The service also shared learning from these audits in the monthly quality newsletter.

Managers engaged actively with other local health and social care providers to ensure that an integrated health and care system was commissioned and provided to meet the needs of the local population. We spoke to four external agencies who said they had found the service to be mostly responsive. The service had reviewed their patient specification which had meant a reduction in concerns as they were now accepting the correct patients for the service type.

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

Good 

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

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

Requires Improvement 

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

Safe and clean care environment

Denholme ward was safe, clean, well equipped, well furnished, well maintained and fit for purpose. At the time of this visit some redecorating was underway on the ward and had yet to be completed.

Safety of the ward layout

Staff completed and regularly updated thorough risk assessments of all ward areas and removed or reduced any risks they identified. Staff could observe patients in all parts of the wards.

The ward complied with guidance and there was no mixed sex accommodation. Denholme is a female only ward.

Staff knew about any potential ligature anchor points and mitigated the risks to keep patients safe. There was a regularly updated ligature risk assessment and a ligature point poster on the office wall. The bedrooms ensuite bathroom doors had been replaced with new ligature mitigating saloon style panels.

Staff had easy access to alarms and patients had easy access to nurse call systems. We saw examples of these in use and staff responded appropriately.

Maintenance, cleanliness and infection control

Ward areas were clean, well maintained, well-furnished and fit for purpose. Staff made sure cleaning records were up-to-date and the premises were clean.

Staff followed infection control policy, including handwashing. This was also in line with government guidance on mitigating the risks surrounding Covid-19.

Seclusion room

The Seclusion room located on the ward allowed for clear observation and two-way communication. It had a toilet, shower and a clock visible through a glass panel.

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

Good 

Clinic room and equipment

The clinic room was fully equipped, with accessible resuscitation equipment and emergency drugs that staff checked regularly. Staff checked, maintained, and cleaned the equipment on a regular basis.

Safe staffing

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

Nursing staff

The ward had enough nursing and support staff to keep patients safe. However, the service had a high vacancy rate for qualified nurses (50%). The service had high rates of agency nurse and support worker use. Between May 2020 and April 2021 Denholme ward used nurse agency staff for 701 12-hour shifts and support agency staff for 1985 12-hour shifts. Staff and patient did not report any issues as a result of the high use of agency staff on this ward.

Managers requested staff familiar with the service and made sure all bank and agency staff had a full induction and understood the service before starting their shift.

Turnover across all three core services was 30.99% across 12 months. The service was not able to give specific turnover rates for the psychiatric intensive care ward.

Managers supported staff who needed time off for ill health and levels of sickness were reducing. Sickness across all three core services was 5.19% from May 2020 to April 2021. The service was not able to give specific sickness rates for this ward. However, this was lower than the previous comprehensive inspection report with 8.3% between 1 September 2018 and 31 August 2019.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants for each shift. There was an establishment of staff for the ward which could be adjusted if the needs or acuity of the ward changed. There was evidence that this happened on a regular basis and that managers were always able to respond to ensure there was enough staff.

Patients had regular one to one sessions with their named nurse. Patients told us that these sessions were helpful to them and that nurses went out of their way to make sure they happened.

Patients rarely had their escorted leave or activities cancelled, even when the service was short staffed.

Staff shared key information to keep patients safe when handing over their care to others.

Medical staff

The ward had enough daytime and night-time medical cover and a doctor available to go to the ward quickly in an emergency.

Mandatory training

Staff had completed and kept up to date with their mandatory training. The overall training compliance rate was 94%. The mandatory training programme was comprehensive and met the needs of patients and staff.

Managers monitored training compliance and alerted staff when they needed to update their training.

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

Good 

Assessing and managing risk to patients and staff

Staff assessed and managed risks to patients and themselves well and followed best practice in anticipating, de-escalating and managing challenging behaviour. Staff used restraint and seclusion only after attempts at de-escalation had failed. The ward staff participated in the provider's restrictive interventions reduction programme.

Assessment of patient risk

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

Management of patient risk

Staff knew about any risks to each patient and acted to prevent or reduce risks. Staff identified and responded to any changes in risks to, or posed by, patients. There were a number of mechanisms for staff to share information about changes to patient risk. The ward had a daily handover meeting between each change of shift, a daily risk summit and regular ward round meetings.

Staff could observe patients in all areas of the ward and the ward was able to apply a flexible approach where changes to risk meant a patient required higher observation levels.

Staff followed company policies and procedures when they needed to search patients or their bedrooms to keep them safe from harm.

Use of restrictive interventions

Levels of restrictive interventions were appropriate for this type of ward.

However, staff and patients told us that patients had to open their mail with staff, and this was listed as a restriction for parcels on most patients care records that we looked at. There was no individual patient risk assessment for the opening of mail to be monitored.

Staff participated in the provider's restrictive interventions reduction programme, which met best practice standards. This included all bank and agency staff that were expected to work on the ward.

Staff made every attempt to avoid using restraint by using de-escalation techniques and restrained patients only when these failed and when necessary to keep the patient or others safe. We reviewed a number of incident records which detailed the efforts that staff had made to avoid any type of physical restraint. As a result of these efforts, the use of restraint was low on this ward.

Staff understood the Mental Capacity Act definition of restraint and worked within it.

When a patient was placed in seclusion, staff kept clear records and followed best practice guidelines. We did not see any example of long-term segregation on this ward.

Safeguarding

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

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

Good 

Staff received training on how to recognise and report abuse, appropriate for their role. They kept up -to- date with this training.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act.

Staff knew how to recognise adults and children at risk of or suffering harm and worked with other agencies to protect them. The hospital had improved the way they worked with local safeguarding teams and as a result communication had improved.

Staff knew how to make a safeguarding referral and who to inform if they had concerns.

Managers took part in serious case reviews and made changes based on the outcomes.

Staff access to essential information

Staff had access to clinical information, and they could maintain high quality clinical records. However, the hospital stored patient information across a range of different systems, including a mix of paper based and electronic records. Whilst carrying out the inspection, staff and inspection team members found these records difficult to navigate and information was not always easily accessible in a timely manner.

Although the ward used a combination of electronic and paper records, staff made sure they were up-to-date and complete.

Records were stored securely.

Medicines management

The ward had systems and processes in place to safely store, administer and record medicines use. A pharmacist reviewed the prescription charts and associated Mental Health Act authorities every two weeks and most records were clearly completed.

Baseline physical health checks were completed and where vitamin D levels were low, a supplement was prescribed in line with current guidance. The required blood tests were completed and checked for patients prescribed medicines that needed additional monitoring. A self-reporting tool was used to monitor for potential side effects of antipsychotic medicines.

However, injections administered to acutely unwell patients were not always handled in accordance with hospital policy. We saw several examples where zuclopenthixol acetate (a long acting medicine for the treatment of acute psychosis) was prescribed. Individual's health records did not always clearly detail the 'decision and rationale for its use along with the required circumstances for its use, monitoring requirements and guidance for staff should emergency intervention be required'. On two occasions it was administered with a second different injection, contrary to hospital policy. Additionally, Physical health monitoring was not always clearly completed.

We raised this concern with the provider, and they made immediate changes to ensure that their policy was being followed by staff and that the policy was fit for purpose.

Track record on safety

The ward had a good track record on safety.

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

Good 

Reporting incidents and learning from when things go wrong

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

Staff knew what incidents to report and how to report them. Staff raised concerns and reported incidents and near misses in line with the provider policy. Staff reported serious incidents clearly and in line with provider policy. We looked at a number of incident reports and saw evidence of clear documentation and that the appropriate people had been involved in reviewing of incidents.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong.

Managers debriefed and supported staff after any serious incident. Staff reported that they felt well supported by the management team at the hospital when serious incidents occurred.

Staff met to discuss the feedback and look at improvements to patient care. We saw evidence of daily risk meetings and regular MDT's where changes to care were discussed in relation to changing risks and needs. There was evidence that changes had been made as a result of feedback.

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

Good 

Our rating of effective stayed the same. We rated it as good.

Assessment of needs and planning of care

Staff assessed the physical and mental health of all patients on admission. They developed individual care plans which were reviewed regularly through multidisciplinary discussion and updated as needed. Care plans reflected patients' assessed needs, and were personalised, holistic and recovery oriented.

Staff completed a comprehensive mental health assessment of each patient either on admission or soon after.

Patients had their physical health assessed soon after admission and regularly reviewed during their time on the ward.

Staff developed an individualised care plan for each patient that met their mental and physical health needs.

Best practice in treatment and care

Staff provided a range of treatment and care for patients based on national guidance and best practice. They ensured that patients had good access to physical healthcare and supported them to live healthier lives. Staff used recognised rating scales to assess and record severity and outcomes. They also participated in clinical audit and quality improvement initiatives.

Staff provided a range of care and treatment suitable for the patients in the service.

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

Good 

Staff identified patients' physical health needs and recorded them in their care plans.

Staff made sure patients had access to physical health care, including specialists as required.

Staff met patients' dietary needs and assessed those needing specialist care for nutrition and hydration.

Staff helped patients live healthier lives by supporting them to take part in programmes or giving advice.

Staff used technology to support patients. External agencies and families and carers have been able to talk to patients and attend patient meetings during the COVID pandemic with the use of teleconferencing. External agencies have told us that when this is requested it has been set up quickly.

Staff took part in clinical audits, benchmarking and quality improvement initiatives. We saw examples of audits of care plans, risk assessments, mental health act paperwork and audits of the physical environment including the clinic room and general cleanliness.

Managers used results from audits to make improvements. Clinical outcomes were discussed in the providers regular clinical governance meetings and shared with external teams and organisations. Ward managers shared the audits at local staff meetings and any feedback from the governance meetings. The service also shared learning from these audits in the monthly quality newsletter.

Skilled staff to deliver care

The ward team had access to the full range of specialists required to meet the needs of patients on the ward. Managers made sure they had staff with the range of skills needed to provide high quality care. They supported staff with appraisals, supervision and opportunities to update and further develop their skills. Managers provided an induction programme for new staff.

The service had access to a full range of specialists to meet the needs of the patients on the ward. However, there was a high turnover of consultant psychiatrists and this meant that patients were sometimes having to get to know a new consultant over the course of their treatment. There was also a high vacancy rate for qualified nurses, this meant that a large number of qualified nurse shifts were covered by agency nurses. Although the hospital told us they used regular agency nurses we felt this could lead to a lack of consistency for patients.

Staff and patients told us that there was not always enough staff on the wards to ensure activities were available to the patients 7 days a week. Patients told us that at the weekend they often only had access to the outdoor courtyard and self directed activities.

Managers ensured staff had the right skills, qualifications and experience to meet the needs of the patients in their care, including bank and agency staff. Managers gave each new member of staff a full induction to the service before they started work.

Managers supported non-medical staff through regular, constructive clinical supervision of their work. Managers supported staff through regular, constructive appraisals of their work.

Managers made sure staff attended regular team meetings or gave information from those who could not attend. We reviewed a sample of team meeting notes from previous months and meetings were well attended, detailed discussion took place and notes from the meetings were made available on the ward.

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

Good 

Multi-disciplinary and interagency team work

Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care.

Staff held regular multidisciplinary meetings to discuss patients and improve their care.

Staff made sure they shared clear information about patients and any changes in their care, including during handover meetings.

Ward teams had effective working relationships with external teams and organisations.

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

Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice and discharged these well. Managers made sure that staff could explain patients' rights to them.

However, we saw one example of an error that occurred during the admission of a patient to the ward. This error would have been spotted with a more thorough admission process. We spoke to managers about this and they assured us that changes had already been made to the way that patients were admitted to ensure this error did not happen again.

Staff received and kept up-to-date with training on the Mental Health Act and the Mental Health Act Code of Practice and could describe the Code of Practice guiding principles.

Staff had access to support and advice on implementing the Mental Health Act and its Code of Practice.

Staff knew who their Mental Health Act administrators were and when to ask them for support.

The service had clear, accessible, relevant and up-to-date policies and procedures that reflected all relevant legislation and the Mental Health Act Code of Practice.

Patients had easy access to information about independent mental health advocacy and patients who lacked capacity were automatically referred to the service. There was a poster detailing who the advocate was and when they would visit the ward and we saw evidence of their involvement in a number of people's care.

Staff explained to each patient their rights under the Mental Health Act in a way that they could understand, repeated as necessary and recorded it clearly in the patient's notes.

Staff made sure patients could take section 17 leave (permission to leave the hospital) when this was agreed with the Responsible Clinician.

Staff requested an opinion from a Second Opinion Appointed Doctor (SOAD) when they needed to.

Staff stored copies of patients' detention papers and associated records correctly and staff could access them when needed.

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

Good 

Managers and staff made sure the ward applied the Mental Health Act correctly by completing audits and discussing the findings and suggesting improvements where it was necessary.

Good practice in applying the Mental Capacity Act

Staff supported patients to make decisions on their care for themselves. They understood the hospital policy on the Mental Capacity Act 2005 and assessed and recorded capacity clearly for patients who might have impaired mental capacity.

Staff received and kept up-to-date with training in the Mental Capacity Act and had a good understanding of at least the five principles. There was a clear policy on Mental Capacity Act and deprivation of liberty safeguards, which staff could describe and knew how to access.

Staff knew where to get accurate advice on the Mental Capacity Act and deprivation of liberty safeguards.

Staff gave patients all possible support to make specific decisions for themselves before deciding a patient did not have the capacity to do so.

When staff assessed patients as not having capacity, they made decisions in the best interest of patients and considered the patient's wishes, feelings, culture and history.

The service monitored how well it followed the Mental Capacity Act and acted when they needed to make changes to improve.

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

Good 

Our rating of caring stayed the same. We rated it as good.

Kindness, privacy, dignity, respect, compassion and support

Staff treated patients with compassion and kindness. They respected patients' privacy and dignity. They understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition.

Staff were discreet, respectful, and responsive when caring for patients. Staff gave patients help, emotional support and advice when they needed it. Patients explained that staff were always available to support them and offered help and support where it was needed. Patients we spoke to expressed their gratitude for the progress they had been able to make during their time at the ward. We also saw a number of thank you cards that had been sent by patients or families and carers of patients stating their thanks for everything staff had done to support them in their journey.

Staff supported patients to understand and manage their own care treatment or condition. Staff were able to show that they understood and respected the individual needs of each patient.

Staff felt that they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards patients.

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

Good 

Staff followed policy to keep patient information confidential.

Involvement in care

Staff involved patients in care planning and risk assessment and actively sought their feedback on the quality of care provided. They ensured that patients had easy access to independent advocates.

Involvement of patients

Staff introduced patients to the ward and the services as part of their admission.

Staff involved patients and gave them access to their care planning and risk assessments where it was requested.

Staff made sure patients understood their care and treatment and found ways to communicate with patients who had communication difficulties. We saw evidence that they used interpreters for patients whose first language was not English and a signer for a patient that had hearing loss.

Staff involved patients in decisions about the service, when appropriate. We observed a community meeting which gave patients the opportunity to discuss any possible barriers they faced or suggestions for improvements to the way the ward operated.

Patients could give feedback on the service and their treatment and staff supported them to do this.

Staff made sure patients could access advocacy services.

Involvement of families and carers

Staff informed and involved families and carers appropriately.

Staff supported, informed and involved families or carers of patients despite the complexities that covid 19 caused. Staff helped patients keep in touch with families and carers by telephone and video calls. Where it was appropriate staff supported families and carers to attend meetings so that they could input into the treatment of their family member.

Staff gave carers information on how to find the carer's assessment.

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

Good 

Our rating of responsive stayed the same. We rated it as good.

Access and discharge

Staff managed beds well. A bed was available when needed and patients were not moved between wards unless this was for their benefit. Discharge was sometimes delayed for reasons beyond the control of the ward.

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

Good 

Bed management

Managers made sure bed occupancy did not go above a manageable level for the staffing levels and level of current risk on the ward.

Managers regularly reviewed length of stay for patients to ensure they did not stay longer than they needed to. The average length of stay on this ward was 40.5 days, the average length of stay of the patients when we visited was 22.43. We saw that the majority of patients were able to transfer or step down almost as soon as they were ready, a small number of patients stayed for longer because of the availability of a suitable alternative option. The psychiatric intensive care unit always had a bed available if a patient needed more intensive care.

The service had a high number of out-of-area placements. It was explained that there was a national shortage of this type of placement therefore it was often unavoidable for the ward to admit patients that lived far from their homes.

Managers and staff worked to make sure they did not discharge patients before they were ready. We saw clear discharge plans which were developed almost as soon as patients arrived on the ward. Where there was difficulty moving patients on, we saw evidence of work that teams were doing to support this process.

Staff did not move or discharge patients at night or very early in the morning.

Discharge and transfers of care

The service had a small number of delayed discharges since the last inspection. These delays were because of a lack of alternative placements elsewhere. Managers monitored the number of delayed discharges and took necessary steps to try to support this process.

Staff carefully planned patients' discharge and worked with care managers and coordinators to make sure this went well.

Facilities that promote comfort, dignity and privacy

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

Each patient had their own bedroom, which they could personalise if they wanted to.

Patients had a secure place to store personal possessions. Each patient had access to a small safe in their own bedroom and there was a larger room available to store personal belongings if needed.

Staff used a full range of rooms and equipment to support treatment and care. There were a number of different spaces available to carry out one to one work, the hospital had a well equipped gym and a large courtyard that patients could access when they wanted.

The ward had several quiet areas and a room where patients could meet with visitors in private. Despite the fact that some patients on the ward were quite unsettled, the ward was large enough for patients to be able to find some space for themselves.

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

Good 

Patients could make phone calls in private. There was a ward mobile phone and patients had access to their own devices where it was appropriate.

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

The ward offered a variety of good quality food. There was a rolling 3-week timetable of meal options which offered a wide variety of options and patients could also make specific requests if they wanted something different.

Patients' engagement with the wider community

During the time period where Covid safety measures were required the staff helped patients to stay in contact with families and carers.

Staff encouraged patients to develop and maintain relationships both in the service and the wider community.

Meeting the needs of all people who use the service

The ward was able to meet the needs of all patients, including those with a protected characteristic. Staff helped patients with communication, advocacy and cultural and spiritual support.

The ward could support and make adjustments for disabled people and those with communication needs or other specific needs. Although the ward was on the first floor, there was a lift that patients and staff could make use of to access the ward when coming or going. As the whole ward was on one level, rooms would be easily accessible for people with mobility problems.

Staff made sure patients could access information on treatment, local services, their rights and how to complain.

The ward had access to information leaflets in languages spoken by the patients and local community. Managers made sure staff and patients could get help from interpreters or signers when needed.

The service provided a variety of food to meet the dietary and cultural needs of individual patients.

Listening to and learning from concerns and complaints

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

Patients, relatives and carers knew how to complain or raise concerns. There were posters up on the ward and staff were able to explain and give examples of how they had supported patients with complaints in the past.

Staff showed that they had a good understanding of the policy on complaints and knew how to handle them. Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint.

Managers investigated complaints and identified themes which they went on to discuss with staff, for example at team meetings.

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

Good 

The service used compliments to learn, celebrate success and improve the quality of care. There was a file and a noticeboard located on the ward which contained a number of cards and letters from recent patients giving their thanks and gratitude for the treatment they received whilst admitted to the ward.

Are Acute wards for adults of working age and psychiatric intensive care units well-led?

Good 

Our rating of well-led improved. We rated it as good.

Leadership

Leaders had the skills, knowledge and experience to perform their roles. They had a good understanding of the services they managed and were visible in the service and approachable for patients and staff. Staff told us that they saw hospital managers on a regular basis and that they could approach them with concerns if they had them. They felt confident that they would be listened to.

Vision and strategy

Staff knew and understood the wards vision and values and how they were applied to the work of their team.

Culture

Staff felt respected, supported and valued. They said the ward promoted equality and diversity in daily work and provided opportunities for development and career progression. They could raise any concerns without fear.

Governance

Our findings from the other key questions demonstrated that governance processes operated effectively at ward level and that performance and risk were managed well.

However, we identified a concern in relation to safe prescribing of medication which we would have expected to have been picked up by good governance systems.

Ward and hospital staff carried out a number of audits of their work and used the results of these audits to make improvements. We saw examples of audits of care plans, risk assessments, mental health act paperwork and audits of the physical environment including the clinic room and general cleanliness.

Management of risk, issues and performance

Teams had access to the information they needed to provide safe and effective care and used that information to good effect.

The service had a risk register that was regularly reviewed and updated. The risk register was accessible by all staff who had access to the shared drive. The service held regular team meetings and there were regular regional governance meetings to share learning. There were daily risk assessment meetings. The service had created a regular quality newsletter which highlighted safety issues and lessons learnt from within the service and from external services, that was available for all staff to read in the staff rooms.

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

Good 

Information management

Staff collected analysed data about outcomes and performance and engaged actively in local and national quality improvement activities.

Managers engaged actively with other local health and social care providers to ensure that an integrated health and care system was commissioned and provided to meet the needs of the local population. Managers from the service participated actively in the work of the local transforming care partnership.

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

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Treatment of disease, disorder or injury

Regulation

Regulation 9 HSCA (RA) Regulations 2014 Person-centred care

The provider must ensure that care records are easily accessible for patients and staff. Ensuring that agency staff can access patient information quickly and that care records are written in a way that patients can understand.
(Regulations 9(1)(c)(3)(a)(b)(c)(d)(e)(f)(g)(h))

Regulated activity

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Treatment of disease, disorder or injury

Regulation

Regulation 18 HSCA (RA) Regulations 2014 Staffing

The provider must re-assess establishment levels and ensure the current permanent staffing levels match the needs of the service and work to reduce the amount of agency staff used.
(Regulations 18(1))

Regulated activity

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Treatment of disease, disorder or injury

Regulation

Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

The provider must ensure that all medicines are administered in accordance with hospital policy and that the policy is fit for purpose.

Regulated activity

Regulation

This section is primarily information for the provider

Requirement notices

Treatment of disease, disorder or injury

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Regulation 17 HSCA (RA) Regulations 2014 Good governance

The provider must ensure that systems and processes are established and operated effectively to ensure that accurate, complete, and contemporaneous records are being maintained and updated in respect of each patient, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided.
(Regulations 17(1)(2)(c)(f))

The provider must ensure that all staff are aware of the clinic room record keeping processes and complete audits to ensure records are being kept up to date.
(Regulations 17(1)(2)(d)(ii))