Cygnet Acer Clinic

Quality Report

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

Ratings

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

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

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

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

Summary of findings

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

Overall summary

We rated Cygnet Acer Clinic as good as because:

- Staff completed and updated risk assessments for each patient and used these to understand and manage risks individually. Staff supported patients to make their own decisions about their care and staff assessed and recorded capacity clearly. Care plans were personalised, holistic, recovery orientated and up to date. Patients had been involved with writing them.
- Staff understood their roles and responsibilities under the Mental Health Act (1983) and the Mental Capacity Act. The completion rates for training were 100%. Staff used restraint as a last resort and had positive behavioural plans in place to help patients develop strategies to manage their challenging behaviour.
- The hospital was visibly clean, and furniture was in good order. Domestic staff cleaned all areas of the ward regularly and both clinic rooms were clean. Staff stored medication correctly and they carried out daily checks on equipment.
- Staff understood what abuse was and how to report it. Safeguarding training was 95%.
- Patients accessed independent advocacy services and staff supported and encouraged them to access services in line with the Mental Health Act Code of Practice.
- The team included a good range of specialists to help meet the needs of the patients.
- Patients had rooms with ensuite facilities which they were able to personalise.
- Staff worked with individual patients to maximise the amount of time they could spend in the community accessing various groups including educational facilities, animal help groups, personal support groups and charities.

However:

- Staff had not updated the current ligature risk assessment since access to two areas had changed, and staff had not changed the risk assessment to reflect the change.
- There was a raised level of complaints and concerns about staffing levels and staff attitudes towards patients.
- We observed in two out of 10 patient notes staff had identified concerns but no care plans written to action or support the concerns..
- No all appropriate information was displayed in patient areas to inform patients of the complaints procedure, how to contact the CQC, provide information on mental health. Nor information for informal patients about their right to leave,the manager rectified this once informed
- The provider should improve the engagement of staff in knowing the vison and values of the organisation.
- The provider should ensure there is sufficient staff on the wards to facilitate patient activities including one to one sessions and planned leaves.
- The provider should ensure that SOAD is requested when required in order to ensure the correct authorisation for treatment is in place.

Summary of findings

Contents

Good

Cygnet Acer Clinic

Services we looked at

Long stay/rehabilitation mental health wards for working-age adults.

Summary of this inspection

Background to Cygnet Acer Clinic

Acer registered with the CQC in May 2015 to undertake the following regulated activities:

- assessment and treatment for persons detained under the Mental Health Act 1983
- treatment of disease, disorder or injury.

Cygnet Healthcare Limited purchased CAS Behavioural Health in 2018. This did not change the registration with CQC as there was no change to the legal entity of the company, so the current registration remained valid.

The hospital is a Longer Term High Dependency Rehabilitation Unit providing assessment, treatment and rehabilitation for up to 28 women with complex mental health needs, challenging behaviour and personality disorder.

Acer comprises two separate buildings, Upper House and Lower House. Both wards have 14 beds for females with a primary diagnosis of personality disorder. Upper House is the assessment and initial treatment ward; it offers a pathway through to Lower House which has a focus on rehabilitation. The service accepts patients detained under the Mental Health Act as well as informal patients. There were 14 female patients in Upper House. And 14 female patients in Lower House on the day of our inspection.

Acer had a registered manager and a nominated individual. The registered manager was on duty on the day of our inspection. We undertook a comprehensive inspection of this hospital in May 2016 and a focused inspection in July 2017 following information of concern. We rated Acer as Good at the May 2016 inspection and didn't change the rating following the July inspection.

The CQC undertook a Mental Health Act review in November 2015 and February 2018. The second review found many concerns mainly relating to staffing levels and the impact on care. The provider returned an action plan to demonstrate the concerns were addressed. Lower House opened in March 2017 and has not yet had a Mental Health Act review or inspection.

Our inspection team

The team that inspected the service comprised 3 CQC inspectors and one specialist advisor in rehabilitation.

Why we carried out this inspection

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

This inspection was unannounced.

How we carried out this inspection

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

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

Before the inspection visit, the CQC sent out a provider information request pack. We reviewed this and other information that we held about the location and asked a range of other organisations for information.

During the inspection visit, the inspection team:

Summary of this inspection

- visited both wards at the hospital, looked at the quality of the ward environment and observed how staff were caring for patients
- spoke with nine patients who were using the service
- spoke with the registered manager for the hospital and head of care for Lower House
- spoke with 11 other staff members; including doctors, nurses, occupational therapist, psychologist, receptionist, Mental Health Act administrator and social worker;
- received feedback about the service from three care co-ordinators or commissioners
- spoke with an independent mental health advocate
- attended and observed a multidisciplinary team morning meeting, the daily patient meeting and a patient care program approach meeting
- spoke with three carers
- received feedback from four commissioners
- collected feedback from two patients using comment cards
- looked at 10 care and treatment records of patients
- looked at the Mental Health Act paperwork for six patients
- looked at all medication cards and where relevant consent forms called T2s
- carried out a check of the medication management on both wards; and
- looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the service say

Three patients had mixed views about the service. Whilst some were pleased and satisfied with the care and treatment and gave positive feedback about the staff. Two patients were very dissatisfied and had requested treatment at other hospitals. These two patients said they felt unsafe and did not feel they were getting correct treatment. Commissioners also held mixed views. Three commissioners had commended the service, one commissioner had expressed concerns over care and treatment and had moved patients due to unsatisfactory care.

Two carers expressed dissatisfaction with the service and one was very positive.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Requires improvement

We rated safe as requires improvement because:

- Staff had not updated the ligature risk assessment. We found two areas had changed, and staff had not reviewed and updated the risk assessment to reflect these changes.
- One patient had been refusing medication and treatment and still had a T2 in place. Although staff had transferred the patient to another hospital the staff should have made a request to the CQC for a review by a second opinion appointed doctor.
- The provider should ensure there is sufficient staff on the wards to facilitate patient activities including one to one sessions and planned leaves.

However:

- The hospital had schedules in place to ensure regular cleaning and maintenance. The records we checked were up to date. The hospital was visibly clean, and furniture was in good order.
- Staff completed and updated risk assessments for each patient and used these to understand and manage risks individually.
- All emergency equipment was clean and serviced.
- When incidents occurred, staff investigated and shared learning with other staff. The team reported incidents appropriately both internally, and to external bodies such as the CQC.

Are services effective?

Good

We rated effective as good because:

- Staff completion rates for Mental Health Act and Mental Capacity Act training was at 100%.
- Patient care plans were personalised, holistic, recovery orientated and up to date.
- Patients had physical health care folders that had relevant health information in them.
- The team at Acer included different disciplines such as occupational therapists, psychologists, therapy co-ordinators and social workers.
- The manager held the weekly staff team meetings on different days and times to capture as many staff as possible.
- Staff supported patients to make their own decisions about their care and staff assessed and recorded capacity clearly.

However:

Summary of this inspection

- Two patient records documented concerns which did not have related care plans in place.

Are services caring?

Good

We rated caring as good because:

- Staff encouraged patients to be involved in their care and treatment.
- Most staff treated patients with kindness, compassion and respect.
- Patients assisted with interviewing staff and staff teaching sessions.
- Patients facilitated their own meetings and a patient representative was part of the clinical governance group.
- An advocate attended the ward weekly to help patients voice their concerns and complaints.

However:

- Three incidents reported concerned patients making complaints about poor staff attitude. Also, two patients requesting treatment at another hospital elsewhere due to perceived lack of care and support.

Are services responsive?

Good

We rated responsive as good because:

- Staff ensured good discharge planning by holding discharge planning meetings, inviting care coordinators, community nurses and family.
- Patients had their own rooms secured by individual key fobs. They were able to personalise their rooms and keep their belongings safe.
- The service treated concerns and complaints seriously. Management took action following investigations and shared the lessons learnt.
- Staff were active in the community promoting patient involvement.

However:

- There were no leaflets on relevant mental health problems.

Are services well-led?

Good

We rated well-led as good because:

- The hospital manager and heads of care were visible in the service and approachable to both patients and staff.

Summary of this inspection

- The service was very responsive to feedback from patients, staff and external agencies.
- There were clear frameworks for managers and staff to follow and this helped staff discuss the appropriate themes in meetings.
- The manager dealt with recommendations from internal and external reviews quickly.
- The service had plans for emergencies in the business continuity plan. Examples included flooding, gas leakage, minor and major accidents.

However:

- Staff were not yet clear on the new providers vision and values.

Detailed findings from this inspection

Mental Health Act responsibilities

We do not rate responsibilities under the Mental Health Act 1983. We use our findings as a determiner in reaching an overall judgement about the provider.

All staff had a good understanding the Mental Health Act. Mandatory training figures showed 100% of staff completed Mental Health Act training.

The hospital had a Mental Health Act administrator. Staff and patients spoke highly of the work they did. The administrator was able to offer advice to support to patients and staff with matters concerning the Mental Health Act.

Staff explained to patients their rights under the Mental Health Act in a way they could understand, repeated it as required and recorded they had done it. Rights information was available in easy read format for patients that required it.

Staff ensured patients took section 17 leave. Staff told us this wasn't always possible if a patient's risk deteriorated but they demonstrated good positive action to help for example reviewing one patients needs with medical staff, so they could have leave with one member of staff rather than two. Home leave was never cancelled/rearranged due to staffing.

The Mental Health Act administrator kept all the original section papers in their file and provided copies for the patient files. All care notes reviewed had all the correct detention papers present.

The providers policies and procedures were up to date with current guidance.

The two wards did not display an easy to see sign that told informal patients they could leave the ward freely. The manager rectified this once informed.

Patients had access to information about Independent Mental Health Act advocacy services. Staff displayed posters about advocacy services in Lower House. Staff said they had taken posters down in Upper House because of a patient's risk assessment. We saw a weekly visit from the advocate visiting patients during the inspection.

Care plans had discharge plans that included section 117 aftercare where appropriate.

Staff undertook audits of the use of the Mental Health Act every six months.

Staff understood the role of a second opinion doctor and when to request one. At the time of inspection there had been no patients who had needed a second opinion although one patient had needed a second opinion prior to their transfer to another hospital. Staff adhered to consent to treatment and capacity requirements. We reviewed ten medicine charts and staff had attached the correct consent to treatment forms. This meant nurses administered medicines to patients under the correct legal requirements.

Mental Capacity Act and Deprivation of Liberty Safeguards

All staff had a good understanding the Mental Capacity Act. Mandatory training figures showed 100% of staff completed Mental Capacity Act training.

The Mental Capacity Act is legislation that maximises an individual's potential to make informed decisions wherever possible. The Act and associated Code of Practice provide guidance and processes to follow when someone is unable to make capacitated decisions.

There were no Deprivation of Liberty Safeguarding between 31 July 2017 and 31 July 2018 and staff had received training and did understand when they would have to make a referral.

The provider had a policy for the Mental Capacity Act and Deprivation of Liberty Safeguards and the provider stored this electronically, and staff had easy access to this.

Patients had their capacity assessed and recorded. All care notes we viewed patients had capacity assessments where it was relevant, and they were decision specific.

Detailed findings from this inspection

Staff understood best interest decisions. Staff were able to give good examples of patient concerns the team had discussed through the multidisciplinary team but had not become best interest decisions because the patient held capacity.

Staff audited the use of the Mental Capacity Act monthly and actions taken where necessary.

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Long stay/ rehabilitation mental health wards for working age adults	Requires improvement	Good	Good	Good	Good	Good
Overall	Requires improvement	Good	Good	Good	Good	Good

Long stay/rehabilitation mental health wards for working age adults

Good

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

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

Requires improvement

Safe and clean environment

Safety of the ward layout

- Managers completed an environmental and ligature risk assessment in February 2018. Staff also carried out daily ward environment checks, ligature anchor risk assessments, building risk assessments and fire audits to quickly identify and minimise any potential risks.
- The ligature risk assessment had identified potential ligature anchor points and identified the action taken to reduce the risk. Changes in Lower House meant the assessment was not up to date. There were ligature anchor points in the patient kitchen. The patients now had free unsupervised access to this room and managers had not reflected this in the assessment. There was also a visitor/staff toilet with a door that patients could easily open with a coin. In the toilet there was a fixed shower screen and pipe work patients could use as a ligature anchor point. The taps on the sink were not anti-ligature. Both these areas had intermittent staff observations.
- Staff managed identified ligatures through ongoing clinical risk management and observations.
- The provider had installed closed circuit television cameras in communal areas of the hospital. Managers did not actively monitor the cameras but could use camera recordings as evidence in the review of incidents.
- On each ward the layout had been designed around the garden area and was on two floors. It was not possible to observe all bedrooms from the main corridor and staff reduced the risks by observation and risk assessment. Staff could increase observations based on a patient's level of risk. Records confirmed observations took place as per policy and staff completed records in real time. During our inspection, we saw staff observing the ward and other areas to help keep people safe.
- The wards were single sex and therefore complied with Department of Health guidance on eliminating mixed sex accommodation. All areas on both wards were clean, had good furnishings and were well-maintained. The provider employed two maintenance people full time.
- Rotas showed domestic staff cleaned all areas of the ward regularly. Staff told us domestic and maintenance staff would thoroughly clean and redecorate a room after the hospital discharged a patient.
- Staff adhered to infection control principles, including hand washing. Staff used the hand wash when they entered the unit. There were also hand washes in the toilets. There were no posters demonstrating correct hand washing techniques either on the ward or in the toilet.

Seclusion room

- The hospital did not have any seclusion rooms.

Clinic room and equipment

Long stay/rehabilitation mental health wards for working age adults

Good

- Each ward had a clinic room where the service stored physical health monitoring equipment and medication. Staff checked the equipment was working and clean and the check lists were all signed and dated correctly. A local pharmacy supplied medication and their pharmacist carried out weekly audits. They also provided a monthly summary for each ward.
- Staff had checked fridge temperatures daily. Staff kept emergency grab bags including oxygen, and an automated external defibrillator in ward offices so equipment would be easily available in emergencies. The staff checked the equipment daily. Electrical safety stickers were visible and in date.

Nursing staff

Safe staffing

- There was one manager for the hospital with a head of care in post on each ward. The establishment for qualified nurses was 12 whole time equivalents and 38 for healthcare assistants. For Upper House the sickness rate between 1 July 2017 to 30 June 2018 was 4% percent and the turnover rate was 45%. Vacancies were also 4%. Lower House had a sickness rate of 3%, a turnover rate of 33% and vacancy rate of 0%. The manager attributed some of the high turnover rate to new staff not successfully completing their probationary period or leaving shortly after starting. Management had discussed this in governance groups and this had led to a better induction for new staff.
- Staff said they would try and cover shifts where needed and the use of bank and agency was a last resort. The hospital had its own bank of staff and had access to Cygnets local bank. In the three months from 1 April 2018 to 30 June 2018 bank or agency staff covered 274 (14%) of shifts and there were 116 (6%) shifts not covered.
- The wards operated two shifts over 24 hours. Each shift had a minimum of one qualified member of staff on each ward but there were usually two. At night there was usually one qualified on each ward. There was also a head of care and the hospital manager who were available nine to five. The number of support workers varied each shift and rotas displayed between seven and 11 support workers on day shift across the two wards and between six and nine at night. The rotas did not show where staff worked on the day for example if a staff member was moved from one ward to another.
- The manager had used the provider's Staffing Analysis and Minimum Staffing Levels tool on calculating staff safety numbers. Duty rotas showed managers maintained safe staffing levels and above. When unexpected sickness or absence occurred, staff were able to request staff through their own bank of staff, the regional bank or from a local agency.
- In certain emergencies managers or senior staff would move staff from one ward to the other to help. Daily morning meetings reviewed staffing levels.
- Eight patients thought there were times when staffing was not safe. They thought staff hadn't responded quickly when they had activated alarm bells and that staff did not carry out observations appropriately. Patients described times when staff were unable to talk with them. Three patients did not feel they received their one to one time. One patient's record showed that the patient had declined one session and that staff had missed two sessions over the six months prior to the inspection.
- Staff explained they would rearrange some activities and leave but not cancel them. Staff gave examples of when they had rearranged activities such as due to poor weather, relatives visiting and changes in patient's risk behaviour. Some patients said staff had cancelled leave because of low staff numbers.
- There were enough staff to carry out physical interventions and all staff had received training in the Management of Actual or Potential Aggression.

Medical staff

- There were two doctors employed at Acer clinic, a psychiatric consultant and a staff grade doctor. The doctors were part of a rostered rota to provide out of hours cover. Staff spoke highly of the responsiveness of the medical team who could arrive within an hour of a call. The local GP surgery provided physical health cover.

Mandatory training

Long stay/rehabilitation mental health wards for working age adults

Good

- Data up to August 2018 showed over 85% of staff across all disciplines and departments had attended mandatory training, which included information governance, safeguarding and confidentiality. Separate records showed 100% of staff had completed Mental Health Act and Mental Capacity training. Only 30%(15) staff had training in intermediate life support. Patients with mental health problems are already at increased risk of coronary heart disease, cerebrovascular disease, diabetes, epilepsy and respiratory disease; all of which can be made worse by the effects of rapid tranquillisation and restraint. National Institute for Health and Care Excellence guidelines in violence and aggression: recommends all staff should have training in Intermediate life support training and be immediately available to keep patients safe when treatment involves medications and potential restraint. The hospital told us that their policy was to update staff with the practical elements of resuscitation and administration of oxygen in emergency situations annually, this include an assessment of staff's ability to perform CPR and use a defibrillator, As recommended by the Health and Safety Executive (2010). The hospital carried out recorded fortnightly resuscitation drills. The hospital audited its locations with defibrillators to make sure staff could reach them within three minutes.

Assessing and managing risk to patients and staff

Assessment of patient risk

- We reviewed ten patient risk assessments as part of the review of patient records
- Staff undertook a risk assessment of every patient before admission and then completed on admission. Staff updated risk assessments daily in the morning meetings, after incidents and reviewed them in the ward rounds held every month. Staff said patients were involved with reviewing their risk.

Management of patient risk

- Staff updated risk assessments according to patient need in the ten care plans reviewed. The multidisciplinary team held morning meetings and risks for individual patients updated. Staff identified and responded to changing risk to or posed by patients.
- The service used National Institute for Health and Care Excellence guidelines to develop their observation and search policies and procedures. Staff did not search patient bedrooms and only conducted pat searches (staff pat down the outer surfaces of a person's clothing) where necessary.
- Staff used a recognised risk assessment tool called the Short Term Risk Assessment and Treatability tool. The assessment considered a number of risk categories which included self-harm, substance misuse, self-neglect and vulnerability.
- There were no blanket restrictions in place at Acer Clinic. Staff managed restrictions through patient risk assessments. Blanket restrictions are the restrictions on the freedoms of patients receiving mental healthcare that apply to everyone rather than being based on individual risk assessments.
- The hospital had a no smoking policy within the building but patients were allowed to smoke in the garden.
- Informal patients knew they were free to leave but there were no clear signs to inform them they could leave the ward when they wished. The manager rectified this once informed.

Use of restrictive interventions

- The provider reported no incidents of seclusion or long – term segregation at Cygnet Acer Clinic between January 2018 to June 2018. The provider had a policy and procedure for seclusion and another for long-term segregation. All staff reported they did not use seclusion and long-term segregation.
- Rapid tranquilisation had recently taken place with two different patients on two occasions. There had been none within the reporting period 1 January 2018 to 31 May 2018. On these occasions the records indicated staff had followed the guidance set out by the National Institute for Health and Care Excellence.
- In the period between 01 January 2018 and the 31 May 2018 Upper House reported 220 incidents of restraint involving 16 patients. There were eight incidents of prone restraint which involved one patient. Staff were quick to return the patient to a supine or sitting position. In Lower House there were 18 reported incidents with six patients involved. There were no prone restraints reported. Acer have changed their training from the

Management of Violence and Aggression to Management of Actual and Potential Aggression . This training allows a greater focus on de-escalation and reduces the amount of physical restraint.

- Staff were clear they only used restraint after de-escalation techniques failed. Staff developed de-escalation techniques with the patients as well as formulating positive behaviour support plans. These are plans which are based upon a principle that someone can be taught a more effective and acceptable behaviour then the challenging behaviour will reduce.
- The provider had a reducing restrictive practice policy to guide staff practice. Staff reported on restrictive practices at monthly governance groups. The hospital's action plan included plans for reducing restrictive practices. This included annual audits, identifying staff and patients leads, and attendance at regional meetings to share good practice from other sites.

Safeguarding

- Staff received training in safeguarding and the training rate was 95%. Staff knew how and when to make a referral. The hospital had a safeguarding lead.
- Staff understood the protected characteristics under the Equality Act (2010) and were able to give good examples of how to protect patients from harassment and discrimination.
- Between the dates 31 July 2017 and 31 July 2018, the CQC received 18 safeguarding concerns and noted staff had dealt with these correctly.
- The provider had made a room available off the ward area for children to visit. Staff knew and followed the safe procedure for children if they visited.

Staff access to essential information

- The hospital used paper and electronic notes for keeping patient records and staff reported no problems accessing either. Staff had access to patient information.

Medicines management

- Staff followed good practice in the storage, dispensing, administration, reconciliation and followed National Guidance. The hospital had a visiting pharmacy and their pharmacist undertook weekly audits which the manager actioned, and they provided monthly summaries to the wards.
- There had been four dispensing discrepancies from 1 January 2018 to 30 June 2018 and they were all on the same day. Staff had checked the medication on arrival to the hospital and realised there were physical medicines missing. This had resulted from a problem between the GP and the pharmacy. Lessons had been learnt and the errors had been discussed and rectified with the pharmacist who now visits Acer Clinic weekly and completes a medication audit.
- We looked at 10 patient medication records on Upper House and they had all been correctly written, dated and signed. All patients held under the Mental Health Act, had consent to treatment forms signed called T2's. If a T2 was present it implied the patient had consented to medication and treatment. However, one patient had been refusing medication and treatment and still had a T2 in place. Although staff had transferred the patient to another hospital for physical health treatment the doctor should have requested a second opinion appointed doctor to review the patient's capacity in line with the Mental Health Act guidance.

Track record on safety

- There had been five serious incidents between 1 October 2017 to 1 October 2018 and there were no themes identified.
- The provider had investigated each incident and made action plans to prevent them again.

Reporting incidents and learning from when things go wrong

- Staff knew what incidents they needed to report and how to report them. Staff said it was better to over report than not report. We reviewed incident records and saw staff had taken appropriate action. Senior staff gave debriefs after incidents and any lessons learnt managers shared through staff meetings and email. Staff and managers discussed incidents in a variety of ways and this included morning meetings, reflective practice forums and team meetings.
- Managers also discussed incidents in monthly governance groups to identify themes, trends, lessons learnt, and any actions still not done.

Long stay/rehabilitation mental health wards for working age adults

Good

- The manager provided CQC with examples of changes made following these reviews and included all staff wearing belt bags containing individual ligature cutters to speed up access to patients when they had ligated.
- Staff were open and transparent and explained to patients when something went wrong. The hospital's policy for incident reporting and management detailed what Duty of Candour applies to, and the requirements and processes for staff to follow. Staff could give examples of speaking to patients and carers when things went wrong. This included an explanation of the incident and a written apology.

Are long stay/rehabilitation mental health wards for working-age adults effective?

(for example, treatment is effective)

Good

Assessment of needs and planning of care

- We looked at ten care plans and risk assessments for the patients, six in Upper House and four in Lower House. All the care plans were personalised, holistic (meaning the plan looked at the whole person, not just the illness), recovery orientated and up to date. One patient had not signed their care plan. The named nurse had written the reason why the patient had not signed it. This care plan clearly displayed patient involvement. Two of the patient notes had concerns identified but no care plans written to address these concerns or support the patients.
- Each patient had a separate physical health folder stored in the clinic rooms. They included all known physical health care problems such as diabetes and the necessary information about treatment.

Best practice in treatment and care

- Staff provided a range of care and treatment interventions suitable for this patient group. They used interventions recommended by the in the National Institute for Health and Care Excellence guidelines. They include but not limited to dialectal behaviour therapy, positive support plans and compassion focused therapy.
- Staff supported patients with their physical health and ensured they had access to physical healthcare as needed, following the National Institute for Health and Care Excellence guidance. The hospital had a service level agreement with a local GP surgery to meet the physical health needs of patients. Staff described the work with the surgery as very good.
- Staff used recognised rating scales to assess and record severity and outcomes. Staff used Health of the Nation Outcome Scales to record and review a patient's progress. Occupational therapists used the Model of Human Occupation Screening Tool to gain an overview of patients' occupational abilities. Staff were involved with different clinical audits across the hospital. This included but not limited to controlled drugs and storage of medication, quarterly care audit and audits on the Mental Capacity Act.

Skilled staff to deliver care

- The multidisciplinary team included an occupational therapist, a social worker, nurses, a consultant, a staff grade doctor, psychologists and therapy co-ordinators. The team also included the cleaners, kitchen staff and the maintenance people who also came into contact with the patients. A local pharmacist visited weekly.
- A lot of staff had the experience and the necessary knowledge and skills to work with the client group. Some staff did not feel they had sufficient training to understand the complex needs of the patients. The provider had introduced further specialised training to help staff. Currently 84% of staff who had contact with the patients have had specialised training in Personality Disorder. Managers told us all new staff get this on induction or shortly afterwards. There are some new staff who managers have booked in for training in the next month.
- Management staff had discussed the issue of staff knowledge at governance groups and actions were now in place to provide more reflective practice and supervision. Supervision is a meeting to discuss case management, to reflect on and learn from practice, personal support and professional development. The hospital had increased the frequency of staff supervision to monthly.
- From the 1 November 2017 to 30 June 2018 supervision rates for staff was 87% which was above the 85% target set by the provider. The yearly appraisal rate for

non-medical staff currently is 72%. Other staff have their appraisal booked in for their manager to complete. The medical staff were both 100% compliant with supervision and appraisals. Managers discussed learning needs with staff during supervision and appraisals. The hospital had an annual training plan which identified mandatory and additional training to equip new staff members essential to their roles.

- The manager held weekly team meetings and because staff attendance was not always good the manager was moving the days and times around to try and get better staff attendance.
- The manager and heads of care addressed poor staff performance through staff supervision and where necessary through formal disciplinaries.

Multi-disciplinary and inter-agency team work

- The multidisciplinary team met weekly and saw individual patients once a month. The meetings now included support workers. This gave a better overview of the patient.
- The hospital held morning meetings every day between staff and wards. There were different disciplines involved. The meetings reviewed patients ongoing care, risk, leave and activities.
- Agencies outside the hospital did not raise any concerns with the information shared.

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

- All staff had a good understanding the Mental Health Act. Mandatory training figures showed 100% of staff completed Mental Health Act training.
- The hospital had a Mental Health Act administrator. staff and patients spoke highly of the work they did. The administrator was able to offer advice to support to patients and staff with matters concerning the Mental Health Act.
- Staff explained to patients their rights under the Mental Health Act in a way they could understand, repeated it as required and recorded they had done it. Rights information was available in easy read format for patients who required it.
- Staff ensured patients undertook section 17 leave when the doctor had given it. Staff told us this wasn't always possible if a patient's risk deteriorated but they demonstrated good positive action to help for example reviewing one patients needs with medical staff so they could have leave with one member of staff rather than two. Home leave was never cancelled/rearranged due to staffing.
- The Mental Health Act administrator kept all the original section papers in their file and provided copies for the patient files. All care notes reviewed had all the correct papers present. The providers policies and procedures were up to date with current guidance.
- The two wards did not display an easy to see sign that told informal patients they could leave the ward freely.
- Patients had access to information about Independent Mental Health Act advocacy services. Staff displayed posters about advocacy services in Lower House. Staff said they had taken posters down in Upper House because of a risk towards a patient. An advocate visited patients during the inspection.
- Care plans had discharge plans which included section 117 aftercare where appropriate.
- Staff took audits of the use of the Mental Health Act every 6 months.
- Staff understood the role of a second opinion doctor and when to request one. At the time of inspection there had been no patients who had needed a second opinion although one patient had needed a second opinion prior to their transfer to another hospital.
- Staff adhered to consent to treatment and capacity requirements. We reviewed ten medicine charts and staff had attached the correct consent to treatment forms. This meant nurses administered medicines to patients under the correct legal requirements.

Good practice in applying the Mental Capacity Act

- All staff had a good understanding the Mental Capacity Act. Mandatory training figures showed 100% of staff completed Mental Capacity Act training.
- The Mental Capacity Act is legislation that maximises an individual's potential to make informed decisions wherever possible. The Act and associated Code of Practice provide guidance and processes to follow when someone is unable to make capacitated decisions.

Long stay/rehabilitation mental health wards for working age adults

Good

- There were no Deprivation of Liberty Safeguarding between 31 July 2017 and 31 July 2018 and staff had received training and did understand when they would have to make a referral.
- The provider had a policy for the Mental Capacity Act and Deprivation of Liberty Safeguards and the provider stored this electronically, and staff had easy access to this.
- Patients had their capacity assessed and recorded. All care notes we viewed patients had capacity assessments where it was relevant, and they were decision specific.
- Staff understood best interest decisions. Staff were able to give good examples of patient concerns the team had discussed though the multidisciplinary team but had not become best interest decisions because the patient held capacity.
- Staff audited the use of the Mental Capacity Act was monthly and actions taken where necessary.

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

Good

Kindness, privacy, dignity, respect, compassion and support

- Nine patients (including comment card feedback) felt staff treated them with respect, compassion and support. They also reported most staff respected their privacy and treated them with kindness. Three patients said not all staff did this and at times staff had been rude to them. Complaint records showed this had been the case and the manager had taken appropriate action with some staff. During the inspection we observed staff engaging with patients in a respectful manner.

Involvement in care

- Staff encouraged patients to be actively involved in their care. Staff worked with patients with their care plans, risk assessments and other interventions such as best de-escalation techniques to use when the patient became unwell. These are known as advanced decisions-decisions made in the present day to refuse treatment in the future when the patient can't make their own decisions.
- Patients were also involved in taking part in or giving teaching sessions to staff. Patients have also taken part in interview procedures and a patient representative attends the clinical governance meeting. Patients ran their own weekly meetings with staff attending to answer queries.
- Patients were able to give feedback on the service and staff conducted a patient survey yearly.
- Advocacy visited weekly and patients reported the advocate was very supportive. Patients could also access advocacy services by phone if required.

Involvement of families and carers.

- Some patients were clear about what information they would allow staff to share. Staff did share information where the patient had said it was alright.
- Staff invited carers/relatives to care meetings and offered support where appropriate. Staff acknowledged many of the patients were not from the local area and it could be difficult for some families and carers to be actively involved.

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

Good

Access and discharge

Bed management

- The hospital had an average bed occupancy of 87% from 1 January 2018 to 31 May 2018.The hospital accepted patients from across the country because of the specialist nature of the hospital. The hospital did not accept emergency admissions.
- Staff only moved patients when a clinical need arose for example when a patient's risk increased. Where possible

staff discussed this with the patient. When patients took leave staff never used their bed for further admissions. Staff planned moves or discharges at a suitable time of day.

Discharges and transfers of care

- Staff ensured good discharge planning by holding discharge planning meetings, inviting care coordinators, community nurses and family. The service had not reported any delayed discharges between 1 May 2017 and 31 June 2018.
- Between June 2017 and May 2018, the average length of stay for patients on Upper House was 322 days and on Lower House 277 days. Length of stay for patient in a long term high dependency service is usually one to three years.
- Staff supported patients during referrals and transfers of service. Senior staff would allocate staff to stay with the patient if they had to attend hospital emergency departments. Although staff told us the relevant information would go with the patient the local adult acute hospital had previously raised concerns over the sharing of information from Acer clinic when they were treating Acer patients. The staff at that hospital felt Acer staff had not provided enough or the necessary information. Staff from Acer had since rectified that concern.

The facilities promote recovery, comfort, dignity and confidentiality

- The hospital allowed all patients to have their own ensuite bedrooms and they were able to personalise their own rooms. Patients had locked cupboards in their bedrooms in which they could place their own possessions.
- Staff and patients had access to a full range of rooms and equipment to support their care and treatment. There were lounges, clinic rooms, therapy rooms and a gym (recently relocated so patients had a further quiet room). The lounges had computers with internet access. Activities provided included creative writing, mindfulness, baking, garden games/team building,
- Patients had access to visitor and quiet rooms.
- Patients were able to use a private telephone when needed and staff said there were no restrictions on use.
- Patients were able to access garden space and there was a separate garden for each ward.
- The kitchen staff provided food of a good quality and with choice.
- Patients had access to hot and cold drinks 24 hours a day. On Upper House some patients had their own kettles, but some patients would have to rely on staff to access hot water because the kitchen had limited access due to individual risk assessments. Patients had complained staff did not always respond quickly to requests for hot drinks because there were not enough staff. In Lower House staff did not lock the patient kitchen so there was 24 hour access to hot drinks.

Patients' engagement with the wider community

- Staff worked with individual patients to maximise the amount of time they could spend in the community accessing various groups including educational facilities, animal help groups, personal support groups and charities.
- Where possible staff worked with patients to maintain contact with relatives and carers. Staff encouraged relatives, friends and carers to visit where the patient wanted this. Staff have helped visitors with transport problems attend.
- Staff encouraged patients to maintain their relationships with friends and partners.

Meeting the needs of all people who use the service

- The service had made adjustments for people in wheel chairs and other disabilities. Some were specific to patient's disabilities, for example access to easy read leaflets. The hospital had ground floor bedrooms on each ward and lifts were available to gain access to upstairs rooms.
- Staff were clear they would support any wishes patients may have regarding any disability.
- Staff helped patients obtain information on treatments, how to complain and patient rights. Staff provided a welcome pack to patients when they arrived. The Mental Health Act administrator was available to discuss mental health rights. Although there were information leaflets regarding Mental Health Act rights seen on display there were no leaflets on relevant mental health problems.

Long stay/rehabilitation mental health wards for working age adults

Good

- Kitchen staff would change and adapt the food to meet individuals cultural or religious beliefs.
- Patients had no access to a multi faith room. Staff told us they supported patients to attend local spiritual places or had representatives visit from their chosen belief.

Listening to and learning from concerns and complaints

- The service had received 26 complaints between 25 June 2017 and 6 May 2018 and the service had upheld five of these. The manager informed the complainant of the outcome of the investigation in writing and verbally. There were no complaints referred to the Ombudsman. One of the common themes had been staff attitudes. There had been five common themes the management and governance group had identified regarding poor staff attitude and this had led to a change in training.
- Patients knew how to make a complaint. The provider displayed information on how to make a complaint on Lower House, but staff had taken down the information on Upper House due to patient risk. Patients attended daily patient meetings where staff encouraged patients to raise and discuss complaints and concerns. Minutes of these meetings reflected patients did complain and actions taken explained.
- Staff discussed all incidents and complaints at their own and regional clinical governance meetings to identify trends and work towards reducing them.
- Staff knew how to handle complaints appropriately. Staff received feedback from managers where possible about complaints and the outcome of investigations. Not all staff felt this happened.

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

Good

Leadership

- Leaders had the skills, knowledge and experience to perform their roles. They demonstrated a good understanding of the service they managed. They were able to explain how the teams in each ward were working to providing high quality care. Experienced colleagues would support new leaders when appointed and the new leaders were provided with training and development opportunities to ensure they could successfully perform their role. The regional operations manager would visit to offer support.
- The hospital manager and heads of care were visible in the service and approachable to both patients and staff. They held regular meetings for both staff and patients. Some staff didn't feel they were approachable or visible. In reviewing recent team meeting minutes, we saw the managers had discussed this issue with staff. During our inspection the patients knew the senior staff and the managers knew the patients.
- Cygnet healthcare provided staff with opportunities for leadership development. This included Cygnet's apprenticeship scheme, National Vocational Qualification in management and leadership, and university accredited management course.

Vision and strategy

- Staff were not yet clear on the new providers vision and values as they had recently changed. Staff still held the old providers values. The managers had a clear vision of the aims of the service and explained the new values of the provider.
- Staff felt there wasn't a lot of opportunity to contribute to the strategy of the service following the recent takeover. Staff could explain how they were working to deliver high quality care. The manager could authorise important financial decisions regarding patient care quickly.

Culture

- Most staff felt respected, supported and valued and felt positive and proud of working for the provider. In the staff survey eight staff (10%) felt the provider didn't pay them enough and didn't value their work. The results of a recent staff survey reflected this. The hospital manager had drawn up an action plan which included referring the pay issue to the human resources and reviewing activity levels of staff. Human Resource staff were holding clinics every 8 weeks to review staff feedback and experience.

- Staff knew how to raise concerns without retribution. Staff knew the whistleblowing process. The provider had recently appointed some speak up guardians who would be available to Acer Clinic staff.
- Staff completed equality and diversity training as part of mandatory training requirements. When we inspected, 93% of staff had completed this training.
- Managers dealt with poor performance through supervision and support. Staff records and incident reports showed managers also raised concerns with staff directly.
- Teams worked well together and where there were difficulties managers dealt with them appropriately. Staff spoke highly of the team work and support.
- Cygnet provides staff support through a comprehensive Employee Assistance Programme. This offers legal, financial and practical information, as well as confidential counselling. It is open to all permanent staff at Cygnet and their partners or family members. It is free to access and operates every day of the year.

Governance

- The provider had a clear framework of what staff discuss at local clinical governance and regional operational governance meetings. This included key performance indicators to gauge the performance of services, and benchmarking performance against similar services within the region. They also reviewed serious incidents, complaints, restraints, seclusion, safeguarding, medication errors, absence without leave and regulatory notifications. Attendees shared any lessons learnt.
- Staff had implemented recommendations from reviews of incidents, complaints and safeguarding concerns/ alerts at service level. The manager responded quickly to recommendations.
- Staff undertook and participated in local clinical audits. The audits were sufficient to provide assurance and staff acted on the results when needed. The service had a comprehensive audit schedule. Managers reviewed and tracked actions taken through the clinical governance group.
- Staff understood the arrangements for working with other teams, both within the provider and external, to meet the needs of the patients.

Management of risk, issues and performance.

- Staff maintained and had access to the risk register at ward and directorate level. Staff at ward level could escalate concerns when required. Staff concerns matched those on the risk register.
- The service had plans for emergencies in the business continuity plan. Examples included flooding, gas leakage, minor and major accidents.
- There were no cost improvement plans that negatively impacted on patient care.

Information management

- Staff had access to the equipment and information technology needed to do their work. The information technology infrastructure worked well and helped improve the quality of care. Information governance systems included confidentiality of patient records.
- Team managers had access to information to support them with their management role. This included information on the performance of the service, staffing and patient care. Information was in an accessible format and was timely, accurate and identified areas for improvement.
- Staff made notifications to external bodies as needed such as the CQC and local authority safeguarding teams.

Engagement

- Staff, patients and carers had access to up to date information about the work of the provider and the service they used, provided and accessed through emails, the internet and intranet and through information leaflets. Staff received a newsletter.
- Patients and carers had opportunities to give feedback through surveys, meetings and face to face contact.
- Patients were involved with some changes to the services. Cygnet Healthcare now employs a national full-time user involvement lead. Together with other service users they help to run patient forums in the hospitals; participate in a range of co-production work and help with quality assurance visits to services.
- Patients and staff could meet with local senior leadership teams, but this was not yet a regular occurrence.

Learning, continuous improvement and innovation

Long stay/rehabilitation mental health wards for working age adults

Good

- The provider had an overall commitment to be an organisation that is always moving forward providing the best possible healthcare.
- The hospital did not identify participation in national audits relevant to the service.
- The manager gave three examples of their commitment to improvement. These were a commitment to staff development, improvement and training, patient and carer involvement, and open forums for staff at all levels and grades.
- The manager told us they were constantly making efforts to improve the service and had been working on reducing restrictive practice. The service shared good practice with other Cygnet Healthcare services through different ways such as newsletters, emails and their regional governance groups

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure the ligature anchor risk assessment is reviewed and updated following changes to the environment or use of the environment.
- The provider must ensure all staff persons providing care or treatment have the qualifications, competence, skills and experience to do so safely.

Action the provider SHOULD take to improve

- The provider should ensure the appropriate information is displayed in patient areas to include complaints procedure, how to contact the CQC, information on mental health.
- The provider should ensure that the components of intermediate life support are clearly demonstrated in the training staff receive.
- The provider should ensure there is sufficient staff on the wards to facilitate patient activities including one to one sessions and planned leaves.
- The provider should ensure all staff treat patients with kindness, courtesy and respect.
- The provider should ensure that all identified patient concerns have care plans to address the concern.
- The provider should ensure they improve the engagement of staff in knowing the vison and values of the organisation.
- The provider should ensure that SOAD is requested when required in order to ensure the correct authorisation for treatment is in place.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment How the regulation was not being met: Staff had not updated the ligature anchor risk assessment following a change of use to rooms. This was a breach of regulation 12 2(d) ensuring that the premises used by the service provider are safe to use for their intended purpose and are used in a safe way.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing How the regulation was not met: Not all staff providing care or treatment had the qualifications, competence, skills and experience to do so safely. This was a breach of regulation 18 2(a) Persons employed by the service provider in the provision of a regulated activity must receive such appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform.