Cygnet Hospital Bierley

Quality Report

Bierley Lane
Bierley
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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.

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

Summary of findings

Overall summary

We carried out this unannounced focused follow-up inspection to confirm whether Cygnet Hospital Bierley had made improvements to its service since our last comprehensive inspection of the hospital on 16, 17 and 18 June 2015.

When we last inspected Cygnet Hospital Bierley in June 2015, we rated the service as requires improvement. We rated safe as inadequate, and effective, caring, responsive and well led as requires improvement. There were six breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These were in relation to the provision of safe care and treatment, treating patients with dignity and respect, delivering person centred care, safeguarding patients from abuse, the management of premises and equipment, and the overall governance of the service.

The provider had sent us an action plan telling us how it would ensure that it had made the improvements required in relation to these breaches of regulation. At this inspection, we confirmed that some improvements had been made.

We rated Cygnet Hospital Bierley as good because:

- There were sufficient numbers of trained staff on the wards who had the skills they required to carry out their roles. All staff who worked on Bowling ward had received training in dialectical behaviour therapy, the model of treatment used on the ward. Staff accessed clinical supervision and had annual appraisals where they had the opportunity to discuss their performance at work. Staff were positive about the service. They told us that they felt supported and saw senior managers frequently on the ward areas and at meetings.
- Staff carried out thorough patient assessments that were holistic and covered all aspects of patient need, including physical health. Patients had a full physical assessment on the day of admission with the nurse and the doctor. Each patient had a range of comprehensive risk assessments and care plans in place, including discharge plans, which were updated and reviewed on a regular basis. Care records we reviewed showed there was a person centred approach to recovery.
- On Bowling ward, where there had previously been a lack of patient supervision in communal areas, we observed staff to be with patients in all communal areas. Patients reported that this was now normal daily practice. The service operated a buddy system across all four wards where possible to support patients during admission on to the wards. This included information on how to complain. Patients had their own bedrooms with en-suite facilities that they were able to personalise. Activities were available for all patients seven days a week. Patients on Bowling ward told us that they were treated with dignity and had sufficient privacy. The service's involvement coordinator surveyed patients twice a year to monitor progress on areas of concern and to highlight areas of success.
- The service had implemented a 'Restrictive practice reduction strategy' across all wards in the hospital. The strategy outlines the actions taken to reduce the use of all restrictive interventions including prone restraint. Improvements had been made to remove blanket restrictions on Bowling ward which we identified at the previous inspection in June 2015. This included searching patients and restricting access to bedrooms. The hospital search policy for searching patients, visitors, property and the environment had been revised and now met the current guidance within the Mental Health code of practice. The hospital undertook regular audits of compliance with the Mental Health Act.
- Systems were in place across the hospital regarding the storage, disposal and recording of medicines. Nurses completed daily checks of the clinic room to help ensure medicines, including controlled drugs were stored safely and re-ordered when needed.
- There were procedures for reporting incidents and staff said they were clear about what to report. Staff told us they received feedback from managers following incidents which included reassurance and support. The hospital had a local risk register. Systems had been improved to ensure that data reviewed at board level accurately reflected data collected at ward level. In November 2015, the hospital successfully completed the self and peer review parts of the quality network for forensic mental health services annual

review cycle. It was reported by the lead psychologist, that there is a commitment to ongoing training evaluation and audit for Bowling Ward and the psychology service across the whole hospital.

However;

- There remained some concerns on Bowling Ward. The communal bathroom on Bowling ward had areas where the seal had cracked around both the bath and shower. This was an infection risk as it could not be cleaned properly. Area of potential ligature risk were identified by the inspection team during the visit. Furniture on Bowling ward needed replacing. Patient care plans did not always address the potential risks to people of early exit from the dialectical behaviour therapy programme. In addition, the timing of the ward rounds were inconsistent causing distress to patients who told us they would like this to change.
- The hospital had a spiritual room available. However, on the day of the inspection it was being used to store furniture including sofas and chairs.
- Although pharmacist advice was available, clear individual strategies for the use of 'when required' medication were not documented for patients who were at risk of violence and aggression, in line with the National Institute for Health and Care Excellence guidance. There were supplies of emergency medicines and equipment on each ward but wards that used Lorazepam injections for rapid tranquilisation did not keep a stock of the reversing agent. The hospital should discuss and assess this as part of their policy for rapid tranquilisation. Rapid tranquillisation is when medicines are given to a person who is very agitated or displaying aggressive behaviour to help quickly calm them. This is to reduce any risk to themselves or others, and allow them to receive the medical care that they need.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Forensic inpatient/ secure wards	Good 	

Summary of findings

Contents

Good

Cygnet Hospital Bierley

Services we looked at

Forensic inpatient/secure wards

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

Summary of this inspection

Background to Cygnet Hospital Bierley

Cygnet Hospital Bierley is registered with the Care Quality Commission to carry out the following regulated activities:

• Assessment and treatment for persons detained under the Mental Health Act 1983.

• Treatment of disease, disorder or injury.

A registered manager was in place at the location. The registered manager, along with the registered provider, is legally responsible and accountable for compliance with the requirements of the Health and Social Care Act 2008 and associated regulations, including the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and the Care Quality Commission (Registration) Regulations 2010.

An accountable officer was also in place. The accountable officer is a senior manager who is responsible and accountable for the supervision of the management and use of controlled drugs.

Cygnet Hospital Bierley had four wards:

- Bowling ward: An unlocked ward within a locked or 'secure' hospital for female patients with a personality disorder. The ward admits patients who are detained under the Mental Health Act and voluntary patients. Bowling ward is a 16-bedded ward with a four-bedded annexe - Phoenix. Phoenix was in use at the time of the inspection. At the time of our inspection, there were 17 beds in use by patients detained under the Mental Health Act and voluntary patients.
- Bronte ward: A low secure service for women. Bronte ward has 12 beds, which were full at the time of the inspection.
- Shelley ward: A low secure service for men. Shelley ward has 16 beds, which were full at the time of our inspection.
- Denholme ward: A psychiatric intensive care unit for women. Denholme ward has 15 beds, with 14 beds full at the time of our inspection.

Our inspection team

The team leader was CQC inspector Emma Hatfield.

The team that inspected the service comprised six CQC inspectors, a pharmacist inspector, and a specialist adviser who specialised in psychology, personality disorder and dialectical behaviour therapy.

Why we carried out this inspection

Our last inspection of Cygnet Hospital Bierley took place on 16, 17 and 18 June 2015. At that time, the service was not meeting all of the required regulations. The breaches were of:

- Regulation 9 (1) (a) Person-centred care – The policy for searching patients, visitors, property and the environment, did not meet guidance in the Mental Health Act code of practice. It also did not differentiate between voluntary and detained patients.
- Regulation 10 (1) Dignity and respect – The hospital did not give patients on Bowling ward access to their personal space, particularly their bathrooms.
- Regulation 12 (1) (2) (c) (g) Safe care and treatment – We found issues across all four ward areas relating to the management of medicines, including storage, administration and recording of medicines. We told the provider that it must ensure that staff on Bowling ward receive training which enables them to meet the clinical needs of the patients on Bowling ward.

Summary of this inspection

- Regulation 13 (1) Safeguarding service users from abuse and improper treatment – We told the provider that it must introduce measures to reduce the use on patients of face-down (prone) floor restraint by staff. Face-down restraint can put patients at risk of asphyxiation.
- Regulation 15 (1) (c) Premises and equipment – We told the provider that it must make sure the seclusion room and de-escalation room are safe and meet current national guidelines.
- Regulation 17 Good governance – Governance systems did not ensure staff recognise themes, address them and learn from them. Systems for collection and review of data did not ensure that information at board level was consistent with information gathered at ward level.

The provider sent us an action plan telling us how it would meet the regulations. On this inspection, we checked to see if the provider had made improvements and found some improvements had been made.

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, we reviewed information that we held about the location, asked a range of other organisations for information and sought feedback from patients.

During the inspection visit, the inspection team:

- visited all four wards at the hospital, looked at the quality of the ward environment, and observed how staff were caring for patients
- spoke with 24 patients who were using the service
- spoke with the Clinical Manager, the General Manager, the Clinical Quality Compliance Lead and managers or acting managers for each of the wards
- spoke with 19 other staff members, including doctors, nurses, an occupational therapist, a psychologist and a social worker
- attended and observed one multidisciplinary meeting
- looked at 25 care and treatment records of patients
- looked at 35 prescription charts
- carried out a specific check of the medication management on all four wards
- looked at policies, procedures and other documents relating to the running of the service.

What people who use the service say

We gave all patients at the hospital the opportunity to speak with us during the inspection. We spoke with 24 patients from across all four wards.

Patients on Bowling ward told us they believed that they were listened to by most staff and that they could get support when they needed it during day or night.

Patients from all four wards told us staff were caring and approachable. One patient said staff showed a genuine interest in patients through simple gestures like saying hello and asking how they were each day.

Parents we spoke with said staff were caring, kind and professional. The majority spoke very highly of the service and the support they received.

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

- The communal bathroom on Bowling ward had areas where the seal had cracked around both the bath and shower. This was an infection risk, as it could not be cleaned properly. There was an unpleasant smell on Bowling ward which staff told us was due to the furniture needing replacing.
- Ligature risks on Bowling ward and Bronte ward were identified by the inspection team. These had not been included on the hospital ligature risk register.
- There were supplies of emergency medicines and equipment on each ward but wards that used Lorazepam injections for rapid tranquilisation did not keep a stock of the reversing agent. The hospital should discuss and assess this as part of their policy for rapid tranquilisation.
- Although pharmacist advice was available, clear individual strategies for the use of 'when required' medication were not documented for patients who were at risk of violence and aggression, in line with the National Institute for Health and Care Excellence.

  However,
- Systems were in place across the hospital regarding the storage, disposal and recording of medicines. Nurses completed daily checks of the clinic room to help ensure medicines, including controlled drugs were stored safely and re-ordered when needed.
- There were procedures for reporting incidents and staff said they were clear about what to report. Staff told us they received feedback from managers following incidents which included reassurance and support.
- Improvement works had been carried out to areas of the hospital, which we identified as posing risks to patient at our last inspection in June 2015. This included the installation of anti-ligature taps and showers in en-suites and communal bathrooms.In addition, on Bowling ward, cables for the television in the communal lounge had been shortened by tying together the cables with plastic ties and these were not accessible by patients.
- On Bowling ward, where there had previously been a lack of patient supervision in communal areas, we observed staff to be with patients in all communal areas. Patients reported that this was now normal daily practice.

Summary of this inspection

- The hospital search policy for searching patients, visitors, property and the environment had been revised and now met the current guidance within the Mental Health Act code of practice.
- Improvements had been made to remove blanket restrictions on Bowling ward which we identified at the previous inspection in June 2015. This included searching patients and restricting access to bedrooms.
- The service had implemented a 'Restrictive practice reduction strategy' across all wards in the hospital. The strategy outlines the actions taken to reduce the use of all restrictive interventions including prone restraint.

Are services effective?

Good

We rated effective as good because:

- Staff who worked on Bowling ward had received training in dialectical behaviour therapy which was the model of therapy used to treat patients on the ward. There were care plans in place to support staff to care for patients receiving dialectical behaviour therapy.
- Staff received an annual appraisal of their work performance and received regular clinical supervision. The hospital measured compliance with supervisions and appraisals on a month-by-month basis.
- Staff followed the psychiatric intensive care unit and seclusion standards recommended by the National Institute for Health and Care Excellence, and patients could access psychological appropriate psychological therapies in line with this guidance.
- Staff followed medicines management policies.
- Patient records were complete and accurate. They contained care plans and risk assessments which were updated and reviewed on a regular basis. Staff carried out assessments that were holistic and covered all aspects of patient need. Patients had a full physical assessment on the day of admission.
- Care records we reviewed showed there was a person centred approach to recovery.
- The hospital undertook regular audits of compliance with the Mental Health Act.

However,

- On Bowling ward, patient care plans did not always address the potential risks to people of early exit from the dialectical behaviour therapy programme.

Summary of this inspection

- On Bowling ward, the timing of the ward rounds were inconsistent causing distress to patients who told us they would like this to change.

Are services caring?

Good

We rated caring as good because:

- Patients on Bowling ward told us they believed that they were listened to by most staff and that they can get support when they need it during day or night.
- Patients on Bowling ward were asked whether they felt they were treated with dignity and they had sufficient privacy. They were positive about their care in this area.
- The service operated a buddy system where possible to support patients during admission on to all four wards.
- The service's involvement coordinator surveyed patients twice a year to monitor progress on areas of concern and to highlight areas of success.

Are services responsive?

Good

We rated responsive as good because:

- Care records contained comprehensive discharge plans which included an estimated date for discharge from the hospital.
- The ward environments were spacious and nicely decorated. Patients had their own bedrooms with en-suite facilities that they were able to personalise.
- Activities were available for all patients and were facilitated on weekdays by the occupational therapy team. On weekends, nursing staff facilitated these sessions.
- The hospital had a complaints policy and procedure in place which was displayed on all four wards. It was also given to the patients on their admission to the hospital.

However,

- The hospital had a spiritual room available. However, on the day of the inspection it was being used to store furniture including sofas and chairs.

Are services well-led?

Good

We rated well-led as good because:

- Staff across the hospital had access to clinical supervision, annual appraisals and mandatory training. Compliance rates were high which showed that staff had the skills they required for their roles, and had opportunity to discuss and review their performance at work.

Summary of this inspection

- All ward managers told us that they had support from the general manager, the quality lead and the registered manager who managed the service and could go to them with any issues. Nurses and support workers said they saw senior managers frequently on the ward areas and at meetings.
- The hospital had undertaken a staff survey in 2016 which had produced a 78% positive score.
- The hospital had a local risk register. The local risk register had six identified risks, which included recruitment of qualified nursing staff and seclusion.
- In November 2015, the hospital successfully completed the self and peer review parts of the quality network for forensic mental health services annual review cycle.
- It was reported by the lead psychologist that there is a commitment to ongoing training evaluation and audit for Bowling Ward and the psychology service across the whole hospital.
- Systems had also been improved to ensure that data reviewed at board level accurately reflected data collected at ward level.

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.

Training data we reviewed showed 97% of staff had been trained in the Mental Health Act. The training and policies had been updated in line with the revised Code of Practice. Staff referred to a copy of the Mental Health Act code of practice available in hard copy and electronically on all four wards.

Staff completed documentation in respect of the Mental Health Act to an appropriate standard. Paperwork about detention was accessible in patients' records and was stored securely. Staff we spoke with had a good understanding of the guiding principles of the Mental Health Act.

Staff informed patients of their rights verbally and in writing. The manager completed monthly audits to ensure this was in accordance with the requirements of the Mental Health Act.

The hospital had a policy for the administration of the Mental Health Act and a local protocol for the application of the Mental Health Act.

Mental Capacity Act and Deprivation of Liberty Safeguards

The hospital had a policy for the Mental Capacity Act.

General training in the Mental Capacity Act was included as part of the 'safeguarding children and adults at risk' training module which had a compliance rate of 99%.

Staff had a good understanding of the Act and how this applied in their practice. There were no deprivation of liberty applications made by the hospital in the previous 12 months of the inspection.

Medical staff completed a Cygnet document to record patients' consent on admission.

Staff understood and worked within the definition of restraint according to the Mental Capacity Act. Staff were able to give working examples of how they took this into account and described using restraint for the shortest possible time period and to prevent harm.

A local independent mental capacity advocacy service provided patients with advice on mental capacity. Displays in the ward areas promoted this service.

Good

Forensic inpatient/secure wards

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

Are forensic inpatient/secure wards safe?

Requires improvement

Safe and clean environment

At our previous inspection in June 2015, we found that areas of the hospital had ligature risks that were awaiting works to be completed to remove them. The provider had developed an action plan to response to these findings. We found the most of the actions in the plan had been completed and were effective in bringing about improvements.

During this inspection, we found the provider had upgraded bathrooms and they had installed anti-ligature taps and showers in en suites and communal bathrooms. Other items identified as a risk during our last inspection for example the cables for the television in the communal lounge on Bowling ward, had been shortened by tying together the cables with plastic ties and these were no longer accessible. However, we found that some ligature risks on the ward ligature risk register had not been mitigated. For example, hinges on wardrobe doors and bedroom doors. In addition, some ligature risks had not been identified at all on the ligature risk register. These included blinds on the meeting room door and window on Bronte ward. The provider addressed this during our inspection and the manager provided us with a copy of the updated ligature risk register.

The wards were visibly clean although there were areas that smelled unpleasant. There was a particularly strong unpleasant odour on Bowling ward. Staff told us this was related to the furniture on the ward. The provider was in the process of updating and refurbishing furniture across the hospital which we were told would address the problem.

The communal bathroom on Bowling ward had areas where the seal had cracked around both the bath and shower. This was an infection risk as it could not be cleaned properly. The clinic room examination couch was ripped in places and the foam underneath was showing through. This was an infection risk as the foam could not be adequately cleaned. However, managers told us that work was being carried out on the second day of our inspection. They said that this work had been scheduled by the maintenance team to address these issues. Prior to leaving the service, we checked and saw the maintenance team had completed the work.

Staff told us that where maintenance issues were noticed they would email the maintenance team and the work would be added to a maintenance log. We reviewed the maintenance log which showed what work was required and when it would be completed. We also saw an ongoing programme of works which included the decorating of wards. Staff told us that when wards were due for painting this would be discussed with patients who would choose the colours.

At our previous inspection in June 2015, we found that the hospital seclusion rooms did not meet the required standards of the National Institute for Health and Care Excellence published guidance 2015, 'Violence, and aggression: short-term management in mental health, health and community settings'. At this inspection, we confirmed that the provider had made some improvements to the seclusion rooms. The service had removed the identified ligature risks and the seclusion

rooms on both Shelly and Denholme wards provided patients with access to appropriate washing and toilet facilities. There was a clock visible in each suite to ensure the patient could remain orientated to date and time. The service had recently installed a two-way intercom system enabling patients to communicate with staff along with facilities to control the temperature of the rooms. However, the facilities appeared tired and in need of redecoration. We were informed the service was aware of this and had plans to decorate following the installation of the intercom system. We were not given any dates for the completion of these works.

All four wards had L-shaped corridors with communal rooms and bedroom doors that opened onto the corridor. The nursing offices of the four wards were situated in a position that meant the staff inside had restricted vision of the main ward corridors. The layout did not allow staff to observe patients easily and communal corridors did not have mirrors to help with observations. At our previous inspection in June 2015, on Bowling ward, we observed that staff did not supervise the main corridors and staff on duty used a smaller, adjoining nursing office that had no visual access to the ward from which they could hear limited noise from the ward. During this inspection, staff were observed to be with patients in all communal areas, and patients reported that this was now normal daily practice. We noted that there was always a member of staff in the corridor and although at times staff were in the large office working, they were observed to answer the door quickly and respond appropriately when patients knocked on it.

Safe staffing

The hospital measured compliance with mandatory training on a month by month basis. The overall mandatory training compliance rate from July 2016 was 94%. The target for mandatory training compliance was 95%. There were 30 modules considered as mandatory training. Modules below the target for compliance were: food hygiene (75%), immediate life support (89%), security awareness (94%) and Prevent (40%). Prevent training is designed to safeguard people and communities from the threat of radicalisation and supporting terrorism in line with the government's Prevent strategy. The prevent module was introduced in June 2016 which explained the lower than target compliance rate. All staff we spoke with across the hospital were positive about the training they received. They told us they felt they had access to training which meant they had the skills they required to carry out their roles.

The provider used a tool to calculate the number of staff required for the number of patients. At the time of our inspection, Bowling ward had five whole-time equivalent qualified nurse vacancies, which was the highest number of qualified nurse vacancies for a ward and 41% of the total establishment level of whole time equivalent qualified nurses for the ward. Bowling and Denholme wards both had two vacancies for nursing assistants.

- Establishment Levels qualified nurses whole time equivalents: 36
- Establishment levels nursing assistants whole time equivalents: 57
- WTE vacancies qualified nurses: 11.78
- WTE vacancies nursing assistant: 4
- Qualified nurse vacancy rate: 32%
- Nursing Assistant vacancy rate: 7%
- Shifts filled by bank staff to cover sickness, absence or vacancies (last six months): 15%
- Shifts filled by agency staff to cover sickness, absence or vacancies (last six months): 23%
- Shifts filled by overtime to cover sickness, absence or vacancies (last six months): 10%
- Total number of substantive staff: 146
- Total number of substantive staff leavers in the last 12 months: 37
- Total % of staff leavers in the last 12 months: 26%
- Total % vacancies overall: 14%
- Total permanent staff sickness overall (last six months): 3%

The staffing levels were often maintained using bank and agency. This was in relation to covering the number of vacant posts the service had at the time of the inspection. The quality manager told us they had given bank staff temporary contracts and 'block booked' agency staff in order to ensure consistency of care for patients. We spoke with the ward managers who told us they were able to adjust their staffing levels to meet patient need. We looked at the previous four weeks' worth of rotas in place on all four wards and saw that staffing numbers had been maintained and there had been no staffing shortages.

Assessing and managing risk to patients and staff

Good

Forensic inpatient/secure wards

We reviewed 25 patient records and found they contained up to date risk assessments which showed staff had assessed risks in a comprehensive way. The risk assessments we looked at provided staff had clear guidance on how to manage the risks identified. These included physical health, and risk to self and others. We saw staff reviewed the risk assessments on a regular, monthly basis and updated them when an incident had occurred. We saw the hospital used a recognised tool, the short-term assessment of risk and treatability, to assess and review patient risks, which was suitable for acute and forensic mental health services. A Historical Clinical Risk Management tool was completed and regularly reviewed for every patient. A risk sheet with triggers and responses identified was also in place for every patient. These provided staff with clear guidance on how to manage the risks identified.

At our previous inspection in June 2015, we found that medicines were not always handled safely because medicines stocks were not well managed and records were not always completed at the time of administration. The provider had implemented a number of actions in response to these findings, which had been effective in bringing about improvement.

The hospital had a service level agreement in place for both medicines supply and clinical pharmacist advice. The pharmacist completed checks of the prescription charts, authorities and the clinic rooms. Prescription interventions were logged electronically along with the responses to support learning. Nurses also completed daily checks of the clinic room to help ensure medicines, including controlled drugs were stored safely and re-ordered when needed. There were supplies of emergency medicines and equipment on each ward but wards that used lorazepam injections for rapid tranquilisation did not keep a stock of the reversing agent which could put patients at risk if they inadvertently received an overdose. The hospital should consider this as part of their policy for rapid tranquilisation.

We looked at 35 prescription charts and associated authorities across the hospital. The prescription charts were up-to-date and clearly presented to show the treatment people had received. We raised an error when we found on one prescription chart with the ward nurse, immediate action was taken to record and investigate this under the hospital policy. Where required, the relevant legal authorities for treatment were in place and checked by nurses when administering medicines. Patients wishing to self-administer medication were assessed and where possible supported to do so. Discretionary medicines were stored for treatment of minor ailments and administered by staff when required.

We saw that where needed; additional physical health checks and therapeutic drug monitoring was carried out and recorded. Monitoring is important to ensure people are physically well and that they receive the most benefit from their medicines. We saw that nurses monitored patients' physical health after the use of rapid tranquilisation but on one record we examined monitoring had not be recorded for as long as defined in hospital policy.

Patients' medicines and physical health needs formed part of the discussions at patient reviews. However, although pharmacist advice was available, clear individual strategies for the use of 'when required' medication were not documented for patients who were at risk of violence and aggression, in line with the National Institute for Health and Care Excellence guidance. NG10 Violence and aggression: short-term management in mental health, health and community settings May 2015.

At our previous inspection in June 2015, we found that the hospital search policy for searching patients, visitors, property and the environment did not meet the current guidance within the Mental Health Act code of practice. At this inspection, we found the service had reviewed and revised the search policy. This was dated March 2016 and due to be reviewed in March 2017. This search policy was in line with the Mental Health Act code of practice guidance, including direct reference to the revised code of practice and an explanation to staff regarding what this meant in practice.

Staff undertook observations of patients based on their needs and risk level. Enhanced observations were completed for patients identified as high risk. Staff completed minimum hourly checks of patients and these were recorded giving details of the patient's presentation and whereabouts.

At our previous inspection in June 2015, we found that there was a lack of awareness amongst the senior leadership team of the number of prone restraints used in the hospital and therefore no plans as to how to reduce the number of incidents and the use of restraint. On this

inspection, we spoke with the quality lead who told us the service were working closely with a Cygnet wide lead for reducing restrictive practice to make improvements in keeping with the "safe wards" initiative. The hospital provided information about incidents of, seclusion, long-term segregation, and restraint between January 2016 and June 2016. There were 16 reported incidents of seclusion in this period. The level of detail in the data we reviewed showed that there had been improvements made in the way that the hospital gathered information regarding incidents. This meant the reporting and monitoring of incidents and types of restraint was robust.

At our last inspection in June 2015, we were told by staff and patients and our observations confirmed, that there were a number of blanket restrictions in place on Bowling ward. These included;

- Access to bedrooms was restricted for some patients. Incident records showed this had led to incidents where staff were injured and patients restrained and secluded.
- Bowling ward had ligature points in the bathrooms and the hospital was unable to confirm dates for completion of works to remove these. Measures in place to mitigate these risks were that staff supervised all patients whilst having showers.
- We were told that although patients had access to facilities to make hot drinks, they had to ask staff for cups.

During this inspection, we found the hospital had commenced phase two 2016-2017 of their 'Restrictive practice reduction strategy'. Cygnet Health Care has also become a member of the 'Restraint reduction network' which gives a clear and transparent commitment to the reduction of restrictive practices and restraint in their services. We spoke with patients from all wards across the hospital and the involvement lead who told us there had been a large number of patients involved in this work at Cygnet Hospital Bierley. Feedback from staff and patients specifically on Bowling ward was very focused on the reducing restrictive practice work. They said they did not believe that objects were unreasonably held from them and most, except for the most recent admissions had the 'Ward Expectation Booklet' which detailed what they could and could not have. This however, was not being reviewed in conjunction with patients. Staff and patients told us that showers are no longer supervised, bedrooms were open at all times and patients were observed to have free access to their rooms. Patients also reported being able to have cups to enable them to access hot drinks at any time and our observations confirmed this.

At the last inspection in June 2015, we reviewed care records on Bowling ward which showed that care plans were not in place for wound care for those patients who self-harmed. We also reviewed incident records which showed medical staff had not reviewed patients following incidents of self-harm. On this inspection, we reviewed eight care records on Bowling ward and saw the care plans did refer to all aspects of care and risk management for each patient, including triggers to self-harming, most likely time of self-harming. Care plans provided staff with clear guidance also on procedures to follow for informing medical staff and ensuring appropriate reviews were carried out. We also reviewed 32 incident record forms and saw evidence which showed medical staff had been contacted where appropriate in response to assess any injuries.

All staff were required to complete mandatory 'adults at risk' (safeguarding) training. Minutes of meetings we reviewed showed safeguarding was an on-going agenda within team meetings. There were resources available to staff and an out of hours number for safeguarding advice. A social worker based at the hospital also provided any required support to staff. The ward managers and nursing staff said they had good working relationships with local authorities. We reviewed information relating to incidents for the previous 12 months where patients had assaulted other patients. The incident reports included details which showed that safeguarding referrals had been made or advice sought where appropriate. This meant that safeguarding procedures had been robustly followed.

Reporting incidents and learning from when things go wrong

Data we reviewed showed there had been 1022 incidents in the period January 2016 to June 2016;

• Bowling – 451 incidents of which 199 were incidents of self-harm

• Bronte – 121 incidents of which 1 was an incident of self-harm

• Denholme – 382 incidents of which 88 were incidents of self-harm

Good

Forensic inpatient/secure wards

• Shelley – 63 incidents with no incidents of self-harm

Cygnet Hospital Bierley used a paper system to record all incidents. Staff completed forms at the time of an incident, and the ward manager and the registered manager reviewed the forms. Staff collated information from the forms and provided this to managers to enable them to identify any concerns about individuals or patterns across the wards each month. Staff told us they received feedback from managers following incidents which included reassurance and support.

The hospital had implemented a process for reviewing incidents. Staff would complete an incident form that acted as an index for an incident. Separate forms would be completed if the incident involved the use of restraint, seclusion, and rapid tranquilisation. An incident involving all four would have four separate forms completed, with an overarching incident form completed to act as the index. The incident form had a section that documented the outcome of the incident.

The four ward managers and the quality and governance lead met daily in 'morning meeting' to conduct an initial review of incident forms. After this review, the forms would be given to an administrator to be entered on to E-Prime, the hospital's electronic clinical governance programme. The hospital employed a data analyst who was responsible for producing a monthly data pack that included analysis of incident themes and trends. The monthly data pack was used to inform the monthly local clinical governance meeting. The monthly local clinical governance meeting was comprised of the hospital's senior managers and clinicians. The meeting had a standard agenda that reviewed key elements of clinical governance each month including serious incidents, complaints and compliments, and use of restraint and seclusion. Each month the meeting also reviewed key themes such as medication management, advocacy and compliments. Themes were repeated quarterly which meant that the hospital would, for example, review medication management every February, May, August, and November. Actions from the local clinical governance meeting would be passed down to the morning meeting for the ward managers and discussed further at each ward team meeting.

Duty of Candour

The provider had a policy to instruct staff about the different situations where they needed to be open with patients and how to support them, their families and carers. Staff said they followed duty of candour and ensured they initially apologised verbally and then again in writing with a full explanation. Providers of healthcare services must be open and honest with service users and other 'relevant persons' (people acting lawfully on behalf of service users) when things go wrong with care and treatment, giving them reasonable support, truthful information and a written apology.

Are forensic inpatient/secure wards effective?

(for example, treatment is effective)

Good

Assessment of needs and planning of care

We looked at 24 patient care and treatment records. These were stored electronically and the system allowed staff to access them to update and review records when required. We saw that care plans and risk assessments were updated and reviewed on a regular, monthly basis or when an incident had occurred. Care plans addressed individual patient needs and showed the involvement of the patient. Staff carried out thorough patient assessments that were holistic and covering all aspects of patient need.

To meet the additional healthcare needs of patients, the hospital had an agreement for an afternoon per week of appointments at a local GP practice. Clear records of GP advice were maintained however, we saw one example where GP advice had not been promptly acted upon. We raised this with the ward doctor and it was addressed immediately.

Where any patients required urgent physical health, care staff would accompany them to the local accident and emergency department or an out of hour's doctor service. Nursing staff completed monitoring of patients physical health in relation to diabetes, high cholesterol, blood pressure monitoring and electrocardiograms.

Patients had a full physical assessment on the day of admission with the nurse and the doctor. This included physical observations such as body mass index, blood pressure, electro-cardiogram, full blood count, and urinalysis. The hospital used the Lester tool as part of their

physical health monitoring to support improvements in patients' physical health. The Lester tool guides health care workers through the assessment of a person's smoking history, lifestyle, body mass index, blood pressure, glucose regulation and blood lipids, offering appropriate interventions and targets to improve that person's physical health.

The hospital was "smoke free". Nurses told us they had received training in this and we saw that patients were prescribed nicotine replacement therapies if needed. Doctors made the appropriate checks for patients prescribed medicines that could be affected by the patients smoking status.

Best practice in treatment and care

There was an established comprehensive operational audit schedule which included the person responsible for undertaking an audit, the frequency of each audits in a year, and identified the audits which needed the results reporting directly to the clinical governance meeting. In addition, the hospital had established a calendar of clinical audits. Examples of clinical audits undertaken since January 2016 included; an audit of the use of haloperidol and lorazepam together, an audit of the use of clonazepam and an audit of the use of prevention and management of violence and aggression techniques.

Staff followed the psychiatric intensive care unit and seclusion standards recommended by the National Institute for Health and Care Excellence.

The service provided a range of psychological therapies to patients, including supporting patients to understand what may trigger poor mental health and behaviour associated with it such as substance misuse. On Denholme, Shelley and Bronte wards, psychology staff worked with patients on setting treatment and rehabilitation goals as well as planning what patients wanted to do upon returning to the community. On Bowling ward, the treatment model was dialectical behavioural therapy (DBT) which is an evidence based treatment recommended by National Institute for Health and Care Excellence Guidance for the treatment of people with Emotionally Unstable Personality Disorder.

Skilled staff to deliver care

At our last inspection in June 2015, staff on Bowling ward, including members of the nursing team, told us that they felt unable to meet the clinical needs of patients on the ward. This was in relation to practising and using dialectical behaviour therapy skills that they had learnt in treatment. Patients we spoke with on Bowling ward also supported this and said they felt unsupported at times by staff and that they knew staff had not received the necessary training to help them when they felt distressed.

The provider had taken effective action to bring about improvement and at this inspection, we found, all individual therapists and skills group facilitators had been trained by an official dialectical behaviour therapy training organisation. This team included; three clinical psychologists, two senior nurses and a social worker. In addition, it was reported that the staff grade psychiatrist and the new ward manager were also fully dialectical behaviour therapy trained. A training programme has been set up for all staff allocated to Bowling ward. The training is on two levels; one-day awareness training, two-day skills training. The training is on a rolling cycle; each course being delivered once every six months. The ward psychologist talked through the training and the exercises used and we found the training content was appropriate to the needs of the learners and of appropriate length. A database was held of staff that had accessed the training and whether they were still working on the ward. The timetable for the rolling programme of training was also in place. Records of staff that had completed the training we reviewed showed 88% of staff currently working on the ward had received at least the basic level of training. We spoke with staff based on Bowling ward and feedback was positive with staff stating they found the training useful. Also, that they found the experiential aspects of the training particularly useful.

There was a wide range of professional disciplines available on each ward. These included occupational therapists and assistants, psychologists, psychiatrists, speciality doctors, nurses and health care support workers. Nursing staff across all of the four wards were all registered mental health nurses. The ward managers said the rotas were planned to ensure an appropriate skill mix of both qualified and unqualified staff on each shift.

The hospital had a clinical supervision policy. The policy distinguished between three types of supervision; clinical supervision, management supervision, and professional supervision. The policy extended the obligation to undertake regular clinical supervision to bank staff, agency staff and students. The policy set a requirement that staff undertake clinical supervision on a monthly basis. It also

allowed for clinical supervision to be undertaken in a variety of formats including one to one sessions, group sessions or peer to peer session. The hospital measured compliance with supervision per quarter and based on a requirement to undertake supervision sessions every four weeks as a minimum. Compliance during the period January to June 2016 was:

• Bowling – 81%

• Bronte ward – 100%

• Denholme – 98%

• Shelley ward – 104%

The overall compliance rate for clinical supervision was 96%. Supervision compliance over 100% for Shelley ward was explained by staff undertaking additional supervisions within the four week target.

The hospital had a policy in place to support the revalidation of doctors. The policy was issued in February 2013 and was due for review in February 2015.

The hospital measured compliance with appraisals on a month-by-month basis. Compliance rates were:

• Bowling: 69%

• Bronte: 96%

• Denholme: 88%

• Shelley: 100%

• Therapy: 72%

There were processes to address staff performance issues. These included informal discussion in managerial supervisions through to disciplinary procedures dependent on the severity of any issues.

Multidisciplinary and inter-agency team work

Staff carried out multidisciplinary assessments and the different professions worked well together.

Multidisciplinary team meetings and Care Programme Approach meetings took place regularly and patients routinely attended. A multidisciplinary team (MDT) is composed of members of healthcare professionals with specialised skills and expertise. The members work together to make treatment recommendations to ensure quality patient care. The Care Programme Approach (CPA) is a way that services are assessed, planned, co-ordinated and reviewed for someone with mental health problems or a range of related complex needs.

Staff recorded the minutes of the meeting during the meeting so they were open and transparent to the patient. Patients were included as full partners in their meetings and staff sensitively managed patients' comments and views. Carers, family members and community team staff attended the meetings when they could. Occupational therapy, medical, nursing and therapy staff worked together to plan and deliver patient care. The team maintained contact with the patients' home teams and families.

On Bowling ward, staff told us that the time of the ward rounds was not consistent from week to week. It was supposed to start at 10am each week but this was not always the case, the staff who attended had to wait for the consultant and to phone the ward on the day to let them know when the ward round would start. On the second day of our inspection, the ward had been told that the meeting would start at 12.30. We left the ward at 12.45 and the consultant had not arrived.

We returned to the ward at 13.30 the meeting was underway but it stopped again at approximately 14.15 as the consultant needed to leave the ward to do something. They returned 30 minutes later. Throughout our time on the ward, five patients came to the office door to ask when they were due to go in to the ward round. A further three patients came to the office more than once to ask what time they could go into their ward round. They could not be given a time by the nursing staff as they did not know given the circumstances.

This also affected other clinical team members who had to block out two full days a week of their diaries, as the time of the ward rounds were unpredictable. For example, the psychologist on the ward reported an attendance of 62% for the ward round due to the erratic nature of the timings of the meeting.

We observed the patients became very agitated that there was no predictability about the time of the meeting and thus when they would be seen. This is a vital part of the process for the patients for whom their primary diagnosis means that they do not tolerate uncertainty well. When we spoke with patients on Bowling ward and asked if there

was anything they would change, three patients told us inconsistencies of the timing of the ward round. We found this way of conducting the ward round to be disrespectful of both staff and patients on the ward.

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

Training data we reviewed showed 97% of staff had been trained in the Mental Health Act and managers arranged further training to enable the remaining staff to update their training. The training included changes to the Code of Practice in April 2015 and an up to date policy was in place.

Staff completed documentation in respect of the Mental Health Act 1983 to an appropriate standard. Paperwork about detention was accessible in patients' records and was stored securely. Staff we spoke with had a good understanding of the guiding principles of the Mental Health Act. There was a range of systems in place to support nursing and medical staff in meeting the responsibilities of the Act including checklists to support staff out of hours. Staff referred to a copy of the Mental Health Act code of practice available in hard copy and electronically on all four wards.

Staff informed patients of their rights verbally and in writing. Staff gave patients information about their rights of appeal and recorded patients' level of understanding in the patient's record. The manager completed monthly audits to ensure this was in accordance with the requirements of the Mental Health Act.

The hospital undertook regular audits of compliance with the Mental Health Act. We were able to see in clinical governance meetings that the results of these audits were discussed with resulting actions.

Good practice in applying the MCA

The hospital had a policy for the Mental Capacity Act. The policy included the guiding principle of the Act that any person over the age of 16 is assumed to have 'full legal capacity to make decisions for themselves unless it can be shown that they lack capacity'.

General training in the Mental Capacity Act was included as part of the 'safeguarding children and adults at risk' training module which had a compliance rate of 99% in June 2016. This training included the five principles of the Mental Capacity Act and the factors to consider when a person may lack capacity

Staff had a good understanding of the Act and how this applied in their practice. Staff accessed an up to date Cygnet policy, which included the Deprivation of Liberty Safeguards. There were no deprivation of liberty applications made by the hospital in the previous 12 months of the inspection.

Staff we spoke with talked about capacity decisions and assumed patients had capacity unless staff had doubts. Medical staff completed a Cygnet document to record patients' consent on admission. When staff doubted a patient's capacity to consent to treatment staff discussed capacity as part of the patients review using the principles of best interest.

Staff understood and worked within the definition of restraint according to the Mental Capacity Act. Staff were able to give working examples of how they took this into account and described using restraint for the shortest possible time period and to prevent harm.

A local independent mental capacity advocacy service provided patients with advice on mental capacity. This information was displayed on the ward areas to promote this service.

Are forensic inpatient/secure wards caring?

Good

Kindness, dignity, respect and support

At our last inspection in June 2015, we received mixed feedback from patients about the care and treatment they received. During a patient-led meeting on Bowling ward, 14 patients reported they were not always treated with empathy and whilst some staff took the time to listen to them, others did not. Feedback from three patients on Bowling ward regarding their progress on the ward was not positive.

At this inspection, staff were seen to be responsive to patients' needs and spoke to patients with dignity and respect. We observed staff interacting with patients in an open way, offering explanations to decisions and alternatives where requests were not possible. Patients on Bowling ward told us they believed that they were listened to by most staff and that they can get support when they

need it during day or night. Patients on Bowling ward were asked whether they felt they were treated with dignity and they had sufficient privacy. They were positive about their care in this area. They stated that they were not observed when in showers and that staff discussed issues with them more and they believed that solutions were collaborative rather than imposed. Their subjective experience was that there were now very few restraints. Their belief was that self-harm was dealt with well and no one reported feeling that they were humiliated by staff because they had self-harmed.

The reported experience of patients on Bowling ward and the observation of staff interacting with them indicated that staff on the ward had a caring approach and the skills needed to show empathy for the service users. We observed staff supporting a patient who was distressed following comments made by another patient; staff listened to the patient and demonstrated a genuine understanding of the patients' needs through their interactions.

We observed three meetings across the hospital involving patients. Patients were equal participants and encouraged to take part in all the meetings. Staff were seen to listen to patients opinions and include these in making decisions. Where discussions became personal or inappropriate staff effectively refocused the discussion and politely reminded patients of boundaries within the meeting.

Eleven patients we spoke to told us staff were caring and approachable. One patient said staff showed a genuine interest in patients through simple gestures like simply saying hello and asking how they were each day.

The involvement of people in the care they receive

At our last inspection in June 2015, six patients on Bowling ward told us they did not receive sufficient information prior to admission. Feedback from the current patient group suggested that although improvements had been made, this had not been effectively rectified. Staff said that the treatment model was explained to each patient at the assessment for admission and a leaflet was sent to the ward to be given to the patient, once they were accepted for admission. The leaflet that was available was not very patient friendly. Staff told us improvements were to be made to this leaflet in conjunction with patients. It is possible that the service was explained to patients but due to the complexity of the treatment model not fully or readily recalled. Comments we received from the patients, including from four of the most recent six admissions, were that they did not know what treatment and care to expect on Bowling ward. They said they thought that they were told about it but did not fully understand it or remember what was said.

Most of the patients we spoke to on the other three wards said staff had provided them with information about the ward and their rights during their admission. However, some patients said they could not recall been given any information on their admission.

The service operated a buddy system where possible to support patients during admission on to the wards. Patients who were already on the ward and were well enough would show new patients around the ward and help orientate them to the ward environment as part of the admission process.

All the patients we spoke to who had contact with their family told us their family were involved with their care. One patient told us their only family was their sister in Australia and that the ward had contacted her to provide feedback on their care.

Most of the patients we spoke to, said they felt involved in planning their care through one-to-one discussions with their named nurse and discussions within the multidisciplinary ward round. They believed that staff were responsive to them and their requests. However, patients told us that when they attended multidisciplinary team meetings with a particular doctor, they did not feel understood nor listened to.

Patients were all aware of the advocacy service and told us the advocate regularly visited the ward.

The provider employed an involvement coordinator who worked across three sites regionally. The role of the involvement coordinator was to facilitate patient, carer and staff involvement within the service. There was a clear structured process for facilitating patient involvement in the service.

Each ward had a daily meeting between staff and patients to discuss any issues which had arose over the previous 24 hours, staff encouraged patients attendance to plan the day's activities and discuss leave requests. Depending on patient preference wards held weekly or biweekly 'Have your say' meetings, patients could raise concerns and were

involved in problem solving discussions. For example, we observed a meeting where patients raised concerns regarding the lack of healthy options on the menu, to help resolve the issue patients decided to invite the hospital manager and the chef to the next meeting to discuss developing a new menu.

Each ward had a patient involvement lead; who attended a monthly involvement meeting to discuss issues raised in the have your say meetings and identify broader service wide concerns. Representatives from the involvement meeting attended the service governance meeting as a means of providing a clear communication channel between patients and service management. An example of this included patient concerns that if unwell on admission they could not remember all the information provided about the ward this had resulted in the development of 'prompt' cards placed in areas around the ward reminding patients of some of the key information.

The service completed a patient surveys twice a year, this was facilitated by the involvement coordinator who audited the results to monitor the services progress on areas identified as a concern and to highlight areas where the service was doing well.

The hospital launched a service user satisfaction survey with a window for responses which ran from May 2015 to March 2016. The survey was broken down into four key areas: environment, care and treatment, therapies, and information and rights. The survey was carried out in every hospital in the provider group with 775 responses in total, with 75 responses from Bierley hospital. The hospital scored 62% for environment, 62% for care and treatment, 54% for therapies and 70% for information and rights. In all four areas, the hospital scored lower than the organisational average. The survey led to an action plan with fifteen actions and a person responsible identified, and a deadline for completion.

Are forensic inpatient/secure wards responsive to people's needs?

(for example, to feedback?)

Good

Access and discharge

Access to and discharge differed from ward to ward. This depended on the person's reason for admission to a particular ward, their treatment needs and progress whilst at the hospital. Bowling ward received referrals for women of working age that required specialist treatment for personality disorder. Shelley and Bronte ward provided low secure care to patients who were referred into the service by NHS England commissioners. The wards provided a range of care and treatment options to patients from a wide geographical area. Data we reviewed showed the average bed occupancy for the hospital July 15 to June 16 was 83%.

Data for each ward showed;

- Bowling ward – 70%
- Bronte ward – 92%
- Denholme ward – 75%
- Shelley ward– 94%

Data we reviewed on average length of stay for the hospital showed this was 14.4 months. For each ward;

- Bowling ward – 15.3 months
- Bronte ward – 16.1 months
- Denholme ward – 4 months
- Shelley ward – 22.1 months

Data we reviewed on admissions and discharges between June 15 to July 16 showed:

- Bowling ward – 11 admissions and 11 discharges
- Bronte ward – 7 admissions and 5 discharges
- Denholme ward – 168 admissions and 166 discharges
- Shelley ward – 6 admissions and 6 discharges
- Phoenix – 2 admissions (June 2016)

There were no delayed discharges in the previous 12 months.

Care records we reviewed across all wards contained comprehensive discharge plans which included an estimated date for discharge from the hospital. The care records also showed that there was a person centred approach to recovery which included patients' discharge planning.

The facilities promote recovery, comfort, dignity and confidentiality

The hospital had a variety of rooms available to patients including clinic rooms. All of the four wards had quiet spaces for patients to use including multiple lounges and

dedicated quiet rooms. In addition, the wards had telephones situated on the main ward for patients to use and if a patient wanted to talk in private, a cordless phone was provided for them. The ward environments were spacious, nicely decorated. Patients had their own bedrooms with ensuite facilities that they were able to personalise. On each of the wards, patients could store their valuable possessions in the security cupboard, which was accessed by the nurse covering 'security duties' that day. There were set times for access and patients were aware of this.

Activities were available for all patients and were facilitated on weekdays by the occupational therapy team. On weekends, nursing staff facilitated these sessions. Feedback from patients was that activities had improved and they felt this was due to their input and making suggestions. On Bowling ward, patients had told staff they did not want to play bingo and do baking, as they were more interested in hair and make-up. We saw that staff were facilitating groups with patient involvement in relation to this and also products had been purchased for this purpose.

At our last inspection in June 2015, patients on all wards told us that they did not like having time limited access to a shared, outside space. Patients also used the courtyard area for smoke breaks and the wards each had set times on the hour. Patients felt they had limited access to fresh air. Staff told us the limited outside space often frustrated patients and led to incidents occurring on the wards and in the courtyard area when patients did not want to come in. On this inspection, the patients we spoke with did not raise the access to the shared outside space as an issue. A number of them told us that they were no longer smoking and this area was used less. They told us that they now utilised leave when they wanted to go outside and this was not refused unless an incident had occurred. We spoke with staff who told us that only patients who were identified as having risks associated with access to the courtyard had their time limited. They said this was an area of improvement which had come from the reducing restrictive practice work the service had completed. Staff said they felt an increase in activities for patients both on and off the ward had reduced the number of incidents in the courtyard. They told us that the number of patients who no longer smoked had also impacted on this.

Meeting the needs of all people who use the service

Disabled access was available via a lift as two wards were located on the first floor. Corridors and doors were wide enough and had enough space for wheel chair users. Leaflets and posters displayed across the hospital provided information for patients on independent mental capacity advocate and independent mental health advocate support that was available. They had a physical health poster which had a topic every month with provided patients with details about that issue in an easy read format, this month was "blood pressure".

The service had good access to interpreters, including sign language interpreters. For example, a patient in the psychiatric intensive care unit required a sign language interpreter and the service had someone on site for 12 hours a day to support the patient's needs.

We saw facilities were available to ensure snacks and drinks were available 24/7 to patients on all of the wards. Feedback we received from patients regarding the food was mostly positive with most patients saying there was a good amount of choice available to them. We spoke with the catering staff and saw the hospital was able to meet dietary requirements for patients, including Halal, kosher, vegan and vegetarian. A range of options for healthy eating was also included on the menus.

The hospital had a spiritual room available; however, on the day of the inspection it was being used to store furniture including sofas and chairs. We asked one ward manager, where could patients go if they wanted to use this room. They told us they would find another room.

Listening to and learning from concerns and complaints

Within Cygnet Hospital Bierley a centralised complaints process is led and co-ordinated by the hospital manager via a weekly meeting. An annual review of complaints takes place via the Governance meeting, along with a quarterly update, which looks at themes and achievement of resolution.

The hospital had a complaints policy and procedure in place which was displayed on all four wards. It was also given to the patients on their admission to the hospital. We looked at complaints the hospital had received in the last six months between February 2016 and August 2016. There were 26 complaints in total with three being upheld and nine partially upheld. We saw evidence of letters sent to patients explaining and acknowledging their complaints.

Good

Forensic inpatient/secure wards

We looked at two examples of formal apologies written to patients where the hospital acknowledged the errors made on their behalf, explained it to the patients and apologised. We saw that both letters had been sent within the last six months and both complaints had been dealt within the 28 days as per policy.

Are forensic inpatient/secure wards well-led?

Good

Vision and values

The hospital was part of the Cygnet group which is in turn a part of the Universal Health Services group, a provider of mental healthcare based in the United States of America. The Cygnet group had five values:

- Helpful

- Responsible

- Respectful

- Honest

- Empathetic

The values were printed on the back of the identification badges worn by staff. Feedback from staff was consistent in that all they all spoke about team work and pulling together to provide quality care for the patients.

All ward managers told us that they had support from the general manager, the quality lead and the registered manager who managed the service and could go to them with any issues. Nurses and support workers said they saw senior managers frequently on the ward areas and at meetings.

Good governance

The hospital had implemented a process for reviewing incidents. The four ward managers and the quality and governance lead met daily in 'morning meeting' to conduct an initial review of incident forms. After this review the forms would be given to an administrator to be entered on to E-Prime, the hospital's electronic clinical governance programme. The hospital employed a data analyst who was responsible for producing a monthly data pack which included analysis of incident themes and trends. The monthly data pack was used to inform the monthly local clinical governance meeting. The monthly local clinical governance meeting was comprised of the hospital's senior managers and clinicians. The meeting had a standard agenda which reviewed key elements of clinical governance each month including serious incidents, complaints and compliments, and use of restraint and seclusion. Each month the meeting also reviewed key themes such as medication management, advocacy and compliments. Themes were repeated quarterly which meant that the hospital would, for example, review medication management every February, May, August, and November. Actions from the local clinical governance meeting would be passed down to the morning meeting for the ward managers.

The E-Prime system was used to provide assurance at board level. Each quarter the hospital received an additional data pack from the board. The hospital managers were required to provide commentary on any highlighted aspects of the pack where the hospital was regarded as an outlier. The six-monthly board meetings allowed the provider to benchmark the hospital's key performance indicators against other similar services in the group.

Actions and conclusions from the board meeting would be passed to the clinical governance meeting for discussion and then on to the morning meeting for the ward managers. Ward managers in turn had a business meeting with the members of the multi-disciplinary team where they could review actions and conclusions from the morning meeting. Ward managers also undertook monthly staff meetings to pass on lessons learnt to other staff members on the wards.

We reviewed seven sets of monthly meeting minutes from the four wards. We were able to see that at a ward level the staff were able to receive feedback from incidents, safeguarding incidents, audits and complaints. We were able to see that learning was shared between the wards with staff being able to discuss and receive feedback from incidents which occurred on the other wards in the hospital.

We reviewed three months of meeting minutes from the monthly clinical governance meeting. The clinical governance meeting was attended by the hospital manager, the general manager, the hospital medics and psychologist, the ward managers, the clinical quality and

compliance lead, the information analyst, the pharmacist and the advocate. The meeting included a review of data on; audits, complaints and compliments, incidents, medication management, restraint, seclusion, training and vacancies. Meeting minutes were electronic and included embedded documents which provided data broken down to ward level in the key areas of clinical governance. All three meeting minutes included an action plan with a named individual responsible for each action. Actions were reviewed at the start of each subsequent meeting.

We reviewed board meeting minutes from March 2016. The meeting was attended by the corporate directors, the clinical quality and compliance lead and managers of Cygnet hospitals in Bierley and in Wyke. We were able to see that there was oversight of key performance indicators including complaints, serious incidents, and restrictive interventions at a board level.

Staff across the hospital had access to clinical supervision, annual appraisals and mandatory training. Compliance rates were high which showed that staff had the skills they required to carry out their roles, and had opportunity to discuss and have their performance at work appraised. There were effective systems to monitor staff training, supervisions and appraisals at service level in order to ensure staff received training and supervision in line with policy.

The hospital had a policy in place to support the revalidation of doctors. The policy was issued in February 2014 and was due for review in February 2017.

The hospital had regular clinical audit meetings. Clinical audit meetings were timed to coincide with the clinical governance meetings so that staff attending could undertake both together. We reviewed three months' clinical audit meeting minutes. The meeting allowed staff to present audits to senior managers and allowed senior managers to agree actions from these results. Actions were documented in each set of minutes and reviewed in each subsequent meeting.

The hospital undertook regular audits of compliance with the Mental Health Act. We were able to see in clinical governance meetings that the results of these audits were discussed with resulting actions.

The hospital had a local risk register. The local risk register had six identified risks, which included recruitment of qualified nursing staff and seclusion. The register included a description of the risk, an initial severity grading of the risk, the controls to mitigate the risk and a regrading of the risk as a result of the controls. We saw in clinical governance meeting minutes that the risk register was reviewed on a monthly basis. The quality and compliance lead was able to describe a process for escalating risk items on to the provider's corporate risk register. An item on the corporate risk register relating to staffing numbers was on the local risk register and had also been escalated and included on the corporate risk register. The corporate risk register was reviewed in the board meeting minutes.

Leadership, morale and staff engagement

The hospital had undertaken a staff survey in 2016 which had produced a 78% positive score. The top three positive responses were:

- 91% of staff were positive that they would know how to report a concern about fraud, malpractice or wrong-doing
- 89% of staff were positive that they were encouraged to report errors, near misses or incidents
- 88% of staff were positive that they understood Cygnet's values

The top three negative responses were:

- 56% of staff were negative about their pay in relation to their duties and responsibilities
- 50% of staff were negative about their overall benefits package
- 47% of staff stated that they have felt unwell due to work related stress

The survey included an action plan. The first action on the plan was a review of pay and benefits with a deadline for completion in August 2016.

On Bowling ward, staff and patients reported on a significant positive change; particularly over the past six months. This coincided with the appointment of the new ward manager, the stabilisation of the new staff team and the training of staff, all of which has occurred during that time period. Staff reported feeling inspired by and "driven forward" by the new ward manager. Staff particularly report improved confidence in their own skills and better team work both of which was spontaneously commented on by patients.

At our last inspection in June 2015, we recommended that the role of ward managers and support available to them to

carry out their role be reviewed. On this inspection, we spoke with the managers on each of the wards in relation to their role and they all spoke positively about support they received from the quality lead and the registered manager. They told us there had been some changes in the last 12 months in the management of the wards and this had impacted on how they felt as a team of managers.

Commitment to quality improvement and innovation

In November 2015, the hospital successfully completed the self and peer review parts of the quality network for forensic mental health services annual review cycle. Denholme ward is AIMS accredited.

It was reported by the lead psychologist that there is a commitment to on-going training evaluation and audit for Bowling Ward and the psychology service across the whole hospital. There are plans for improvement of the psychology service across all wards in the hospital. The plans in place are consistent with the needs of the patient group but to implement them effectively and reduce the waiting list for interventions it is likely to require an additional full time psychologist.

The Head of Psychology is also seeking to develop arrangements with Nottingham and York Universities' Forensic Psychology Doctorate Courses in order to provide placements for trainees.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

The provider must ensure that ligature risks are identified, recorded on ligature risk register and actions are put in place to ensure these risks are mitigated.

The provider must ensure that furniture on Bowling ward is replaced.

Action the provider SHOULD take to improve

There were supplies of emergency medicines and equipment on each ward but wards that used lorazepam injections for rapid tranquilisation did not keep a stock of the reversing agent. The hospital should discuss and assess this as part of their policy for rapid tranquilisation.

The provider should ensure that the multidisciplinary team review and pharmacist advice is sought when developing individualised pharmacological strategies for the short-term management of violence or aggression. National Institute for Health and Care Excellence NG10 Violence and aggression: short-term management in mental health, health and community settings May 2015.

The provider should ensure that maintenance works are carried out to areas of the hospital which require improvement and redecoration.

The provider should ensure that a room is available for patients which meets their spiritual needs.

The provider should continue in its efforts to improve information available to patients before and during admission.

The provider should ensure that on Bowling ward, the timing of the ward rounds are consistent.

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: We found areas of ligature risks on Bowling ward and Bronte ward which had not been identified on the ligature risk register. These were hinges on wardrobe doors and bedroom doors and the blinds on the meeting room door and window on Bronte ward. The provider must ensure that ligature risks are identified, recorded on the ligature risk register and actions are put in place to ensure these risks are mitigated. This was a breach of regulation 12 (1) (2) (d)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment How the regulation was not being met: There was a particularly strong unpleasant odour on Bowling ward. Staff told us this was related to the furniture on the ward. The provider must ensure that furniture which requires replacing on Bowling ward is replaced. This was a breach of regulation 15 (1)(a)(c)