Cygnet Hospital Stevenage

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.

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

Summary of findings

Overall summary

We rated Cygnet Hospital Stevenage as good because :

- The clinic rooms on all four of the forensic wards contained emergency equipment and emergency drugs which were checked regularly.
- Shifts were covered by a sufficient number of staff at the right grades. Many qualified nurses were short term contracted agency staff due to the high number of vacancies
- Psychological therapies recommended by the National Institute for Health and Care Excellence (NICE) were provided to patients.
- The GP attended the hospital on a weekly basis to provide appointments for patients. The service had a full time physical health care nurse who had undertaken additional specialist training in order to effectively support patients with specific long term illnesses.
- Staff used Health of the Nation Outcome Scales (HoNOS) and HCR-20 which is a risk assessment for managing violence.
- The carers' forum was held on a six monthly basis on a Saturday whereby patients' carers, friends and families were able to come into the hospital and discuss their involvement. There was a quarterly newsletter which was sent out to all carers and carers were invited to contact the social work department to ask questions and give feedback.

However:

- On Peplau ward the couch in the clinic room was dilapidated, torn and needed to be replaced. The fridge was dirty and needed defrosting and cleaning. We found two boxes of two different types of medication in the clinic room on Peplau ward which were out of date (dated November 2017).
- We examined three seclusion records for the forensic wards. We found that the seclusion template limited what was documented. The forms were not fully completed. One form omitted the time the doctor arrived, another did not provide details of therapeutic activities offered and the final form did not provide details of when food was offered.
- Two out of six wards supervision documentation was poor. The manager on Orchid ward was unable to provide all records of individual supervision meetings. The manager on Chamberlain ward provided some evidence that supervision had taken place but these records were incomplete. During the inspection we reviewed a further seven records and found gaps in the documentation

  The provider used newsletters and governance meetings to share lessons learned. However, two of the staff that we spoke with had not received feedback from incidents and complaints. They were not aware of the lessons learned processes in place.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Acute wards for adults of working age and psychiatric intensive care units	Good	
Forensic inpatient/ secure wards	Good	

Summary of findings

Contents

Good

Cygnet Hospital Stevenage

Services we looked at

Acute wards for adults of working age ; Forensic inpatient/secure wards;

Summary of this inspection

Background to Cygnet Hospital Stevenage

Cygnet Health Care was founded in 1988. Cygnet Health Care operates 21 centres across the UK. Two units are registered nursing homes providing long term and respite care and 19 provide inpatient mental health care.

Cygnet Hospital Stevenage opened in May 2006 and consists of six wards: two acute inpatient wards, two medium secure wards and two low secure wards. Acute wards included Orchid ward, a 14 bedded female only ward and Chamberlain ward, a 14 bedded male only ward. Acute wards at Cygnet Hospital Stevenage were last inspected between 26 and 28 July 2016.

Forensic wards included Peplau ward, a 14 bedded male-only medium-secure ward, Pattison ward, a 14 bedded female-only medium-secure ward, Tiffany ward, a 15 bedded female-only low-secure ward and Saunders, a male-only low-secure 15 bedded ward.

The Care Quality Commission previously carried out a comprehensive inspection of this location from the 26th to 28th July 2016. Breaches of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 were identified for regulation 9, person centred care, regulation 12, safe care and treatment and regulation 18, staffing. The provider sent the CQC their action plans to address these.

The Care Quality Commission stipulated that the provider must ensure that staff receive monthly supervision in line with Cygnet Health Care policy; the provider must ensure that all medical devices are checked and serviced on a regular basis; the provider must ensure that all emergency grab bags on forensic wards have an expiry date and regular checks are recorded; the provider must ensure that care plans are holistic, individualised and person centred; The provider must ensure seclusion is carried out in line with the Mental Health Act Code of Practice; the provider must ensure that ligature risk assessments include communal areas used by patients.

At the time of the inspection we saw that most of these areas had been addressed. However we noted that not all care plans were person centred and holistic on acute wards; and supervision records were not consistently complete on two out of six wards.

Our inspection team

Team leader Amber Wardleworth

The team that inspected the service comprised four CQC inspectors, a CQC mental health act reviewer and two specialist advisors who were qualified mental health nurses.

Why we carried out this inspection

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

How we carried out this inspection

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

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

Summary of this inspection

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 six wards at the hospital, looked at the quality of the ward environment and observed how staff were caring for patients;
- spoke with 18 patients who were using the service;
- spoke with the registered manager, senior managers and managers or acting managers for each of the wards;
- spoke with 30 other staff members; including doctors, nurses, occupational therapists, psychologists and social workers;
- attended and observed one hand-over meeting and two multi-disciplinary meetings;
- looked at 44 care and treatment records of patients;
- carried out a specific review of incidents on the wards;
- carried out a specific review of seclusion records;
- carried out a specific check of the medication management on all six 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

We spoke with 18 patients across the hospital. On acute wards, of the five patients that we spoke with four said that staff were good and treated them with kindness, dignity and respect.

All five patients said that they had been offered a copy of their care plans although some had refused.

Three out of five patients said that they felt well looked after and that staff supported them with their physical healthcare needs.

Four out of the five patients said that the food was good and that they could have hot drinks whenever they wanted. One patient said they were unhappy with their section 17 leave and wanted to go out more often. Two patients were dissatisfied with the low level of ward activities at weekends.

On forensic wards we spoke with 13 patients. Of those, 11 patients told us that the wards were usually clean and generally the environment was good. Two patients said that enhanced observation levels meant that there were not always enough staff on the wards and that they didn't get out on leave often enough.

Most patients said that the doctors were good and encouraged them to be involved with their care and treatment.

Patients told us that generally the food was good and that they could ask staff for drinks and snacks throughout the day and into the evening.

All but one of the patients were satisfied with staff support with their physical healthcare. They were able to access the GP and some had been for dental and opticians appointments. All patients said that they had been offered a copy of their care plans and that staff regularly explained their rights under the mental health act to them.

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:

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- On Peplau ward the couch in the clinic room was dilapidated, torn and needed to be replaced. The fridge was dirty and needed defrosting and cleaning. We found two boxes of two different types of medication in the clinic room on Peplau ward which were out of date. (dated November 2017).

  There were two seclusion rooms at Cygnet Hospital Stevenage. One of these was still being renovated. The seclusion room that was operational allowed clear observation. There were toilet facilities and a clock which was visible to the patient. However, there was no intercom to provide clear communication between patient and staff. The seclusion room did not meet the required standard as set out by the Code of Practice; We found a ligature point on the door hinge to the seclusion room en suite bathroom. Whilst the provider identified the ligature point the mitigation was to observe the patient in the room. We could not be assured that this maintained the safety of the patient fully whilst using the room.
- Seclusion did not always follow best practice guidelines, staff and managers told us that patients were occasionally secluded in bedrooms and the de-escalation room. Staff told us that these incidents were not always documented on seclusion paperwork. We reviewed two seclusion records and they were completed fully. Staff completed seclusion care plans as part of the seclusion paperwork. However, staff did not document what therapeutic activity was offered during the seclusion.
- We examined three seclusion records for the forensic wards. We found that the seclusion template limited what was documented. The forms were not fully completed. One form omitted the time the doctor arrived, another did not provide details of therapeutic activities offered and the final form did not provide details of when food was offered.
- All wards were generally clean, tidy and well furnished. On Orchid ward the communal bathroom was dirty and there were no hand soap or paper towels. There were two picture frames containing large screws on the floor in a meeting room that could present a risk to patients. Some areas of Chamberlain ward required decoration. We found that walls had been damaged and paint scuffed. Patients had pulled the notice

board and pictures off the walls. The sofa was ripped. The door to the courtyard had been previously damaged, we checked this with staff and it did not appear robustly secure. The toilet in the de-escalation room had been removed due to damage in October 2017. Repairs for both issues were outstanding at the time of inspection. This room was out of use at the time of inspection

However:

- The clinic rooms on all four of the forensic wards contained emergency equipment and emergency drugs which were checked regularly.
- Staff used a number of de-escalation techniques and restraint was used as a last resort when other interventions had failed. Staff were trained in approved restraint techniques. Cygnet Hospital Stevenage facilitated a Reducing Restrictive Practice (RRP) forum, underpinned by the Cygnet Health strategy. The meeting identified areas for improvement in the use of restrictive practice through action planning. The local physical management of violence and aggression (PMVA) lead had input with ensuring that management of risk was met with the least restrictive intervention. The RRP regional lead had facilitated sessions for staff to underpin the principles of restrictive practice and further sessions were on-going.
- The use of rapid tranquilisation followed the National Institute for Health and Care Excellence (NICE) guidance.

Are services effective?

Good

We rated effective as good because:

We rated effective as good because:

- Of the 33 care records that we examined, most contained up to date, personalised, holistic and recovery orientated care plans. Some care plans on the acute wards were not personalised or holistic. Staff documented in the records when patients refused to sign their care plan.
- The provider employed a full time psychologist, assistant psychologist, an occupational therapist and assistant occupational therapists. Psychological therapies recommended by NICE were provided to patients.
- The GP attended the hospital on a weekly basis to provide appointments for patients. The service had a full time physical health care nurse who had undertaken additional specialist training in order to effectively support patients with specific

Summary of this inspection

long term illnesses. We saw evidence that patients were referred to specialists when required along with regular access to the dentist and the optician. Patients could also access a gym instructor and a dietician if required.
- Staff used Health of the Nation Outcome Scales (HoNOS) and HCR-20 which is a risk assessment for managing violence.
- Staff participated in clinical audits including high dose antipsychotics, patient annual health checks, modified early warning system (MEWS) and self-harm.

However:

- Two out of six wards supervision documentation was poor. The manager on Orchid ward was unable to provide all records of individual supervision meetings. The manager on Chamberlain ward provided some evidence that supervision had taken place but these records were incomplete. During the inspection we reviewed a further seven records and found gaps in the documentation.

Are services caring?

Good

We rated caring as good because:

- Patients that we spoke with told us that staff knocked before entering their bedrooms and that staff were respectful and did their best to help.
- Staff that we spoke with gave detailed information on the individual needs of patients and how they met those needs.
- Patients had Care Programme Approach meetings at which they were encouraged to be actively involved and feedback on their care. Patients were seen in ward rounds every fortnight and were encouraged to attend this and give their feedback on their experiences over the past two weeks.
- The carers' forum was held every six months on a Saturday whereby patients' carers, friends and families were able to come into the hospital and discuss their involvement. There was a quarterly newsletter which was sent out to all carers and carers were invited to contact the social work department to ask questions and give feedback.
- Community meetings were held on the forensic wards on a weekly basis. There was a service user council meeting which was attended by staff and a service user representative from each ward. Patients were also invited to complete patient surveys and iPads were made available on the wards to support that process.
- During the recruitment of the clinical manager there were two interview panels. One of the panels included service users who were able to give input into the recruitment process.

Summary of this inspection

- On admission, staff gave patients a formal greeting and a 'welcome pack' about the ward, catering, activities and treatment. Patients told us that the welcome pack had recently been introduced.
- Patients had access to advocacy services. The advocate visited the ward regularly. There were posters displayed across the ward and patients were provided with leaflets upon admission.

Are services responsive?

Good

We rated responsive as good because:

- There was a full range of rooms and equipment to support treatment and care. This included a clinic room, quiet room, activity room on each of the forensic wards. There was also a pamper room on Tiffany ward.
- Patients could access hot drinks and snacks throughout the day and night.
- Patients were able to personalise their bedrooms and we saw examples of this on all of the forensic wards.
- Adjustments were made for people requiring disabled access. A patient on one of the forensic wards had a wheelchair and specialist chair to support their disability.
- Staff described easy access to interpreters and signers. We saw that one patient had an interpreter for ward rounds and other significant meetings.
- Patients could request, halal, vegetarian, kosher, gluten free and vegan meals as required and this was facilitated by the catering staff.
- There was a prayer room at the hospital and patients with section 17 leave were supported to visit their choice of place to worship. Staff also contacted different spiritual leaders to visit patients if they requested it.
- There was accessible information on treatment available; there was a large timetable of activities in place across the service.

However:

The service reported no delayed discharges from the service. We were not assured that delayed discharges were recorded. On inspection, managers told us that they did not know the process for reporting delayed discharges within the service. At the time of inspection, one patient was ready for discharge but this had been delayed due to waiting for a new placement.

Are services well-led?

Good

We rated well-led as good because:

Summary of this inspection

- Staff received appraisal and supervision in line with policy. Managers did not ensure that they fully completed supervision documentation for staff on two wards. However, managers had ensured across the service that 92% of staff had received supervision and 93% had received appraisal.
- Shifts were covered by a sufficient number of staff at the right grades. Many qualified nurses were short term contracted agency staff due to the high number of vacancies.
- Most staff told us that they felt supported by managers however two staff told us that managers were not visible.
- Staff said that there were opportunities for personal development and that training was appropriate.
- Staff knew how to use the whistle-blowing process and felt able to raise concerns without fear of victimisation. Most staff reported that senior managers were supportive and would listen and act on any concerns they raised.
- We observed supportive and cohesive team working and the atmosphere appeared relaxed and encouraging. Staff told us that morale was good and staff were motivated.
- Most staff we spoke with were positive and passionate about their role and they were proud of the work they carried out and the care that they provided to patients.

However:

- Some staff told us that there was limited opportunity to utilise additional skills.
- Staff described the need for more permanent staff, particularly registered staff to improve the consistency in team working.
- Throughout the inspection we did not observe staff interacting with patients and promoting therapeutic engagement.

Detailed findings from this inspection

Mental Health Act responsibilities

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

Mental Health Act staff reviewed and audited mental health act paperwork. We reviewed the Mental Health Act documents of three patients and found that they were all completed correctly.

Staff knew who the Mental Health Act administrators were and routinely went to them for advice on aspects of the Mental Health Act. We saw records of section 17 leave granted to patients. Records clearly showed the parameters of the leave and appropriate risk and crisis plans were in place. We reviewed medication forms and consent forms were attached to them to ensure that staff could check patients' consent to treatment.

Mental Health Act training was mandatory for staff and compliance was at 85%. Staff that we spoke with had a good understanding of The Mental Health Act, the code of practice and the guiding principles. Administrative support and legal advice on The Act and the code of practice was available from a central team.

Staff routinely explained patients' rights under the Mental Health Act to them on admission. We saw evidence in patient records that staff had explained to patients what their rights were and documented this clearly. The Mental Health Act administrator audited this process and flagged up any concerns at the daily situation report meeting.

We reviewed detention paperwork and found that it was filled in correctly, up to date and stored appropriately.

Mental Capacity Act and Deprivation of Liberty Safeguards

Mental Capacity Act training was mandatory and staff had a good basic understanding of the five statutory principles. Compliance was at 87% for Mental Capacity Act training on forensic wards and 78% for the acute wards.

Staff were aware of the Mental Capacity Act policy and were able to refer to it when needed.

We saw evidence of mental capacity assessments in patients' records and staff were able to give us examples of when capacity needed to be considered. Capacity was assessed by the psychiatrist on a decision specific basis and patients were supported to make specific decisions for themselves where possible. Best interests meetings were held and included discussion with the patient and consideration of the patient's wishes, feelings, culture and history.

Staff referred to the hospitals' Mental Health Act policy, the Mental Health Act administrator and the doctor in seeking advice on the Mental Capacity Act.

There had been no Deprivation of Liberty Safeguards applications made on acute or forensic wards in the last six months.

Overview of ratings

Our ratings for this location are:

Detailed findings from this inspection

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

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

Good

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

Are acute wards for adults of working age and psychiatric intensive care unit services safe?

Requires improvement

Safe and clean environment

- The layout of the wards allowed staff to observe some but not all areas of the wards. Staff mitigated this risk by using mirrors and with nursing observations. 'The closed circuit television CCTV was in place but it was not routinely monitored by staff to observe patients interactions. Staff reviewed footage as part of investigation processes and to establish events.
- The wards had a ligature risk assessments showing managers had identified ligature points. A ligature is a place to which patients intent on self-harm could tie something to harm themselves. Both wards were single sex wards and complied with guidance on same-sex accommodation.
- Each ward had a clinic room with accessible resuscitation equipment and emergency drugs. Both clinic rooms were visibly clean and tidy. Staff used clean stickers on Chamberlain ward to demonstrate when equipment was last cleaned. Orchid ward clinic had limited space, but both clinics contained an examination couch. Staff on both wards told us that the clinic rooms, including the fridge, were cleaned regularly. Staff on both wards told us that weekly clinic checks took place but staff did not know where the records were kept. Staff meeting minutes suggested some issues with weekly checks of emergency equipment, clinic room and physical health equipment. Managers were aware of this and taking steps to address the documentation. Staff across the two wards did not know where the spare key to the clinic was stored.
- There were no seclusion facilities on the wards. The service had an extra care area, away from the wards that contained two seclusion rooms. If patients required seclusion they were taken downstairs or though the communal corridor to the seclusion rooms. At the time of inspection, one seclusion room was out of use due to refurbishment. The second seclusion room did not have an intercom to support communication between patient and staff when the door was locked. The seclusion room did not meet the required standard as set out by the Code of Practice; We found a ligature point on the door hinge to the seclusion room en suite bathroom. Whilst the provider identified the ligature point the mitigation was to observe the patient in the room. We could not be assured that this maintained the safety of the patient fully whilst using the room.
- All wards were generally clean and tidy and well furnished. On Orchid ward the communal bathroom was dirty and there were no hand soap or paper towels. There were two picture frames containing large screws on the floor in a meeting room that could present a risk to patients. Some areas of Chamberlain ward required decoration. We found that walls had been damaged and paint scuffed. Patients had pulled the notice board and pictures off the walls. The sofa was ripped. The door to the courtyard had been previously damaged, we checked this with staff and it did not appear robustly secure. The toilet in the de-escalation room had been removed due to damage in October 2017. Repairs for

both issues were outstanding at the time of inspection. This room was out of use at the time of inspection. There was a refurbishment plan in place across the service.
- Staff had access to personal alarms. The alarm panel that informed staff where response was required was located in the nursing office. On Chamberlain ward we observed a delay in responding to the alarm on two separate occasions.

Safe staffing

- Managers used the service staffing matrix to estimate the number and grades of nurses required, which took into account occupancy levels and enhanced observations. Staffing levels at the time of inspection were two registered nurses and two support workers on Orchid ward for six patients. This reduced to two registered nurses and one support worker at night. Chamberlain ward was working on two registered nurses and three support workers in the day reducing to two registered nurses and one support worker at night for seven patients.
- At the time of inspection, there were two registered nurses and 19 support workers in post on Orchid ward. There were eight registered nurses and five support worker vacancies, which equated to a 59 % vacancy rate. On Chamberlain ward there were three registered nurses and 14 support workers in post. There were seven registered nurse and six support worker vacancies, which equated to a 56% vacancy rate.
- The service relied heavily on agency and bank staff to ensure safe staffing numbers on the wards. Between September and November 2017, 41 hours were filled by bank and 307 hours filled by agency on Chamberlain ward. Overall, 26 hours were unfilled. On Orchid ward 124 hours were filled by bank and hours shifts filled by agency. Overall, five hours were unfilled.
- The ward reported a low turnover of staff within the last twelve months. Five staff had left Orchid ward and one staff had left Chamberlain ward.
- Sickness across the acute wards was low and averaged at 2%.
- Managers had offered short term contracts to registered nurses from the agency to maintain consistency and standards of care. Staff on the wards told us that when agency staff were used, they were usually familiar with the ward.
- The managers were able to adjust staffing levels daily, dependent upon the needs of the patients, enhanced observations and planned activities.
- We saw that there was a staff presence in communal areas across the inspection.
- There were enough staff on duty each shift to enable the staff to have one to one time with patients. We saw that staff recorded some but not all interactions within the care records.
- Some staff told us that leave and activities were occasionally cancelled due to staffing issues.
- There were enough staff to carry out physical interventions if required. A total of 97% had undertaken training in restraint and 88% of staff had undertaken training in breakaway.
- The provider had 19 mandatory training topics, overall compliance for Chamberlain ward was 88%. There were elements of mandatory training where compliance was significantly lower; prevent 73%, Mental Capacity Act 73%, infection control 73% and prescription writing and administration standard at 67%. Overall compliance to mandatory training on Orchid ward was at 86%. There were elements of mandatory training where compliance was significantly lower; information governance 65% and prescription writing and administration standards at 50%.

Assessing and managing risk to patients and staff

- Between July 2017 and November 2017 there were 16 episodes of seclusion reported across the two wards. Four seclusions of patients from Orchid ward and 12 seclusions for patients from Chamberlain ward.
- Between July 2017 and November 2017 there were 45 episodes of restraint on Orchid ward and 25 on Chamberlain ward. Overall, 29 incidents (41% of all restraints) were of prone restraint (face down), 11 on Chamberlain ward and 18 on Orchid ward. Overall, 17 of the prone restraints resulted in rapid tranquilisation being administered. The provider told us that they had a reducing restrictive practice strategy in place however not all senior ward based staff were aware of this. Staff told us that they only used restraint after de-escalation has failed and that they used approved restraint techniques.
- The use of rapid tranquilisation followed National Institute for Health and Care Excellence guidance.

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

Good

- We reviewed 11 care and treatment records. Staff undertook a risk assessment of every patient upon admission and updated these regularly. Staff used a risk assessment, which captured all areas of risk, historic risks, and individual strengths.
- Staff used a variety of recognised risk assessment tools to access patient risk. We saw evidence of collaborative risk assessments.
- We found blanket restrictions were in place regarding access to the patient phone. Staff reported that patients could receive phone calls but not make outgoing calls.This was due to the individual risks of the patients. However, staff had not individually risk assessed or care planned which patients could have access to the phone.
- Orchid and Chamberlain wards did not admit informal patients. At the time of inspection there was one patient who had been made informal on Orchid ward and was waiting discharge. Staff and patients told us that informal patients could leave at will.
- The staff followed policies and procedures for observing patients. Enhanced observations were used when indicated by risk. Staff undertook observations of patients routinely every hour as a minimum. Staff undertook searches of patients and property upon admission and following unescorted leave.
- Staff adhered to best practice guidelines when using the seclusion room.The provider has notified the CQC of one incident when a patient was secluded in their bedroom as they had damaged the seclusion room and it was deemed too unsafe to use.
- Two staff reported during the inspection that there were other incidents when rooms not in line with the Code of Practice for seclusion had been used. We reviewed two seclusion records and they were completed fully. Staff completed seclusion care plans as part of the seclusion paperwork. However, staff did not document what therapeutic activity was offered during the seclusion.
- Staff received and were up to date with safeguarding training. On Chamberlain ward 93% had received safeguarding adults and safeguarding children training. On Orchid ward compliance was at 95% for both training areas.
- Medicines were managed appropriately. Medicines were stored securely. and within the therapeutic temperature range. The visiting pharmacist carried out regular audits of medicines. However, on Orchid ward we found one medication error that had not been reported as an incident as per the provider's process. We were not assured that there was a robust process in place for controlled drugs. We found one missing signature for the dispensing of a controlled drug and staff failed to sign and date on several occasions when they disposed of controlled drugs.
- Staff assessed areas of risk individually. For example, we saw a patient who had nutritional assessments in place where required.
- The service had clear and safe procedures in place for any children who visited. Staff undertook appropriate risk assessments. Visits were facilitated in a visitor's room off the ward.

Track record on safety

- There were three serious incidents that required reporting on Chamberlain ward within the last 12 months. All three were in relation to patient going on unauthorised leave.There were no serious incidents that required reporting on Orchid ward.

Reporting incidents and learning from when things go wrong

- Most staff interviewed knew what constituted an incident and could explain the reporting process in place. Staff used a paper based reporting system. Managers reviewed reported incidents and escalated where required.
- Staff reported some but not all incidents. We found one medication error on Orchid ward that had not been reported as an incident as per the providers process. Staff told us that they did not always document seclusions in bedrooms and de-escalation rooms on the seclusion paperwork.
- Some but not all staff told us that they received feedback from investigation of incidents internal to the service. Some staff told us that they received feedback on the outcome of investigation of complaints and acted on the findings.
- Managers told us that incidents were discussed at daily service meetings, handovers and team meetings and lessons learnt were shared across the service. Both wards had lessons learnt folders which some but not all

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

Good

staff were aware of. We reviewed the wards business meetings and ward staff meeting minutes; lessons learnt following incidents was not always discussed. Monthly ward meetings were not always taking place.

- Some staff confirmed that de-briefs and support was provided following incidents. We reviewed the staff de-brief folder on Chamberlain ward which evidenced that some debrief sessions were taking place. Between March 2017 and December 2018 debriefs were recorded after 15 incidents. Managers reported that all staff involved in major incidents were offered a debrief. However, for incidents not classified as 'major' managers acknowledged that it was not possible to offer a debrief. Some staff told us that they did not feel supported. Staff were not routinely documenting if patients were offered debriefs following restraint or seclusion.

Are acute wards for adults of working age and psychiatric intensive care unit services effective?

(for example, treatment is effective)

Good

Assessment of needs and planning of care

- We examined 11 care records. Staff completed a comprehensive assessment for each patient upon admission.
- Care records showed that physical health examinations upon admission were completed and there was on going monitoring of physical health. Care plans were in place for specific physical health needs and were reviewed and updated regularly. Patients confirmed that their physical health needs were met.
- Care records examined were up to date but not all were holistic or personalised. Staff were not always recording if patients were offered or declined a care plan. Daily progress notes did not capture when care plans had been reviewed and updated.
- The staff used paper records for all patient information. Incident forms were also paper records. Information regarding each patient was therefore readily available to the staff team and external professionals.

Best practice in treatment and care

- Staff followed the National Institute of Health and Care Excellence guidance when prescribing medications. Doctors prescribed antipsychotic medication in line with recommended limits and routine monitoring of patients was in place.
- Psychological therapies were available to assess and provide treatment to individual patients based on need. The service employed a psychologist, who was supported by psychology assistants. Occupational therapy was in place across the wards. There were timetabled therapeutic activities available although we observed little activity taking place across the two wards during the inspection. Patients reported access to occupational therapy and psychology sessions, usually in the form of group participation. Two patients told us that there was little activity available over the weekends.
- There was access to physical healthcare and patients were referred and attended specialist appointments when required.
- There was assessment of nutrition and hydration and care plans were in place for specific patients.
- The service used a variety of tools to capture outcome measures including Health of the Nation Outcome Scales and the Modified Early Warning Scoring System for monitoring aspects of physical health.
- Clinical staff participated in a variety of audits including, self-harm, therapeutic activity, ligature risks, environmental risk audit, the Mental Health Act and care plans. The provider contracted a pharmacy service, which completed regular audits of medication management, storage, and controlled drugs.

Skilled staff to deliver care

- Patients received care and treatment from a range of professionals including nurses, doctors, healthcare assistants, a psychologist and occupational therapy. Additional professionals such as dietician and pharmacy were also available. The service had access to a registered general nurse on to enhance the physical health care provision.
- Staff experience varied across the wards due to on going recruitment.
- An induction program was in place for all permanent staff. Managers told us that they ensured that bank and agency staff received an induction to the wards.

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

Good

- The supervision policy stated that staff should receive monthly supervision as a minimum; this could be individual or group supervision. The provider submitted data to show between January 2017 and December 2017, 92 % of clinical staff received supervision across the core service. Two out of six wards supervision documentation was poor. The manager on Orchid ward was unable to provide all records of individual supervision meetings. The manager on Chamberlain ward provided some evidence that supervision had taken place but these records were incomplete. During the inspection we reviewed a further seven records and found gaps in the documentation. Most staff however, reported feeling supported.
- Whilst senior managers reported that bank staff were supervised via reflective practice, one ward manager was unaware of this. Senior managers reported that bank staff were supervised via weekly reflective practice, although some sessions were cancelled. Overall, 93% of staff had received an appraisal.
- Staff generally reported receiving the necessary training for their role and described the training as appropriate and useful.

Multi-disciplinary and inter-agency team work

- The multi-disciplinary team held weekly meetings where patients care and treatment were discussed. Staff described supportive working relationships across the multidisciplinary team.
- Handovers were taking place twice a day on each ward. Staff described these handovers as detailed and informative. In addition, senior managers and key staff met every day to discuss the service needs including referrals, admissions, discharge, leave, incidents and staffing.
- Managers reported effective working relationships with teams outside of the organisation, for example, with the local authority safeguarding team. Nursing staff invited community care coordinators and commissioners to review meetings.

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

- Staff completed appropriate Mental Health Act paperwork upon admission. We saw evidence of this in case records.
- Staff told us that they would contact the Mental Health Act administrator if they needed any specific guidance. We observed this on one ward in relation to reading of patients' rights.
- Leave forms were in place where required. Those we examined were signed and in date.
- Overall, 80% of staff had received training in the Mental Health Act (MHA). Staff understood the MHA and their responsibilities under the act.
- Consent forms and current medication forms were kept together so staff could check patients' consent for medicines.
- Staff read patients' their Section 132 rights on admission and routinely thereafter. The Mental Health Act administrators monitored this.
- Administrative support and legal advice on implementation of the MHA and code of practice was available.
- Detention paperwork was filled out correctly, was up to date and stored appropriately.
- The provider carried out regular audits to ensure that the Mental Health Act was applied correctly.
- Patients had access to Independent Mental Health Advocacy (IMHA) services. There were posters on all wards providing information about this service.

Good practice in applying the Mental Capacity Act

- Overall 78% of staff had completed Mental Capacity Act and Deprivation of Liberty Safeguards training across the acute wards.
- There were no Deprivation of Liberty Safeguards applications made in the last 6 months and at the time of inspection there were no patients held under these arrangements.
- Staff we spoke with had a general understanding of Mental Capacity Act. Staff could give examples of when they might need to consider it. Staff told us that doctors completed any assessments required.
- A Mental Capacity Act policy was in place that staff was aware of and could refer to for guidance.
- Capacity assessments were in place where required and were decision specific.
- We saw evidence in care records of patients being supported to make decisions. Staff supported patients to participate in discussions.
- Staff knew where to get advice regarding the Mental Capacity Act within the organisation.

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

Good

Are acute wards for adults of working age and psychiatric intensive care unit services caring?

Good

Kindness, dignity, respect and support

- We observed that staff were polite and respectful toward patients and we saw some caring interactions. However, we saw that staff were observing rather than engaging with patients during the inspection.
- Patients generally confirmed that staff who worked across the day shift were respectful, caring and supported them. Most patients told us that they felt safe. Two patients told us that agency staff who worked the night shift could be rude and disrespectful. Two patients told us that they did not feel that staff listened to them.
- Staff demonstrated a good understanding of patient's individual needs, including care plans, observations and risks.

The involvement of people in the care they receive

- We spoke with five patients and reviewed 11 care and treatment records.
- On admission, staff gave patients a formal greeting and a 'welcome pack' about the ward, catering, activities and treatment. Patients told us that the welcome pack had recently been introduced.
- We received varied feedback from patients in regards to their involvement in care plans. Staff wrote the care plans upon admission and most patients told us that they had had opportunity to comment on them. Care plans were not always personalised, and recovery focused. Staff did not routinely document if patients were given a copy of their care plans.
- Patients had access to advocacy services. The advocate visited the ward regularly. There were posters displayed across the ward and patients were provided with leaflets upon admission.
- Families and carers were involved where appropriate to do so.
- Staff told us that patients could give feedback at community meetings and via individual sessions. Community meetings were not taking place consistently across both wards and there was little evidence of follow up and addressing issues that patients raised. .

Are acute wards for adults of working age and psychiatric intensive care unit services responsive to people's needs? (for example, to feedback?)

Good

Access and discharge

- The average bed occupancy on acute wards was 73%. Orchid ward had 102 admissions between January and December 2017 and average length of stay was 29 days. Chamberlain ward had 98 admissions during the same period. The average length of stay was not provided.
- Due to the nature of the service provided the wards accepted out of area placements routinely.
- Patients were not moved between wards unless clinically justified.
- Due to the nature of the service their commissioning teams often moved patients quickly.
- The service reported no delayed discharges. We were not assured that delayed discharges were recorded. On inspection, managers told us that they did not know the process for reporting delayed discharges within the service. At the time of inspection there was one patient that was ready for discharge but this had been delayed due to waiting for a new placement.
- Discharge planning started from admission. Staff and patients were thinking about the next steps in their care. Staff told us that most patients were discharged quickly back to their local area.

The facilities promote recovery, comfort, dignity and confidentiality

- The wards had a range of rooms and equipment to support treatment and care. Patients had access to a lounge area with appropriate furniture, a TV, music and games. Patients consistently told us that there were

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

Good

limited activities across the week. We did not observe activities on the ward during inspection. Occupation therapy was working at reduced levels due to recruitment.
- There was an appropriate room for visiting off the wards and room within the wards where visits could take place.
- Phones were in communal areas, it would be difficult for patients to make a phone call in private using the ward phone. 'Patients were permitted a basic mobile phone following risk assessment. There was no internet connection at the time of inspection.
- Both wards had access to an enclosed outdoor space.
- Patients could choose meals from a daily menu and reported that their likes and dislikes were catered for. Patients told us that they were happy with the food and the choices available to them.
- We saw that patients had access to drinks and snacks across the day. Patients confirmed this.
- Patients did not personalise their bedrooms due to the short length of admission. Patients were able to store their possessions securely.
- Patients and staff told us that there were activities on the weekends.

Meeting the needs of all people who use the service

- There was access for wheelchairs for those that required help with restricted mobility. A lift was available so both floors could be accessed.
- There were a range of information leaflets available on services, patients' rights, how to complain and advocacy. Staff used the walls and notice boards for displaying information. A welcome pack was provided upon admission to patients.
- Staff had access to interpreters and translation services when required and information could be requested in different languages if required. We saw how staff used interpreters during the inspection.
- There was accessible information on treatment available; there was a large timetable of activities in place across the service.
- The hospital catered for all dietary and religious requirements, patients confirmed this and were positive about the menu.
- There was appropriate access to spiritual support.

Listening to and learning from concerns and complaints

- The service received 31 complaints between January 2017 and November 2017. Overall, 17 of these were on Chamberlain ward and 14 on Orchid ward. Themes of the complaints included patients complaining of missing property, environmental issues and staff attitude.
- Patients knew how to report complaints or raise concerns.
- Staff and managers told us that complaints were responded to without delay and often informally. Managers maintained contact with carers in order to address any concerns swiftly. All staff we spoke with knew how to respond to a complaint or where to seek support.
- Some told us they did not received feedback from investigations. Managers told us that feedback was via team meetings however this was not always evidenced in the team meeting minutes.

Are acute wards for adults of working age and psychiatric intensive care unit services well-led?

Good

Vision and values

- The values at Cygnet Hospital Stevenage are helpful, responsible, respectful, honest, and empathetic. These were displayed in reception and on ward office notice boards. Managers and senior staff were aware of the visions and values.
- Staff knew senior managers. Some staff told us that managers visited the wards but others did not. Most staff we spoke with described improvement within the service with the arrival of new management.

Good governance

- Overall, 87% of staff had received mandatory training across the service. There were areas of training where compliance was significantly lower; for example with some topics were lower; prevent 73%, mental capacity act 73%, infection control 73% and prescription writing

and administration standard at 67% on Chamberlain ward. Information governance 65% and prescription writing and administration standards at 50% on Orchid ward.

- Overall, 92% of clinical staff received supervision across the core service. On Orchid ward, supervision documentation was absent and there were gaps in documentation on Chamberlain ward. Most staff we spoke with confirmed that they were receiving supervision and felt supported.
- Overall, 93% of staff had received an appraisal.
- There were sufficient numbers of staff to cover the shifts to ensure that patients were safe and their needs were met. Managers covered staff shifts to the agreed safe level of nurses; they offered staff overtime and used agency staff to achieve this. Managers considered skill mix in additional to staffing numbers. Some agency staff had been given short term contacts to increase consistency on the wards.
- Throughout the inspection we did not observe staff interacting with patients and promoting therapeutic engagement and activities. Two patients and some staff told us that they had little time to spend with patients.
- Clinical staff participated in a variety of audits around medication, physical health, the environment, infection control and compliance to the Mental Health Act.
- The provider used newsletters and governance meetings to share lessons learned. However, two of the staff that we spoke with had not received feedback from incidents and complaints. They were not aware of the lessons learned processes in place
- Safeguarding, Mental Health Act and Mental Capacity Act procedures were followed.
- The service used key performance indicators to gauge the performance of the team's compliance in key areas such as sickness, supervision, and training. These were discussed at clinical governance meetings.
- The managers reported sufficient authority to make decisions and adjust staffing levels when needed and felt supported by senior managers. Administration support was provided to the wards. Most staff told us that they felt supported by managers. Senior managers were described as approachable.
- Managers had the ability to submit items to the providers risk register. This register was reviewed and updated in clinical governance meetings by the senior management team.

Leadership, morale and staff engagement

- Between January 2017 and December 2017 sickness was low and averaged at 2%.
- At the time of inspection, there were no reported cases of bullying and harassment.
- Staff knew how to use the whistle-blowing process and felt able to raise concerns without fear of victimisation. Most staff reported that senior managers were supportive and would listen and act on any concerns they raised.
- We observed supportive and cohesive team working and the atmosphere appeared relaxed and encouraging. Staff told us that morale was good and staff were motivated. Most staff we spoke with were positive and passionate about their role they were proud of the work they carried out and the care that they provided to patients.
- Staff said that there were opportunities for personal development and that training was appropriate. Some staff told us that there was limited opportunity to utilise additional skills.
- Most staff described positive team working across the multi-disciplinary team and we observed collaborative working across professional groups in order to meet the patient's needs.
- Staff felt they could be open and honest to management, other staff and patients if something went wrong. Staff described management as supportive and approachable.
- Some staff we spoke with described a supportive environment and felt a valued member of the team; other staff did not feel supported. Staff described the need for more permanent staff particularly registered staff to improve the consistency in team working.
- Staff reported that they could make suggestions and give feedback to their managers and that suggestions to improve patient care would be supported.

Commitment to quality improvement and innovation

The acute service did not participate in any accreditation or peer review schemes

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

- The ward layout on the forensic wards allowed staff to observe all parts of the ward. There were convex mirrors in communal areas and corridors. The closed circuit television (CCTV) was in place but it was not routinely monitored by staff to observe patients interactions.
- There were ligature points on the forensic wards which were highlighted on the ligature risk audit and managed locally. A ligature point is anything which could be used to attach a cord, rope or other material for the purpose of hanging or strangulation. Recent renovation work had been updated on the ligature risk audit.
- The forensic wards were all single sex with en suite bathrooms and therefore fully compliant with same sex accommodation.
- The clinic rooms on all four of the forensic wards contained emergency equipment and emergency drugs which were checked regularly. On Peplau ward the couch in the clinic room was dilapidated, torn and needed to be replaced. The fridge was dirty and needed defrosting and cleaning. We found two boxes of two different types of medication in the clinic room on Peplau ward which were out of date (dated November 2017). On Saunders ward there was no couch in the clinic room as the clinic room was too small. The hospital had an additional treatment room which staff and patients from Saunders ward could access for physical examinations.
- There were two seclusion rooms at Cygnet Hospital Stevenage. One of these was still being renovated. The seclusion room that was operational allowed clear observation and contained toilet facilities and a clock which was visible to patients. However, there was no intercom to provide clear communication between patient and staff. The seclusion room did not meet the required standard as set out by the Code of Practice; We found a ligature point on the door hinge to the seclusion room en suite bathroom. Whilst the provider identified the ligature point the mitigation was to observe the patient in the room. We could not be assured that this maintained the safety of the patient fully whilst using the room.Staff who showed us the seclusion room did not know about the dimmer switches to adjust the lighting. However, senior managers evidenced that it was working correctly.
- All areas that we inspected were visibly clean.
- Throughout the ward we saw hand wash signs and there was hand wash available on the wards and in communal bathrooms.
- Equipment was well maintained, clean and clean stickers were visible and in date.
- Cleaning records were up to date on Saunders ward only. Staff said that other wards were regularly cleaned but staff could not locate records.
- We reviewed environmental risk assessments on the forensic wards and these were completed regularly.
- There was a nurse call system throughout the hospital and all staff had personal alarms attached at all times.

Safe staffing

- The number of whole time equivalent permanent qualified nurses on forensic wards was three on Peplau ward, zero on Pattison ward, two on Tiffany ward and four on Saunders ward. The number of whole time equivalent permanent nursing assistants was 13 on

Peplau ward, 12 on Pattison ward, 20 on Tiffany ward and 12 on Saunders ward. There were 42 vacancies for qualified nurses and 34 vacancies for nursing assistants across the four forensic wards. The number of hours filled by bank or agency staff was1100 between 01 September 2017 and 30 November 2017. The number of hours not filled by bank or agency staff where there was absence or vacancies was 46 over the same time period.

- All wards had a baseline staff matrix. The matrix was embedded within the electronic duty rota, any further staffing required over the substantive staff rostered was identified as additional needs required.
- The number of nurses matched this number as the provider was able to fill most of the shifts.
- The provider used a significant number of bank and agency staff due to the high level of qualified nurse vacancies within the service.
- Agency staff were employed on short term contracts to support continuity of care and familiarity with wards and patients.
- The ward managers were able to adjust staffing levels daily according to the case mix. Staff rotas were prepared eight weeks in advance. Staffing was discussed at the twice daily situation report meeting and the service also employed a shift co-ordinator who assisted with managing appropriate staffing levels.
- We observed that a qualified nurse was present in communal areas of the ward at all times.
- Patients that we spoke with told us that they generally had regular 1:1 time with their named nurse.
- Escorted leave or ward activities were rarely cancelled because of too few staff.
- We reviewed patient records and saw that physical interventions were carried out. There were facilities for the doctors to stay at the hospital overnight to attend the ward quickly in an emergency.
- All staff received mandatory training. Compliance levels were at 87% across the service. Compliance was below the provider's target of 75% in information governance which was at 63%. Due to the high level of nursing vacancies, the service employed short term agency nurses on three month contracts. A range of training was provided by the agency and agency staff were then required to undertake additional specific training when they commenced work at Cygnet Hospital Stevenage.

Assessing and managing risk to patients and staff

- There were 41 episodes of seclusion over the last six months on the forensic wards. There were no incidents of long term seclusion. Incidents of seclusion were highest on Pattison ward at 28.
- There were 123 episodes of restraint over the last six months, of which 36 were in the prone position. Episodes of restraint were highest on Pattison ward at 93 and were concentrated on five patients over a six month period. The number of prone restraints was highest on Pattison ward at 30 occurrences over a six month period.
- We examined the care records of 33 patients. Staff undertook a risk assessment of every patient on admission and this was updated regularly and after every incident.
- Staff used HCR-20 which is a risk assessment tool for managing violence and aggression.
- There was a blanket restriction on the use of the patients' phone which was locked away and received incoming calls only.
- The forensic wards did not admit informal patients. However, staff knew that informal patients could leave if they wished.
- There were policies in place for the use of observation in order to minimise risk. Patients were only searched by staff in private, following permission from the patient.
- Staff used a number of de-escalation techniques and restraint was used as a last resort when other interventions had failed. Staff were trained in approved restraint techniques. Cygnet Hospital Stevenage facilitated a Reducing Restrictive Practice (RRP) forum, underpinned by the Cygnet Health strategy. The meeting identified areas for improvement in the use of restrictive practice through action planning. The local physical management of violence and aggression (PMVA) lead had input with ensuring that management of risk was met with the least restrictive intervention. The RRP regional lead had facilitated sessions for staff to underpin the principles of restrictive practice and further sessions were on-going.
- The use of rapid tranquilisation followed the National Institute for Health and Care Excellence (NICE) guidance.
- Seclusion followed best practice guidelines on forensic wards.
- We examined three seclusion records for the forensic wards. We found that the seclusion template limited

what was documented. There were gaps such as the omission of arrival time for the doctor on one, details on the type of therapeutic activity on one and when food was offered on one.

- Safeguarding training was mandatory. Overall training compliance for safeguarding adults was at 97% and safeguarding children was at 93%.Staff knew how to make a safeguarding alert and regularly did this when appropriate.
- Medicines management was good. Medicines were stored appropriately and the service had a contract with a local pharmacy to complete regular audit of medication management, storage, and controlled drugs. The audit was published to all ward managers and doctors, with areas for action and dialogue response embedded within the pharmacist's audit findings. However we did find out of date medication (in the clinic room on Peplau ward (dated November 2017).
- There were safe procedures for when children visited the hospital. Visits took place in the family room which was not on a ward. Nursing staff and the social worker undertook risk assessments to ensure that safety was maintained.

Track record on safety

- There had been eight serious incidents in the last 12 months on the forensic wards. Pattison ward had the highest number at four.
- The provider had implemented mandatory staff training on enhanced observations and each shift security nurse completed an audit of batteries. This was due to a recent increase in certain patients swallowing batteries.

Reporting incidents and learning from when things go wrong

- We carried out a specific review of incidents on the forensic wards. All staff knew what incidents to report and completed a paper incident book to record the events.
- There were posters throughout the hospital on the duty of candour. Both incident reporting documentation and serious incident documentation incorporated the duty of candour process for patients, families and carers.
- There were feedback processes in place from the investigation of incidents. However these processes were not fully embedded as not all staff were aware of them.
- Staff discussed feedback at staff meetings, multidisciplinary team meetings, shift handover and the situation report meeting.
- Training in enhanced observations had been provided to all staff following inadequate observations of higher risk patients.
- Staff were debriefed and offered support from ward and senior managers and psychology following serious incidents.

Are forensic inpatient/secure wards effective?

(for example, treatment is effective)

Good

Assessment of needs and planning of care

- During the inspection we examined 33 patient care records. A comprehensive and timely assessment was completed after each new admission to the hospital.
- Care records showed that a physical health examination had been undertaken for each new admission. There was evidence that ongoing physical health monitoring was undertaken for all patients and patients told us that staff supported them with their physical health needs.
- Of the 33 care records that we examined, all contained up to date, personalised, holistic and recovery orientated care plans. Staff offered patients a copy of their care plan and documented in the records when patients refused to sign this. Patients told us staff offered them copies of their care plans.
- Patient records were in paper form and were stored securely in the nursing office on each ward. All information was in an accessible form and was available to staff as and when required.

Best practice in treatment and care

- We saw evidence that staff followed National Institute for Health and Care Excellence (NICE) guidance when prescribing medication. Antipsychotic medication was prescribed within British National Formulary (BNF) limits and patients were consistently monitored.
- Psychological therapies recommended by NICE were provided to patients. This included dialectical behaviour therapy (DBT) group sessions, drop in sessions and a substance misuse, arson and sex offender's treatment

program. There was a timetabled therapeutic programme for patients. We saw little evidence of activities taking place throughout the inspection but were told by staff that these took place off the wards.
- The GP attended the hospital on a weekly basis to provide appointments for patients. The service had a full time physical health care nurse who had undertaken additional specialist training in order to effectively support patients with specific long term illnesses. We saw evidence that patients were referred to specialists when required along with regular access to the dentist and the optician. Patients could also access a gym instructor and a dietician if required.
- Care plans were in place for patients with specific healthcare needs. Nurses monitored patients' nutrition and hydration needs and ensured that these were adequately met.
- Staff used Health of the Nation Outcome Scales (HoNOS) and HCR-20 which is a risk assessment for managing violence.
- Staff participated in clinical audits including high dose antipsychotics, patient annual health checks, modified early warning system (MEWS) and self-harm.

Skilled staff to deliver care

- There was a full range of mental health disciplines to provide input to the service. This included psychiatrists, psychologists, occupational therapists, mental health nurses, a physical health nurse, social workers and a pharmacist.
- Staff undertook mandatory training. Overall compliance was at 87%.
- All permanent staff received an induction. Short term contract agency staff received an induction and were embedded within a specific ward and team in order to maintain consistency and standards of care. On introduction, they worked in a supernumerary capacity in order to understand the operational processes of the ward and the patient group. They were included within the supervision and reflective practice forums in the same manner as substantive staff. They were included in identified unit or ward training initiatives and staff meetings with substantive staff.
- The service had a supervision policy in place which stated that staff should have supervision monthly by attendance at reflective practice group or a one to one session. All staff received supervision and appraisal.
- Appraisal compliance was at 80% on Peplau ward, 90% on Tiffany ward, 93% on Saunders ward and 100% on Pattison ward.
- The hospital submitted data to show supervision compliance was at 90% on Peplau ward, 92% on Tiffany ward, 95% on Saunders ward and 88% on Pattison ward. Recording and documentation of supervision was not consistent on two out of six wards across the hospital. On Tiffany ward the manager was able to evidence consistent recording of supervision. Bank staff received supervision at reflective practice. Staff that we spoke with told us that supervision was taking place.
- The percentage of non-medical staff that had received an appraisal in the last 12 months was 95%.
- Staff that we spoke with said that they received the necessary specialist training for their role and that there were opportunities for additional training on request.
- Ward managers told us that they would implement performance management to address performance issues. They could access support from senior managers and human resources for support and guidance with this.

Multi-disciplinary and inter-agency team work

- Multi-disciplinary team meetings were held weekly. During the inspection we observed a multi-disciplinary team meeting which was effective and patient centred.
- Handovers took place on each ward twice per day and staff said that they were detailed and informative. There was also a situation report meeting which took place at 9.30am and was attended by all ward managers and senior managers. Staff highlighted incidents, physical health concerns, depot medication due, admissions, discharges and staffing issues. We attended a situation report meeting and saw that it enabled managers to risk manage and share information across the wards.
- Both ward and senior managers described good handovers and sharing of information with care co-ordinators and other organisations.
- There were effective working relationships with the local authority, police, nursing agencies and the GP practice. Meetings had been held with the local police and nursing agencies to strengthen the relationship and agree protocols for future engagement.

Adherence to the MHA and the MHA Code of Practice

Good

Forensic inpatient/secure wards

- Mental Health Act staff reviewed and audited Mental Health Act paperwork. We reviewed the Mental Health Act documents of three patients and found that they were all completed correctly.
- Staff knew who the Mental Health Act administrators were and routinely went to them for advice on aspects of the Mental Health Act.
- We saw records of section 17 leave granted to patients. Records clearly showed the parameters of the leave and appropriate risk and crisis plans were in place.
- Mental Health Act training was mandatory for staff and compliance on the forensic wards was at 85%.
- Staff that we spoke with had a good understanding of the Mental Health Act, the code of practice and the guiding principles.
- We reviewed medication forms and consent forms were attached to them to ensure that staff could check patients' consent to treatment.
- Staff routinely explained patients' rights under the Mental Health Act to them on admission. We saw evidence in patient records of ongoing explanation of rights and staff documented this clearly. The Mental Health Act administrator audited patient's rights and flagged up any concerns at the daily situation report meeting.
- Administrative support and legal advice on the Mental Health Act and the code of practice was available from a central team.
- We reviewed detention paperwork and found that it was filled in correctly, up to date and stored appropriately.
- The Mental Health Act administrator completed regular audits to ensure that the Mental Health Act was being applied correctly. There had been a previous error in the paperwork of one patient and the audits ensured that similar errors did not reoccur.
- The independent Mental Health Act advocate attended the ward three days per week. There were advocacy posters and leaflets on all of the wards and staff understood the advocacy role. Some of the patients that we spoke with told us that they had accessed the advocacy service.

Good practice in applying the MCA

- Compliance was at 87% for Mental Capacity Act training on forensic wards.
- There had been no Deprivation of Liberty Safeguards (DOLS) applications made in the last six months.
- Mental Capacity Act training was mandatory and staff had a good basic understanding of the five statutory principles.
- Staff were aware of the Mental Capacity Act policy and were able to refer to it when needed.
- We saw evidence of capacity assessments in patients' records and staff were able to give us examples of when capacity needed to be considered. Capacity was assessed by the psychiatrist on a decision specific basis and patients were supported to make specific decisions for themselves where possible.
- Best interests meetings were held and included discussion with the patient and consideration of the patients' wishes, feelings, culture and history.
- Staff had received appropriate training in restraint. Where appropriate they worked within the Mental Capacity Act definition of restraint.
- Staff referred to the hospitals' Mental Health Act policy, the Mental Health Act administrator and the doctor in seeking advice on the Mental Capacity Act.

Are forensic inpatient/secure wards caring?

Good

Kindness, dignity, respect and support

- During the inspection we observed that staff were respectful, patient and kind in their interactions with patients.
- Patients that we spoke with told us that staff knocked before entering their bedrooms and that staff are respectful and do their best to help.
- Staff that we spoke with gave detailed information on the individual needs of patients and how they met those needs.
- Patients were invited to complete an annual patient questionnaire to give feedback about the service.

The involvement of people in the care they receive

- All patients were given an admissions handbook when they were admitted to the ward. Patients were supported by a fellow patient in a buddying role. All newly admitted patients were assigned a named nurse and were shown around the ward and introduced to staff.

Good

Forensic inpatient/secure wards

- Patients had Care Programme Approach meetings at which they were encouraged to be actively involved and feedback on their care. Patients were seen in ward rounds every fortnight and are encouraged to attend this and give their feedback on their experiences over the past two weeks. The care plans that were completed and reviewed monthly were written in conjunction with the patients and they were encouraged to give their own feedback within these.
- There were advocacy posters on all of the ward noticeboards and the advocate attended the ward three times per week and more often on request. Patients and staff were familiar with the advocate's role and some of the patients we spoke with had used the advocate.
- The carers' forum was held on a six monthly basis on a Saturday where patients' carers, friends and families came into the hospital to discuss their involvement. There was a quarterly newsletter which was sent out to all carers and carers were invited to contact the social work department to ask questions and give feedback.
- Community meetings were held on the wards on a weekly basis. There was a service user council meeting which was attended by staff and a service user representative from each ward. Patients were also invited to complete patient surveys and iPads were made available on the wards to support that process.
- During the recruitment of the clinical manager there were two interview panels. One of the panels included service users who were able to give input into the recruitment process.
- Care plans showed that patients had advanced decisions in place.

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

(for example, to feedback?)

Good

Access and discharge

- The male low and medium secure wards had a waiting list and new admissions could not take place until existing patients had been discharged.
- As an independent provider, the hospital routinely accepted out of area placements.
- Beds were available when needed to people living in the catchment area. Only one out of four wards was at full occupancy at the time of the inspection.
- There was access to a bed on return from leave.
- People were not moved between wards during an admission episode unless it was clinically necessary.
- When people were moved or discharged this was carefully planned at an appropriate time of the day.
- We saw evidence of discharge planning in patient records. There were no delayed discharges on the forensic wards at the time of inspection.
- Care plans referred to identified section 117 aftercare services for those patients to whom this was applicable under the mental health act.

The facilities promote recovery, comfort, dignity and confidentiality

- There was a full range of rooms and equipment to support treatment and care. This included a clinic room, quiet room and activity room on each of the forensic wards. There was also a pamper room on Tiffany ward.
- There was a quiet lounge on each of the forensic wards. Patients could meet visitors in the visitors' room close to the main reception area.
- The patients' payphone was situated in a small triangular cupboard in the main ward area. Patients were individually risk assessed in order to have a basic mobile phone provided by the hospital. However not all patients were sufficiently low risk to access this option.
- Each ward had an outside space with a secure fence surrounding it which patients could access.
- The patients we spoke with told us that the food was generally of a good quality and was varied and well cooked.
- Patients could access hot drinks and snacks throughout the day and night.
- Patients were able to personalise their bedrooms and we saw examples of this on all of the forensic wards.
- All of the bedrooms locked securely. The doors had recently been changed as part of the hospitals refurbishment program. Patients could also ask the staff to store valuable items if they wished.
- There was access to activities including gardening, healthy living, dance, football, cooking and courses for independent living at the recovery college on site. There were limited activities at weekends.

Meeting the needs of all people who use the service

Good

Forensic inpatient/secure wards

- Adjustments were made for people requiring disabled access. A patient on one of the forensic wards had a wheelchair and specialist chair to support their disability.
- The information leaflets available were available in English only. However staff told us that leaflets could be accessed for patients for whom English was their second language.
- There were noticeboards throughout the forensic wards which displayed information on local services, patients' rights, complaints and advocacy.
- Staff described easy access to interpreters and signers. We saw that one patient had an interpreter for ward rounds and other significant meetings.
- Patients could request, halal, vegetarian, kosher, gluten free and vegan meals as required and this was facilitated by the catering staff.
- There was a prayer room at the hospital and patients with section 17 leave were supported to visit their choice of place to worship. Staff also contacted different spiritual leaders to visit patients if they requested it.

Listening to and learning from concerns and complaints

- The total number of complaints in the last 12 months was 35 and the total number upheld was four. We did not see evidence of any complaints being referred to the Ombudsman.
- Complaints posters were displayed on all of the wards and leaflets were available for patients to fill in. Patients that we spoke with knew how to complain and some had made complaints and received written or verbal feedback**.**
- Staff that we spoke with told us that they had supported patients to complain and they were familiar with the complaints process.
- The learning from complaints investigations was fed back at multidisciplinary team meetings, staff meetings and supervision. However, some of the staff we spoke with told us that they had not received feedback from complaints in order to act on the findings.

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Are forensic inpatient/secure wards well-led?

Good

Vision and values

- The values at Cygnet Hospital Stevenage were helpful, responsible, respectful, honest, and empathetic. We saw posters displaying the values and all staff had been given a keyring displaying the values. We observed that staff knew the values and used them in their everyday work.
- The appraisal documents that we reviewed showed a direct link between the team objectives and the organisations values and objectives.
- Staff knew who the most senior managers were and those managers had visited the ward.

Good governance

- All staff received mandatory training and the overall compliance rate was 87%.
- Staff received appraisal and supervision in line with policy. The recording of supervision was not consistent across the service.
- Shifts were covered by a sufficient number of staff at the right grades. Many qualified nurse were short term contracted agency staff.
- On forensic wards staff maximised shift time on direct patient care activities.
- Incidents were reported and staff participated in a range of clinical audits. There were processes in place for lessons learned but these were not fully embedded and effective across the wards.
- Mental Health Act and Mental Capacity Act and safeguarding training was mandatory and appropriate procedures were followed in relation to these areas.
- Ward managers had sufficient authority and some administrative support in carrying out their role.
- Ward and senior managers submitted items to the risk register as required.

Leadership, morale and staff engagement

- The results of the staff survey were generally positive. Concerns raised by the staff group were about pay and rewards and facilities. Both of these areas were being addressed by the provider.
- Sickness rates were low on all forensic wards with the highest being on Pattison ward at 4%.

Good

Forensic inpatient/secure wards

- There had been no bullying and harassment cases.
- There was a whistle blowing policy and staff knew how to use the whistle blowing process.
- Staff told us that they were able to raise concerns without fear of victimisation.
- Staff morale was improving with some staff reporting job satisfaction from their role.
- There were opportunities for leadership development. Some staff had been promoted into acting manager roles and others were being supported by the provider to take qualified nursing courses.
- We observed evidence of team working and staff were generally mutually supportive of each other.
- Staff were open and transparent and had received training in the duty of candour. An example was given of when an error had been made by staff and they had apologised to the patient concerned.
- Staff were able to give feedback on the service in team meetings and through the staff survey.

Commitment to quality improvement and innovation

- Cygnet Hospital Stevenage participates in the Quality Network for Forensic Mental Health Services. This network seeks to promote quality improvements through the sharing of good practice in low and medium secure mental health services

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that supervision is documented consistently across the service..
- The provider must ensure that out of date medication is disposed of appropriately.
- The provider must ensure that the seclusion room is in line with the Mental Health Act code of practice.
- The provider must ensure that all seclusion records are documented consistently and that all episodes of seclusion are recorded.

Action the provider SHOULD take to improve

- The provider should ensure they do not use blanket restrictions unless this is clinically necessary to manage risk.

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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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment • The provider did not ensure that the seclusion room facilities were in line with the mental health act code of practice. • The provider did not ensure that all seclusion records were consistently completed in full. • The provider did not ensure that out of date medication was disposed of appropriately.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance • The provider did not ensure that supervision records were documented consistently across the service.