Cygnet Hospital Taunton

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?	Good
Are services effective?	Requires improvement
Are services caring?	Good
Are services responsive?	Requires improvement
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

This was a short notice announced re-inspection to determine what progress Cygnet Hospital Taunton had made since being rated inadequate at the previous Care Quality Commission inspection in February 2016.

During this inspection (February 2017) progress had been made and we were able to amend the ratings for safe from inadequate to good, caring and well led from requires improvement to good and effective from inadequate to requires improvement. Overall we were able to re-rate the hospital from inadequate to good.

At this February 2017 inspection we rated Cygnet Hospital Taunton as good because:

- Some work had been carried out to improve the environment within the hospital since our inspection in 2016, for example wards had been redecorated and carpet had been replaced with vinyl flooring.
- Wards were clean, and free of odour.
- The senior management team within the organisation had supported new managers at the hospital to make a range of service improvements. The new managers provided strong leadership and staff that we spoke with had embraced the drive to improve the service.
- Patients and relatives commented positively on the care they and their family members received. Care records contained up-to-date, personalised, recovery orientated care plans.
- The provider had reviewed their medicines administration systems to ensure that medicines were administered to patients in a timely manner and followed safe practice.
- Required staffing levels had been achieved regularly. There was appropriate use of bank and agency staff. Staff had completed a thorough risk assessment for each patient. Records indicated that staff were carrying out the required level of patient observations.
- The provider had a pro-active approach to reporting safeguarding incidents. The provider had demonstrated learning from serious incidents and displayed an open approach when liaising with external agencies.
- Eighty-eight percent of staff were up-to-date with mandatory training.
- Staff from all disciplines participated in audits. Audits were reviewed at a monthly team meeting, actions were generated at the meeting in the form of action plans.
- We saw evidence of good discharge planning throughout the hospital.
- Staff told us that they felt able to raise issues through their managers and that their concerns were responded to appropriately. Staff told us that morale was good and teams functioned well.

However:

- Some staff were unable to tell us about the needs of the client group and how best to support them. Psychological interventions were delivered by the psychologist only. Ward staff did not describe using psychologically informed approaches in their interaction with patients. This was relevant as many patients displayed challenging behaviour and it was not clear how this was being addressed.
- Staff on an upstairs ward told us that often they could not facilitate patients going outside due to staff availability. Staff told us that when patients said they did not wish to go outside they would respect this. We did not see staff distracting two patients who were becoming agitated.
- Some patients had rooms that had been personalised by relatives or staff but not all. Staff that we spoke with on the wards about this did not appear to see this as their role. There was more work to do on the wards to make them appropriate for the needs of the client group, this included consideration of appropriate furniture and decoration.
- Staff had difficulty telling us how they might apply the principles of the Mental Capacity Act on a day to day basis in their interactions with patients. We found that in most care plans reference to mental capacity was completed with standard phrases. In some files we saw that assessments of capacity had not recently been completed and it was not clear if they had been reviewed or updated to ensure their ongoing validity.

Summary of findings

- Whilst some changes had been made to the environment since the last inspection, it still lacked some resources for people with dementia such as items in the environment to cognitively stimulate patients. Some wards had features or furniture that was not appropriate for the client group such as bookcase wallpaper. Furnishings were in good condition but some were not appropriate for the safety of the client group. For example there were small side tables in patient lounges, some were located next to armchairs. On the day of the inspection we saw that two patients had difficulty manouevering around a small table to sit down in an armchair.
- There was no training for staff on mental illness.

Summary of findings

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Good

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Services we looked at
Wards for older people with mental health problems

Summary of this inspection

Background to Cygnet Hospital Taunton

Cygnet Hospital Taunton, formerly Orchard Portman House Hospital, is an independent mental health hospital near Taunton, Somerset, providing a range of specialist mental health services. The hospital specialises in the care and rehabilitative support of people, often older, who have cognitive impairment and/or functional mental illness. This can include people detained under the Mental Health Act and those with challenging behaviour, as well as patients with long-term mental illness and additional physical health conditions.

Cygnet Hospital Taunton has 46 beds. At the time of this inspection there were 26 patients. The reduced patient numbers were due to a reduction in referrals following the last inspection and support from the provider's senior management team to allow staff to embed quality improvement changes. The provider had appointed a new hospital manager in November 2016 and a new clinical manager role was introduced in January 2017.

There are five separate wards within the hospital.

Starling ward, a nine bed, emergency admission ward for men with a primary diagnosis of a functional mental illness, who were likely to have a range of complex needs, including a secondary organic presentation.

Swift ward, a nine bed female only service. It supported older women, who had an enduring mental illness; were likely to have physical health needs and presented with challenging behaviour.

Nightingale ward, a five bed unit for men .The unit had a focus on rehabilitation, to support an individual's ability to care for themselves.

Willow ward, a fifteen bed ward for men with a primary diagnosis of an organic mental health condition, with complex needs.

Mulberry ward, an eight bed ward for older men who were cognitively impaired. Patients were likely to slowly transition to a nursing home setting, however an end of life care pathway was provided in specific circumstances.

Cygnet Healthcare Limited had bought the hospital and registered it with the Care Quality Commission in April 2015. The hospital is registered to carry out two regulated activities; (1) assessment or medical treatment for persons detained under the Mental Health Act 1983, and (2) treatment of disease, disorder or injury.

The Care Quality Commission last inspected Cygnet Hospital Taunton in February 2016.

At the time of this inspection the hospital manager had commenced their application to be the new registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered persons have the legal responsibility for meeting the requirements and regulations of the Health and Social Care Act 2008.

Our inspection team

Team leader: Kate Regan, Inspector.

The team that inspected the service comprised of five CQC inspectors, an inspection manager, a CQC pharmacy inspector, a specialist advisor nurse consultant with experience of leading older persons mental health services, a consultant psychiatrist with experience of working with older people in liaison psychiatry, a Mental Health Act reviewer and an expert by experience (a person with experience caring for someone using older person's services, and/ or direct experience of using services themselves).

Summary of this inspection

Why we carried out this inspection

We undertook this short notice announced inspection to find out if Cygnet Healthcare Limited had made improvements to Cygnet Hospital Taunton since our last comprehensive inspection of the service in February 2016.

When we last inspected the provider at this location in February 2016 we rated Cygnet Hospital Taunton as inadequate overall. We rated the service as inadequate for safe and effective, and requires improvement for responsive, caring and well led.

Following the February 2016 inspection we told the provider that it must make the following improvements to Cygnet Hospital Taunton:

- The provider must ensure staff have clear lines of sight to observe the ward and regular patient observations are carried out and recorded.
- The provider must review safe staffing levels to ensure care is provided in an individualised and timely manner and assess staffing levels to reflect the needs of the patients. The provider must reassess the amount of qualified staff covering the hospital at night.
- The provider must ensure patients' liberty is not restricted due to low staff numbers.
- The provider must address the unpleasant odour on some wards.
- The provider must regularly review care plans for all identified patient risks.
- The provider must deploy sufficient numbers of skilled staff to ensure patients have access to regular psychology and physiotherapy treatments.
- The provider must ensure that there is a skilled mix of staff input into patient care planning and ward rounds.
- The provider must ensure there are appropriate arrangements in place for the safe administration of medicines, including directions for the covert administration of medications.
- The provider must ensure physical health monitoring from the point of admission is carried out and regularly reviewed.
- The provider must ensure that all staff receive regular supervision and appraisals.
- The provider must develop meaningful systems to ensure patients are given the opportunity to input directly into their care and treatment plans, service delivery and they have accessible systems in place so patients can make a complaint.
- The provider must adapt the environment to support the specific needs of patients with dementia.

We issued fourteen requirement notices which related to breaches of regulations under the Health and Social Care Act (Regulated Activities) Regulations 2014.

During the February 2017 inspection, we concluded that the provider had taken sufficient action to address thirteen of these fourteen requirement notices from the 2016 inspection, and was still in the process of addressing the requirement notice regarding adapting the environment to support the specific needs of patients with dementia.

We did identify two further breaches of regulation in this February 2017 inspection which are detailed at the end of this report. These related to the Mental Capacity Act and psychologically-informed person centred care.

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 and relatives using comment cards.

During the inspection visit, the inspection team:

- visited all five wards at the hospital and looked at the quality of the ward environment and observed how staff were caring for patients
- spoke with two patients who were using the service
- provided comment cards and a comments box but received no completed responses
- spoke with seven relatives and family carers both face to face and over the phone
- spoke with the hospital manager, clinical manager, quality manager and managers for each of the wards
- spoke with other staff members; including doctors, permanent and agency nurses and health care support workers, the Mental Health Act Administrator, the visiting GP and a pharmacist
- attended and observed one multidisciplinary meeting
- looked at 21 care and treatment records of patients
- carried out a specific check of the medicines management
- 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 two patients and they told us that staff looked after them well and were nice. Relatives told us that staff were welcoming, and they had seen a big improvement in the service under the new managers. Family members told us that staff responded well to their relative's individual needs.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Good

We rated safe as good because:

- The clinic rooms were clean and locked. Routine access was restricted to registered nurses and medicines were stored safely. The provider had reviewed their medicines administration systems to ensure that medicines were administered to patients in a timely manner and followed safe practice.
- Wards were clean, and free of odour. Carpets had been replaced with vinyl flooring.
- On both day and night shifts the number of qualified nurses on duty had been increased. Required staffing levels had been achieved regularly. The provider had made progress with recruitment to vacancies and had developed alternative measures for posts that were difficult to recruit to, such as permanent qualified nursing vacancies. The hospital made appropriate use of bank and agency staff. Eighty-eight percent of staff were up-to-date with mandatory training.
- Records indicated that staff were carrying out the required level of patient observations.
- Equipment that we saw such as assisted beds, was in good order and had been checked.
- Staff had completed a thorough risk assessment for each patient. Staff used a standardised risk assessment tool across the hospital. The provider had a pro-active approach to reporting safeguarding incidents.
- The provider demonstrated learning from serious incidents and had adopted an open and transparent approach in relation to these.

However:

- Care plans to guide staff on infection control measures to take for any individual infection risk presented by a patient were not always prominently placed in patient folders. We saw an example of this for a patient with an infection risk that all staff needed to be aware of.
- Furnishings were in good condition but some were not appropriate for the client group. For example there were small side tables in patient lounges, some were located next to armchairs. On the day of the inspection we saw that two patients had difficulty manouevering around a small table to sit down in an armchair.

Summary of this inspection

Are services effective?

Requires improvement 

We rated effective as requires improvement because:

- At this inspection we found, in records we examined, that patients had support plans in place for challenging behaviour. However, some staff on the ward were unable to tell us about the needs of the client group and how best to support them.
- Psychological interventions were only delivered by the psychologist. Staff did not appear to be using approaches with patients that were informed by psychological interpretations or 'formulations' of a patient's behaviour.
- On Mulberry ward we found that, whilst some changes had been made to the environment, we did not see pictures that might cognitively stimulate a patient or 'reminiscence' items from an older person's youth such as old ornaments in use. The provider advised that they did have some items designed to stimulate patients however. Some wards had features or furniture that was not appropriate for the client group such as bookcase wallpaper, that we saw confused a patient.
- There was no training for staff on mental illness. Although some staff were registered mental health nurses, some qualified nurses were not. Staff told us that an increasing proportion of patients were being admitted with this need as opposed to dementia.
- Training and guidance on the Mental Health Act and Mental Capacity Act was provided for staff. Staff had difficulty telling us how they might apply the principles of the Mental Capacity Act on a day to day basis in their interactions with patients. The provider's training did not ask staff to consider many scenarios which might help develop this understanding. We found that in most care plans reference to mental capacity was completed with standard phrases. In some files we saw that assessments of capacity had not recently been completed and it was not clear if they had been reviewed or updated to ensure their ongoing validity.

However:

- Care records contained up-to-date, personalised, recovery orientated care plans.
- All patients received a physical health examination on admission and staff developed care plans to address any needs identified.
- Staff from all disciplines participated in audits. Audits carried out such as medicine management audits were reviewed at a monthly team meeting, actions were generated at the meeting in the form of action plans.

Summary of this inspection

- Care and treatment records showed regular contact with external care coordinators.

Are services caring?

Good

We rated caring as good because:

- Patients and relatives commented positively on the care they received. The provider had made efforts to increase the participation of relatives in patient care plans, responding to comments made by relatives about the service, and writing to all relatives.
- The majority of patients whose records we reviewed had limited capacity; however staff had endeavoured to get as much information from both patients and families about their care needs.

However

- However, we observed two separate situations where staff did not support cognitively impaired patients in the most effective way. Staff tried to reason with the patients instead of using distraction techniques; they were unable to reach any mutual agreement as the patients' reason and judgement were impaired.

Are services responsive?

Requires improvement

We rated responsive as requires improvement because:

- The wards needed more work to make them appropriate for the needs of the client group. There was limited space on the wards for people with dementia to move around. Lamps that had been introduced for patients were not appropriate for the needs of a patient with dementia.
- Staff had provided clear signage on patients' bedroom doors. However for other rooms that patients accessed such as bathrooms, we saw that pictures were sometimes used to help patients interpret signs and identify rooms, and sometimes not.
- On Mulberry ward we found that, whilst some changes had been made to the environment, we did not see pictures that might cognitively stimulate a patient or 'reminiscence' items from an older person's youth such as old ornaments in use. The provider advised that they did have some items designed to stimulate patients however.

Summary of this inspection

- Patients on the first floor had to travel by lift or stairs to access the downstairs gardens. Staff on an upstairs ward told us that often they could not facilitate patients going outside due to staff availability. Staff told us that when patients said they did not wish to go outside they would respect this.
- On Starling Ward we were told there was a quiet area for patients, however this appeared to be a chair at the end of a corridor. Patients usually met their visitors in their bedrooms. There was a family room near the reception area for families visiting with children.
- Some patients had bedrooms that had been personalised by relatives or staff but not all. Staff that we spoke with on the wards about this did not appear to see this as their role.

However:

- We saw evidence of good discharge planning throughout the hospital which in most cases was planned at an appropriate time. The hospital was a regional provider in the independent sector, and beds were allocated following assessment based on need.
- Some work had been carried out to improve the environment within the hospital since our inspection in 2016. Every ward had been decorated and carpet had been replaced with vinyl flooring.
- The hospital provided a book in reception for relatives to leave feedback. Relatives told us they had received feedback when they raised queries such as clothing going missing.

Are services well-led?

Good

We rated well-led as good because:

- A new hospital manager had been employed and a clinical manager role had been added to the management team since the last inspection. More senior posts for qualified nurses as clinical team leaders had been introduced.
- We received very positive feedback from ward staff about the new hospital manager and clinical manager. All staff told us how visible the managers were and how they found them open and approachable. All staff we spoke with spoke positively about the many changes they had noticed at the hospital in the previous few months. Staff appeared to share the vision and values and drive to improve the service. Relatives also had positive feedback and noted improvements at the hospital.

Summary of this inspection

- The senior management team within the organisation had supported new managers at the hospital to make service improvements. The new managers provided strong leadership and staff that we spoke with had embraced the drive to improve the service.
- Ward managers completed monthly reports for the integrated governance meeting. These reports covered a range of key performance indicators such as staffing and sickness levels, supervision and appraisal rates and use of agency workers. Any risks were escalated through the hospital's risk register for monitoring by the hospital manager. The new hospital manager had introduced a number of new initiatives to improve governance at the hospital such as a monthly audit meeting to review audits.
- Staff could raise issues through their line managers. Staff told us that they thought their concerns were responded to appropriately. Staff told us they were positive about the new management team and the changes that had been made. We spoke with permanent and agency staff, and were told that morale was good and that teams functioned well.

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.

Eighty six percent of staff were up-to-date with the provider's training in the Mental Health Act.

Cygnet Hospital Taunton had a Mental Health Act administrator based on the hospital site. There was a national lead for the Mental Health Act within the Cygnet organisation. There was a forum to support Mental Health Act administrators.

We found that administration of the Mental Health Act was well organised. Consent to treatment, patient rights and leave forms were all in order. There was evidence of risk assessments and care plans relating to patients' leave decisions.

There was access to Independent Mental Health Advocacy. Audits had been commenced into the use of the Mental Health Act. These were undertaken by administrative staff, clinical staff were not involved in these.

Mental Capacity Act and Deprivation of Liberty Safeguards

Ninety one percent of staff had completed training in the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards. Training and advice on the MCA was led by administrative staff. We found that the application of the MCA by staff was lacking a broader patient focus such as considering how to apply the principles in day to day interactions with patients.

Care plan documents prompted staff to comment on a patient's capacity in a range of areas. We found that in most cases these were completed with standard phrases such as 'has dementia and does not have capacity'. In some files it was not clear if assessments of capacity had been reviewed or updated.

Staff we spoke with were not able to discuss the use of restraint in relation to the MCA although all staff we asked were able to say that restraint was used as a last resort.

There were 17 Deprivation of Liberty Safeguards applications made in the six months prior to inspection.

The hospital had access to Independent Mental Capacity Advocates from a local advocacy service.

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Wards for older people with mental health problems	Good	Requires improvement	Good	Requires improvement	Good	Good
Overall	Good	Requires improvement	Good	Requires improvement	Good	Good

Good

Wards for older people with mental health problems

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

Are wards for older people with mental health problems safe?

Good

Safe and clean environment

- At the previous inspection in February 2016 we found that the ward layouts did not allow staff to observe all parts of the ward and the mitigation plan was not consistently implemented. During this inspection we found that staff could not see all areas of the wards easily. The provider had installed mirrors to improve lines of sight but these did not always allow sight of corners and recesses. However, patients were observed a minimum of hourly on all wards and the frequency of observations could be increased depending on the patient's risk. We reviewed all patients' observation records on all wards for the past 48 hours prior to inspection and found that all had been completed correctly.
- There were potential ligature points around the hospital (ligature points are anything that could be used to attach a cord, rope or other material for the purpose of hanging or strangulation). We reviewed ligature audits for all five wards and all were up date to date and subject to regular review. However, we did find that some ligature risks including wall mounted air fresheners and pictures and whole areas, such as gardens and the corridor on Nightingale ward had not been assessed. There were rooms including the hair salon and laundry areas that were not accessible to patients unless supervised by staff. These had not been fully assessed in the audit. The audit described these as 'locked'. However these rooms required staff to remember to lock them. Each ward had a completed action plan to address the ligature risks. However, we noted that the action plans were generic and were not tailored to each individual ward. Timelines were all set as 'ongoing'. We brought this to the attention of the hospital manager who undertook a full review of the ligature audits, submitting further evidence post inspection. Other management of ligature risks was by observations of patients. Staff completed patient observations as per their care plans and risk assessments.
- There were no issues with regards to same sex accommodation as all five wards were gender specific.
- The clinic rooms were clean, locked, and medicines were stored safely. There were two clinic rooms for the hospital which were shared by the wards. Both were located on the ground floor. An air conditioning unit was in place for both clinic rooms which kept the temperature at 20 degrees Celsius. It was necessary to maintain this room temperature to ensure medicines remained effective when stored. The keys for the clinic room were kept securely and routine access was restricted to registered nursing staff.
- There was no seclusion facility or use of seclusion at the hospital.
- At the last inspection we found that some wards had unpleasant odours. At this inspection we found that ward areas were generally clean, with just a couple of minor exceptions. The provider had replaced carpet with vinyl flooring and wards were free of odour. Furnishings were in good condition but some were not appropriate for the client group. For example there were

small side tables in patient lounges, some were located next to armchairs. Patients with dementia can have problems with spatial awareness. On the day of the inspection we saw that two patients had difficulty manouevering around a small table to sit down in an armchair. On one ward we saw two bedrooms in which there was a bed but no chair, lamp, pictures or photographs. When we asked about this we were told that items had been removed as the patients' behaviour was challenging.

- Staff we spoke with said they had done the provider's mandatory infection control training. Staff told us they carried out hand washing assessments as part of the mandatory training but did not receive any subsequent checks.
- Care plans to guide staff on infection control measures to take for any individual infection risk presented by a patient were not always prominently placed in patient folders. We saw an example of this for a patient with an infection risk that all staff needed to be aware of. Whilst the patient's diagnosis was recorded on the handover sheet, this was not referred to further in the care needs, risks or nursing summary on the handover document to show that staff were being reminded or guided at the handover about this.
- The equipment we observed such as floor cleaning equipment, lamps, hoists and assisted beds were in good order. The relevant equipment had been checked and PAT tested. The hospital manager told us that pressure sensor mats were available for patients who had been assessed as needing them, as they were at risk of falling.
- Cleaning records were up-to-date and consisted of a weekly deep clean for the communal areas of each ward, a monthly deep clean of patients' bedrooms and a full deep clean of the bedroom when a patient was discharged.
- There was an effective and recently improved system in place for patients' laundry. This was managed by a designated member of staff. Patients' clothes were labelled, washed separately and kept in separate storage areas whilst in the laundry. The member of staff would take patients' clothes to their rooms once they were clean.
- Records demonstrated that environmental risks including fire and the management of legionella were reviewed regularly.
- Staff carried personal alarms which were issued when they arrived on duty. The hospital manager took responsibility for maintenance and replacement of alarms. One member of staff told us that previously there were not always enough alarms for each member of staff. However they had been replenished by the time of our inspection.

Safe staffing

- At the previous inspection in February 2016 we found that there were not enough staff on duty to provide adequate care and treatment to patients on the female ward and there was no evidence of how staffing levels had been assessed to reflect the needs of the patients on all wards. Since then the senior management team had established ward staffing levels following a full review, using the provider's weighting matrix. The management team had established that when fully occupied the hospital required 21 whole time equivalent (wte) qualified nurses and 62 wte health care assistants. At the time of our inspection 13 of the 21 wte nursing posts were vacant and 15 of the 62 wte health care assistant posts. The provider employed agency staff whilst these vacancies existed and had not reduced staffing levels even though the hospital was not fully occupied. A safe staffing notice board had recently been introduced which showed on a daily basis how many staff should be on each shift and how many had actually been provided. A qualified nurse was allocated to each of Starling, Swift, Mulberry and Willow wards during the day which was an increase since the 2016 inspection and an additional nurse had been allocated overnight. This meant that nurses were not moving between wards which helped with the continuity of care. Staff we spoke with said this had had a positive impact on the service. A qualified nurse from one of the other wards provided qualified nursing input or advice to Nightingale ward, a smaller rehabilitation ward as required. Nightingale ward was always staffed with healthcare support workers.
- The hospital ran a two shift system, consisting of long days (7.45am to 8.15pm) and night shifts (7.45pm until 8.15am). Shifts consisted of four registered mental

health nurses or registered general nurses and 12.5 support workers during the day. During the night shift the hospital aimed to have two registered nurses and nine support workers on duty.

- Staff turnover in the 12 months prior to the inspection was 52%. Although this was a high figure we were advised that a number of staff had left to join a new hospital which had opened nearby.
- The provider reported that for the preceding 12 months the average staff sickness rate was 7% across Starling, Swift and Nightingale wards and 2% across Willow and Mulberry wards.
- The provider reported difficulty in recruiting suitably qualified and skilled nurses, however there was ongoing recruitment with a range of initiatives in place to recruit staff. These included the introduction of more senior posts for qualified staff nurses (clinical team leaders) and a rolling recruitment of health care assistants with interviews held weekly.
- We checked rotas on all of the wards and confirmed that the minimum staffing levels had been achieved over the eight weeks prior to inspection. We also made a number of spot checks going back further than this time frame and confirmed that the required staffing numbers had been achieved.
- The ward managers were able to authorise shifts to be covered by agency staff. The provider had arranged for agency nurses to have short-term contracts until the registered nurse vacancies were filled. This ensured that, where possible, cover was provided by staff that had knowledge of the wards and the patients.
- We looked at the figures for shifts staffed by agency staff. In the three months prior to the inspection 590 shifts had been filled by agency staff. Only 1% of shifts had been unfilled.
- The provider ensured that bank and agency staff received a local induction which included the specific safety requirements for each ward. We saw records to show this was the case. All agency staff received regular supervision. All new staff whether agency or substantive were given a, 'buddy'. This was a member of staff familiar with the wards and patients who served as a first port of call for the new staff member.
- Nursing staff that we spoke with said that the clinical manager and hospital manager were extremely responsive when discussing the staffing requirements needed to ensure care, treatment and support was provided to a good standard and in a safe manner.
- Each morning a meeting of administrators, clinical, medical and managerial staff was held which considered staffing levels as part of the standing agenda. This was intended to ensure that safe staffing levels were provided every day and night across the hospital. Incidents, enhanced observation, care plan changes and infection control issues were also discussed at this meeting.
- Staff were available to offer regular one to one support to patients. There were enough staff on each shift to facilitate patients to have leave and for activities to be delivered.
- Staff told us that activities were rarely cancelled due to staffing issues but at times had to be re-arranged. One member of staff told us there was more time to take patients out since our inspection last year.
- Consultant medical cover was provided by three staff over Monday to Friday, one of which was employed as a locum. There were no junior medical staff employed, although the hospital manager told us the provider was going to review the situation.
- Staff could access a doctor in an emergency via the hospital's on call procedure. An allocated on call consultant could then be contacted out of hours if required, such as for an emergency admission.
- A local GP attended the hospital each Tuesday to review and monitor patients physical health needs.
- There were 28 mandatory training courses, which included medication management for qualified nurses, resuscitation, prevention and management of violence and aggression, physical health policy and safeguarding adults and children. The hospital manager told us that all courses were face to face apart from online medication courses. At the time of the inspection the overall completion rate of mandatory training courses was 88%.

Assessing and managing risk to patients and staff

- The hospital kept a record of restraint which prompted staff to explain what attempts they had made to

de-escalate a situation prior to restraining a patient. Staff we spoke with were able to explain how they might attempt to do this. Reducing restrictive interventions was covered in a hospital policy. We saw that 82% of permanent staff were up-to-date with prevention and management of violence and aggression (PMVA) training which aimed to reduce use of restraint. The PMVA training was adapted for use with an older patient group. The provider's policy, updated in January 2017, also addressed the needs of older patients when carrying out restraint.

- There were 212 episodes of restraint in the six months prior to inspection. Two of the restraints were in the prone (lying face down) position; one had been on Mulberry ward and one on Willow ward. Seventeen of the restraints in the six months prior to the inspection had been in the supine (lying face upwards) position. One prone restraint had been for ten minutes and the other for 20 minutes. A manager had investigated this second prone restraint and re-classified this as a supine restraint. The provider's policy advised staff that intentional use of prone and supine restraint should be avoided and staff must do all they could to manage the situation in a standing or seated position, except for in extreme circumstances where there was a risk of serious harm to others and the risk could not be safely managed using a less restrictive option.
- The hospital manager advised that all data relating to restraints was reviewed by the hospital's integrated governance group. The manager advised that this meeting discussed how levels of restraint could be reduced and if a prone or supine restraint occurred this would be a priority. The manager advised that a prone or supine restraint would also be discussed at the morning meeting and the patient's multidisciplinary meeting. The manager advised that the hospital had a reducing restrictive practice lead and a PMVA lead who could be called upon to provide patient specific interventions. The manager advised that there had not been a prone or supine restraint of a patient since he started at the hospital in November 2016.
- We reviewed restraint and incident books on Starling ward. We saw from the records that staff were assaulted regularly, however the provider subsequently confirmed that these incidents had resulted in negligible or no harm. A senior manager told us that incident forms should indicate if a debrief had occurred following a restraint or assault. It was not evident from the records that we looked at on Starling ward that there was a debrief for staff or post incident review following a restraint or assault. Staff on the wards confirmed that an incident such as a restraint would be followed by a debrief.
- When we inspected the service in 2016 we found that identified risks did not always have a care plan to address them, and risks and care plans were not always regularly reviewed. During this inspection we reviewed eight care records across all wards. Staff had completed a thorough risk assessment for each patient, and had rated risk areas as red, amber or green (RAG). Risk assessments included physical health, use of bed rails, nutrition and hydration, choking, and falls. Staff had updated risk assessments when new risks were identified. Each identified risk had a time period for re-assessment; for example for patients at risk of developing pressure ulcers the risk assessment review period was monthly and this was being adhered to.
- At this inspection no patients were in the last few weeks or days of their lives. We did however look at the anticipatory end of life care plans for two patients who were receiving palliative care. These plans showed that staff were communicating well with the patients and their families. The end of life care plans were detailed and covered all aspects of individual physical, psychological and practical needs. Advanced patient directives gave staff good guidance on interventions to be made during the last few days of life.
- A do not attempt resuscitation order (DNAR) is intended to provide immediate guidance on the best action to take should a patient suffer cardiac arrest or die suddenly. We saw examples of these orders on patient care records. They had been completed correctly and all had been made within the preceding year.
- Almost all of the patients were detained under the Mental Health Act or subject to Deprivation of Liberty Safeguards. We spoke with an informal patient and their relative who were aware of the patient's legal status and their right to leave.

Good

Wards for older people with mental health problems

- The hospital had a policy relating to the use of observations and the searching of patients in order to minimise risk of harm to self and others. Records indicated that staff were carrying out the required level of patient observations.
- There was a rapid tranquillisation (RT) policy in place which included physical health monitoring post a RT event (rapid tranquilisation is the use of specific oral and intra muscular (IM) medicines to rapidly sedate patients in the event of agitated behaviour). One patient had injectable rapid tranquillisation medicines prescribed on their prescription chart, but none had been administered.
- Staff were trained in safeguarding adults and children from abuse. There was information displayed around the wards on how to respond to a safeguarding concern and how to raise an alert. Staff were able to explain safeguarding processes. Safeguarding incidents were discussed with the safeguarding lead for the hospital. There was daily morning meeting which considered a range of issues in the hospital and provided staff and managers the opportunity to review incidents from the previous 24 hours. This was with the aim of ensuring that any immediate safeguards were in place and to ensure that appropriate incidents were reported. The safeguarding lead for the hospital held a central log of safeguarding alerts in order to monitor their progress. There was regular liaison between the hospital managers and the local authority safeguarding team. The majority of safeguarding incidents related to one patient being aggressive to another.
- At the previous inspection in February 2016 we found that administration of medicines did not always follow safe practice, medicines were not always administered at the correct time. At this inspection we reviewed medicines management practice. The provider had reviewed their medicine administration systems to ensure that medicines were administered in a timely manner. Stock and individually dispensed medicines were administered in line with local policies.
- The provider had a contract with a community pharmacy who supplied all medicines. A review of all medicine charts was completed weekly and any gaps without reasons were recorded and reviewed by the visiting pharmacist. We saw that for medicines that were prescribed for only when necessary, records stated the time and quantity of the medication administered. Nurses received medicines management training at induction which was via a pharmacy e-learning package. The hospital could also book up to three face to face medicine training sessions per year from the community pharmacy.
- Medicine incidents were reported and investigated. All medicines checked were in date. Expired medicines and refused doses were recorded and then disposed of in the pharmaceutical waste bin on the ward. The date of opening was recorded on all liquid medicines. Audits were carried out of controlled drugs, medicines storage and prescription chart completion. The audits and medicine incidents were reviewed on a local level once a month and action plans developed for any issues that had been identified.
- Ward staff monitored and recorded fridge temperatures daily on all wards. We saw that all minimum, maximum and current temperatures recorded were within range.
- All 'controlled drugs' were individually dispensed and no stock was kept. All orders for controlled drugs were countersigned by a doctor (GP). Controlled drugs were checked every day by two trained nurses and disposed of safely.
- There was an annual audit of medicines storage and a three monthly controlled drug audit completed by pharmacist. Ward managers completed weekly drug chart audits which included gaps of medicine administration on prescription charts.
- There was a resuscitation trolley in an area restricted to staff only. Emergency medicines were accessible to staff and the expected range of medicines was available. The defibrillator was checked daily. All equipment was in date.
- At the last inspection in February 2016 we found that patients were not provided with explanations, information or support regarding their medication. At this inspection we observed a medication round and saw that when medicines were administered staff told patients what they were for and patient information leaflets were available. We spoke with the pharmacist who advised they would discuss medicines with patients when requested.
- The wards had a supply of medicine information leaflets from the medicine manufacturers. Patients had a form with their prescription chart which stated if a person

Good

Wards for older people with mental health problems

had been offered information about their medicines. Of the 19 forms we saw the majority stated 'lacks capacity' or 'declined' with one form stating the information was accepted by the patient.

- Children were not permitted onto wards but they were able to have supervised visits with patients in the family room at the hospital. This was in line with the provider's policy on child visits.

Track record on safety

- There were five serious incidents requiring investigation between 1st July 2016 and 31st December 2016.
- The provider had demonstrated learning from serious incidents. We saw that a root cause analysis report following a patient's unexpected death had made a number of recommendations that the hospital had implemented. The changes included quality assurance of records through the supervision process, staff training in competent record keeping and the review of care plans in ward rounds.
- Staff we spoke with said there was an open culture for reporting medicine incidents. In the three months prior to inspection there had been three reported incidents involving medication errors. Any medicine incidents were reported to the ward manager who investigated the incident. All incidents involving medicines were sent to the pharmacist for review. The pharmacist sent a summary report to the governance committee every month and the service could access reports from the pharmacy system whenever they wished. We saw evidence to show this was the case.
- Staff explained how they recorded incidents on paper prior to transfer onto the electronic system. Recent improvements included training staff in order to embed incident reporting in practice. Staff we spoke with were aware of which incidents needed to be reported.
- Some incident records demonstrated that staff received debrief after certain incidents. Staff on the wards confirmed that an incident such as a restraint would be followed by a debrief. However we did not see this being recorded on incident forms that we looked at on Starling ward. Incidents were shared within the hospital through the hospital's daily morning meeting, this allowed any immediate changes that needed to be made were discussed and implemented. Staff received incident feedback through staff meetings.
- We found evidence of the hospital adopting an open and transparent approach, fulfilling its duty of candour following incidents. The registered manager for the service showed us letters written to family members and a root cause analysis of a serious incident which had been shared with the patient's family.

Are wards for older people with mental health problems effective?

(for example, treatment is effective)

Requires improvement

Assessment of needs and planning of care

- Staff carried out assessments of patients' needs following admission and used this to inform the risk assessment and care plans. Staff assessed areas such as falls, continence, cognition, personal hygiene needs, environmental needs, any challenging behaviour, and depression. Staff assessed each person's likes and dislikes and any preferred activities.
- At the last inspection in February 2016 we found that there were delays in physical health care monitoring and reviews. At this inspection we reviewed physical healthcare, records showed that physical healthcare monitoring was being carried out and regularly reviewed.
- All patients received a physical healthcare examination on admission. Staff developed care plans to address any physical health needs identified. For example we saw that patients were referred for speech and language, physiotherapy and occupational therapy where needed.
- Care records contained up-to-date, personalised, recovery oriented care plans. Each patient's care record contained information about their preferred name, information about their likes and dislikes and how they liked their appearance to be maintained. For example one patient's notes explained exactly how he liked to wear his beard and hair.

Good

Wards for older people with mental health problems

- At the previous inspection in 2016 we found that there had been a lack of care plans in place to manage challenging behaviour. At this inspection we found, that patients had support plans in place for challenging behaviour. However, some staff were unable to tell us about the needs of the client group and how best to support them.
- Patients' care plans reflected their assessed needs. Staff had developed a care plan for each need. Patients who were at risk of choking had been assessed by a speech and language therapist and had a clear care plan to ensure staff knew how to provide safe support with eating and drinking. Patients at risk of falls had been assessed by a physiotherapist and had a care plan which aimed to reduce falls risk. All patients had received a thorough occupational therapy assessment which identified their preferred activities and suggestions of activities to try.
- Where patients were unable to provide information about their needs and preferences staff had consulted relatives to obtain important information about patients' histories. We saw one excellent example of a care plan developed for a recently admitted patient. The patient's care plan explained clearly the reasons for some behaviours which staff may have found challenging. The care plan explained the patient's personality and work history. Staff were directed to the best way to communicate and what communication methods to employ.
- The provider had a paper-based system for patient records. We found notes to be well-organised with care plans clearly labelled. However, there were a number of different care plans containing a great deal of information. This could be further developed to indicate coping strategies and risk triggers to better inform staff when dealing with patients. The provider did use a 'my story' document to capture information regarding someone's background and preferences.

Best practice in treatment and care

- We looked at 24 prescription charts. A new prescription chart was written on admission by the admitting doctor. Allergies and patient details were recorded on all prescription charts. The pharmacist did not complete medicines history or medicines reconciliation, this was completed by the admitting doctor. All medicine charts that were reviewed adhered to British National Formulary (BNF) and National Guidelines. All prescriptions were signed and dated. The maximum dose, reason and frequency was recorded for all medication that was prescribed for when necessary (PRN).
- Some patients were receiving covert medication. When medicines were administered covertly it was in line with the provider's policy. The required discussions had taken place and documentation was correctly completed. We saw evidence that discussion with the family and ward staff exploring whether covert medication was in the best interests of the patient had taken place. A number of people had documentation which stated that medicines were to be given overtly and only certain medicines were to be given covertly if they had been refused. Advice was sought from the pharmacist on how these medicines could be administered. The pharmacist annotated the prescription chart with instructions when medicines were to be crushed.
- On the day of the inspection we saw any missed doses on inpatient prescription charts were annotated with an explanation.
- We asked nursing staff about psychological approaches and interventions and they explained that this was the role of the psychologist at the hospital. When we spoke with qualified nurses it did not appear that they had been provided with psychological formulations for individual patients that might influence day to day interactions with them. We did not observe and staff on the wards that we spoke with did not appear familiar with using approaches such as cognitive stimulation, or structured reminiscence sessions for individual or groups of patients with memory problems. We also did not see evidence of staff on the wards being familiar with cognitive behavioural therapy approaches in their interactions with patients or adopting behavioural management approaches such as observing for any patterns with confused patients such as more agitation in late afternoon which is common with this client group.
- The visiting GP aimed to review all patients at Cygnet hospital Taunton at least once a month. The GP described a good working relationship with the local general hospital. Nursing staff told us they were able to

access responsive medical care during working hours. Staff told us that accessing responsive medical care was more challenging out of hours but the duty doctor for Cygnet Hospital Taunton would assess the patient and could access help. Nursing staff told us that patients' physical health was reviewed in regular multidisciplinary patient care reviews, ward rounds and at patient care programme approach (CPA) review meetings. The consultant psychiatrists completed physical assessments of patients as there were no junior medical staff to share this responsibility.

- A senior manager told us they employed registered general nurses and did not need to access district nurses for patients. The provider was able to access the services of a speech and language therapist (SALT) via a referral through the GP, or the SALT therapists would come out to visit patients at the hospital.
- Where appropriate staff assessed and implemented care plans for nutrition and hydration. All patients were assessed for nutrition using the malnutrition universal screening tool (MUST) and a plan put in place if the tool indicated the need. Staff also assessed patients' risk of developing pressure areas using the Waterlow tool.
- Patients' records clearly identified food preferences and any intolerances or allergies. Staff completed food and fluid charts for those patients assessed as being at risk of insufficient intake or output.
- Clinical audits conducted by staff included medicines management, clinical notes audits, physical health audits, safeguarding and restrictive interventions. The hospital manager had introduced a monthly clinical audit meeting to review every audit and generate actions for action plans. We saw evidence to show how these were reported on to the hospitals integrated governance group and the provider's regional management team. Staff from all disciplines participated in audits.

Skilled staff to deliver care

- At the last inspection in February 2016 we found that patients did not have adequate access to a skill mix of psychology or physiotherapy staff. At this inspection we found the psychology time had increased from two to three days a week, and the hospital manager advised us that the psychologist was due to increase to full time hours by May 2017. The physiotherapy time had increased from one to two days a week since the last inspection, this was judged by the provider to be appropriate for the level of referrals.
- Since our inspection in 2016 other additional staff had been recruited, and clinical team leaders increased from one to two per ward. The provider had created a clinical manager role for the hospital, the post holder had started in January 2017.
- The provider employed two occupational therapists (OTs) and a social worker.
- All new staff had received a thorough induction. The provider had devised a face to face induction programme for new staff joining that was due to commence in March 2017. The programme covered topics such as infection control, manual handling, safeguarding, dementia, hospital policies and risk management. The provider also had an induction book which had been updated since the last inspection and was based on the care certificate standards. The general manager told us that staff completed this at a pace that was suitable for their learning needs.
- We spoke with nursing assistants who had been recruited in the few months prior to the inspection who had also had a face to face induction. One told us that she would like to repeat some of this as she had been completely new to care work and it might be more meaningful now that she had some experience, this was fed back to the hospital manager.
- At the last inspection in February 2016 we found that staff on the on some wards were not being regularly supervised. At this inspection we found that the provider had set a target of 95% for staff supervision. In January 2017 92% of nursing staff had received supervision. The average figure for supervision of nursing and support worker staff in the five months before inspection was 76%. The clinical manager had recently started and new clinical team leader roles had been created. The social worker and psychologist received supervision but it had not been in place for the occupational therapist who had been in post for a year at the time of the inspection. Following the inspection the provider advised us that they had made arrangements for supervision of this member of staff.
- At the last inspection in February we found that appraisal rates were low across the hospital. In January 2017 100% of nursing staff appraisals due that month

had taken place. The hospital manager told us that staff were counted in appraisal figures once they had been in post for 12 months. In the 12 month period prior to inspection 83% of nursing qualified and health care assistant staff and 83% of ancillary staff had received appraisals. There had been no appraisals for non-nursing staff from the multidisciplinary team such as social work and OT staff in the year prior to the inspection.

- We spoke with two nurses about their training and skills to provide for patients receiving palliative care. Both were knowledgeable and said the community palliative care team were very responsive if they needed any advice and/or training. A local Macmillan nurse had delivered training on the use of syringe drivers (for administering pain relief) for patients who cannot take oral medicines.
- There was training available for staff in addition to the mandatory training. Topics included end of life care, syringe driver training, risk management, information governance, tissue viability and stress management. However staff identified that there was no training on mental illness for staff such as healthcare support workers or nurses who were not registered mental health nurses. Staff told us that as the hospital was now admitting some younger patients with a functional mental illness they considered this was a gap in knowledge for some staff.
- Staff performance was being addressed effectively through supervision and appraisal systems. However members of the multidisciplinary team had not received appraisals and the occupational therapist had not been in receipt of supervision. Managers we spoke with told us they felt very supported by the human resources team when addressing poor performance. We also saw the system used for staff to be referred to the provider's occupational health service.

Multi-disciplinary and inter-agency team work

- At the last inspection in February 2016 we found that there was a lack of evidence of multidisciplinary input into care plans and ward rounds. At this inspection the hospital manager told us that they had tried to improve the multidisciplinary input in a number of ways. For example there was a section in the main patient paper files for recording interventions from the different therapies and there was a clearer referral system for accessing the input of a therapist. The provider told us that this was intended to speed up access to an appropriate therapist and referrals could be prioritised as requiring an urgent (within 48 hours) intervention. When we reviewed patient care records they included assessments and care plans by speech and language therapists, OTs and physiotherapists.
- We observed a multidisciplinary meeting to review patients' care. The team for the meeting comprised of medical, nursing, OT and social work staff. This was also attended by an Independent Mental Health Advocate (IMHA) although they were not specifically representing the patients discussed. The patients whose care was discussed did not attend the meeting, nor did they have relatives or carers at the meeting we observed. The multidisciplinary meeting took place weekly for Starling, Mulberry and Swift wards and monthly for Willow and Nightingale wards.
- We reviewed records for the nursing handover and spoke with a senior nurse about the handovers. One nursing handover occurred for all the wards, and was attended by a senior nurse from the ward. The meeting would consider what needed doing for that shift and allocate staff, along with clinical matters.
- Staff held nursing handovers twice daily between shifts in the morning and evening. In addition, all the managers would hold a daily meeting where issues which had occurred overnight or the previous afternoon were discussed and reviewed.
- We saw how managers had increased their contact and flow of information with external agencies over the last few months. This included attendance at external meetings such as a service improvement meeting with the local clinical commissioning group and regular meetings with the local authority safeguarding team, monthly updates on developments and maintaining communications.
- Care co-ordinators were kept up-to-date and invited to multidisciplinary team reviews and care programme approach (CPA) meetings.

Adherence to the MHA and the MHA Code of Practice

- Eighty six percent of staff were up-to-date with the provider's training in the Mental Health Act (MHA).

- The training programme for the MHA had been devised by the MHA administrator. The staff that we asked said it had been a while since they did the training and they could not remember the content. Copies of the MHA code of practice were available on all wards.
- We reviewed consent to treatment forms for patients detained under the MHA. We found these forms had been correctly completed for all the detained patients.
- We reviewed five sets of notes for patients detained under the MHA and found that in all cases there had been a recent attempt to give their rights under the MHA.
- Administrative support and advice was available for staff. During normal working hours this was provided by the MHA administrator. Out of hours this support was provided by the duty manager. Support was available for the MHA administrator via access to a MHA lead for all Cygnet hospitals based in Bradford and a MHA administrators' forum within the organisation.
- We saw that all sets patient files that we reviewed had a checklist at the front to aid staff in checking that the legal paperwork was filled in correctly. Information was on display in all the wards for staff on the legal requirements for accepting and transferring patients from the hospital. We also saw records for detained patients' authorised leave from the hospital. It was evident that risk assessments and care plans had been completed in relation to leave.
- Original MHA papers were kept in a locked filing cabinet which was in a secure staff only area. We were told that old MHA papers were kept in another drawer of the cabinet. When that was full they were archived, then disposed of when that was permitted.
- There was scrutiny of MHA paperwork and prompts from MHA administration to staff to complete MHA papers such as patient rights and consent to treatment forms. The prompts came in the form of informal emails and notices from the MHA administrator and it was not clear whether they had been followed up.
- We saw evidence of audits of MHA applications being completed in Jan and Feb 2017 in accordance with an action plan devised by the MHA admin and the quality assurance manager. This was in its infancy and very much led by the MHA administrator so it was not clear that there was ownership of MHA by ward based staff.
- The provider had commissioned Independent Mental Health Advocacy (IMHA), and the advocate attended the hospital two days a week. An IMHA was at the hospital on the day of our inspection.

Good practice in applying the MCA

- Ninety one percent of staff had completed training in the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards.
- There were 17 Deprivation of Liberty Safeguards applications made in the six months leading up to the inspection. At the time of our inspection the wards with the highest proportion of patients subject to Deprivation of Liberty Safeguards were Willow and Starling ward.
- Care plan documents prompted staff to comment on a patient's capacity in a range of areas. We found that in most cases these were completed with standard phrases such as 'has dementia and does not have capacity'. In some files we saw that assessments of capacity had not recently been completed and it was not clear if they had been reviewed or updated to ensure their ongoing validity.
- The provider had a policy on the MCA. We asked one qualified nurse to show us where the MCA policy was on the IT system. They could not find it.
- Restraint is defined in the MCA as the use of force, or the threat of force, to make someone do something that they are resisting; or restrict a person's movement, whether they are resisting or not. Restraint is justified under the MCA in certain circumstances. Staff we spoke with were not able to explain how they would use the principles of the MCA when making a decision regarding restraint, although all staff we asked were able to say that restraint was a last resort.
- We talked to staff about their understanding of the MCA and reviewed MCA training materials. We found that staff we spoke with had a very basic awareness of the principles of the MCA and how to undertake an assessment. However staff didn't demonstrate evidence of how the principles of the MCA might influence their day to day interactions with patients such as doing

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Wards for older people with mental health problems

everything they could to assist a person to understand or giving options when a patient was getting dressed. We noted that the training materials did not include many scenarios of patient care situations that staff may encounter.

- Following the inspection the hospital manager advised us that he had asked a member of nursing staff on each ward to take a lead role with the MCA.
- We reviewed 'do not attempt resuscitation' records and saw that the previous wishes of patients as stated by them or their family were recorded.
- The hospital had introduced a new system to monitor use of the MCA and Deprivation of Liberty Safeguards. A spreadsheet was used to track progress on authorisation decisions for Deprivation of Liberty Safeguards.
- The hospital had access to Independent Mental Capacity Advocates from a local advocacy service commissioned by the hospital.

Are wards for older people with mental health problems caring?

Good

Kindness, dignity, respect and support

- We observed staff being responsive to and involving patients in an activity and during a community meeting. Examples of this were where staff discretely offered practical and emotional support to a patient, to enable him to return to his room during an activity. We also saw staff respond promptly to a patient in distress, providing appropriate support to reduce the patient's anxieties.
- We spoke with two patients on the day of the inspection, and both told us that staff looked after them well and were nice. We also spoke with seven relatives during the inspection. Relatives told us that staff were welcoming, and that they had seen a big improvement in the service under the new managers. Family members told us that staff responded well to their relative's individual needs, and they observed that staff had attended to their relative's personal care when they visited.
- However, we observed two separate situations where staff did not support cognitively impaired patients in the most effective way. Staff tried to reason with the patients instead of using distraction techniques; they were unable to reach any mutual agreement as the patients' reason and judgement were impaired. One patient's notes had clear and comprehensive information about communication, which included avoiding arguments. We saw a member of staff telling this patient that he needed to move away from an interaction with another patient, the exchange between the nurse and this patient appeared to escalate rather than diffuse the situation.

The involvement of people in the care they receive

- Relatives gave positive feedback on their experience of their family member's admission. We saw that staff had sourced pictures of a patient's home town which were on the walls of her room. A relative told us that there was a picture of a flower on her family member's bedroom door to represent the patient's love of flowers.
- At this inspection, one patient told us that they were allowed to be as independent as possible, for example they were asked what they wanted to do for the day and included this in their care planning. Relatives told us that they had been included in care planning and care reviews. One relative told us that they had never been involved in care plans or risk assessments
- The majority of patients whose records we viewed had limited capacity; however staff had endeavoured to get as much information from both patients and families about their care needs.
- The advocacy service commissioned by the provider was able to offer advocacy to all patients.
- Relatives that we spoke with told us of their experience of being involved in a number of ways. For example the new hospital manager had written to them, they had been invited to share information on their relative, were regularly invited to care planning meetings and friends and family meetings. Relatives gave us examples of being made aware of incidents or changes in their family member's behaviour. Relatives told us they had experienced support and kindness from staff and described feeling able to ring, and that staff knew who they were and knew about their relative.

Good

Wards for older people with mental health problems

- Relatives told us that there was a comments book and comments were initialled by the hospital manager to indicate that they had been read. The manager had told relatives that the book was checked every day. Relatives told us they had been invited to complete a survey initiated by the hospital manager to ascertain their views.
- We saw evidence of advance decisions in files for two patients, one of these patients had a living will.

Are wards for older people with mental health problems responsive to people's needs?
(for example, to feedback?)

Requires improvement

Access and discharge

- The hospital had a reduced level of patients in the six months prior to this inspection. When at full capacity the hospital could accommodate 46 patients. At the time of this inspection there were 26 patients. The hospital manager explained that there had been less patients referred and also that the regional management team had supported a period of under-occupancy, to allow the hospital to make improvements needed following the last inspection in 2016. The provider told us that they had often had very brief transitional admissions for patients who then moved to an NHS bed, this sometimes presented a challenge for the service and the older patients who might be unsettled by this.
- The average occupancy for the six months prior to the inspection was 74%. The hospital had accepted 38 out of area admissions between 1st July and 31 December 2016.
- The hospital did not have a specified catchment area, although the majority of patients came from the south west area. The bed occupancy had reduced to around 50% at the time of our inspection so there were beds available.
- Staff told us that it was rare for patients to require a bed after a period of leave, although they could easily make provision for a return if commissioners agreed.
- There were no episodes of transfers between wards in the last 12 months prior to inspection.
- We saw good evidence of discharge planning throughout the wards, which was always planned at an appropriate time. However, we were made aware of several examples where commissioners had asked for a patient to be returned within short timescales, which did not allow Cygnet staff to plan accordingly. In one case a patient had only been admitted less than 24 hours to the hospital when they were transferred to another provider.
- If a patient required a psychiatric intensive care bed this would be arranged through their home clinical commissioning group.
- There were no reported issues over delayed discharges, although staff told us that sometimes care packages could take time to organise as they had to rely on external provider's to set these up and agree payment.

The facilities promote recovery, comfort, dignity and confidentiality

- At the previous inspection we found that the premises were not decorated, furnished nor had adequate relevant equipment for the purpose of supporting patients with dementia. At this inspection we found that each ward had a 'you said', 'we did board'. Issues raised in the hospital community meeting were recorded on the board. The information on the boards was the same on each ward so they were not ward specific. There were two items recorded on the board which had been addressed by the hospital.
- On Mulberry ward we found that, whilst some changes had been made to the environment, we did not see pictures that might cognitively stimulate a patient or 'reminiscence' items from an older person's youth such as old ornaments in use. The provider advised that they did have some items designed to stimulate patients however.
- Patients had requested lamps and clocks in their bedrooms. The provider had supplied these; however, insufficient attention had been paid to their suitability, particularly for patients with dementia. One patient complained that the lamps were too small at the patient community meeting, however three patients

said that the lamps were good. Staff had removed the lamps on Mulberry ward as patients had been picking them up whilst they were still connected to the electricity supply.

- Staff had provided clear signage on patients' bedroom doors. For other rooms that patients accessed such as bathrooms, we saw that pictures were sometimes used to help patients interpret signs and identify rooms, and sometimes not.
- Furnishings were in good condition but some were not appropriate for the client group such as tables and other small items of furniture which made it difficult for patients with dementia to move around, a patterned tiled floor and bookcase wallpaper which could be confusing for someone with dementia. We saw two instances of patients struggling to move around a small table when attempting to sit in a chair.
- There was an activity program displayed on each ward. Activities took place in a variety of locations on and off the ward.
- On Starling Ward we were told there was a quiet area for patients, however this appeared to be a chair at the end of a corridor. Patients usually met their visitors in their bedrooms. There was a family room near the reception area for families visiting with children.
- Patients could ask to use cordless phones to make private calls in their rooms. However there was no evidence (e.g. via pictures, or a regular feature of the patients care) to suggest that this was conveyed to patients.
- We observed that the need for privacy and family time was respected for the relative of a patient who was in need of ongoing support from two members of staff. We saw that this relative was invited to spend private time in the room alone with the patient with staff waiting nearby.
- Patients on the first floor had to travel by lift or stairs to access the downstairs gardens. Staff on an upstairs ward told us that often they could not facilitate patients going outside due to staff availability. Staff told us that when patients said they did not wish to go outside they would respect this. Some relatives that we spoke with told us their family member had access to outside space and going out into the community on trips.
- One patient was able to tell us that the food was very good, that they were offered choice and that staff knew what they liked. One relative told us that the food had definitely improved in the time their family member had been at the hospital. Relatives gave examples of their family member being shown picture menus and of their relative's weight being maintained or improved on. A relative told us of staff making a cake for their family member's birthday.
- There was fresh fruit, snacks and drinks available on all wards apart from Willow Ward. This was due to most of the patients having a pureed diet and being at risk of choking on solid foods. There were signs on the walls on Willow Ward with the following wordage 'If you would like a drink or snack ask a staff member'. However, the signs were positioned quite high on the wall and with small, unclear font as opposed to more accessible pictures of food and drink placed in a lower position. This meant that anyone in a wheelchair or with limited sight may have difficulty reading them. Relatives told us they could have tea or coffee whenever they liked.
- Some patients had rooms that had been personalised by relatives or staff but not all. Staff that we spoke with on the wards about this did not appear to see this as their role.
- There were storage facilities in all the patients' bedrooms.
- Each ward had an activity board which displayed the activities program. Patients were able to participate in activities at weekends as well as weekdays.Records showed that occupational therapy staff had identified patients' preferred activities. For patients with communication difficulties activities staff had consulted families or observed patient reactions to activities. Four activity co-ordinators worked across all wards in the hospital.
- Relatives gave us examples of their family member responding well to activities such as animals being brought into the hospital, singing and dancing with staff, being involved in cooking, being taken out on the minibus and a member of staff sitting and looking at a book with them.

Meeting the needs of all people who use the service

Good

Wards for older people with mental health problems

- Patient's bedrooms, shower areas and communal bathrooms were fairly spacious, but corridors in main ward areas could be difficult to navigate for any patients in wheelchairs, as they were narrow with many corners.
- At the inspection in February 2016 we found that there were no systems in place to provide accessible information to patients about their care and treatment options. All wards had a patient information folder located in the lounges which were accessible to patients and carers. This folder contained information such as identifying different staff from their uniform, how to complain, advocacy and legal matters.
- Staff told us that if interpreters were required these would be sourced from a specific company via the providers head office, although they had not required any in the last 12 months. Staff told us that it was possible to access some leaflets in other languages if required.
- There was a four weekly menu rota with pictures of the food on offer displayed in a folder on each ward. We were informed that staff went through this with each patient every day. The information within the menu folders offered a variety of diets and meal choices.
- A local vicar visited the hospital regularly to offer spiritual support and could arrange attendance by religious leaders of other faiths if required. The family room on site was also used as a multi faith room and had copies of the bible and Quran available.

Listening to and learning from concerns and complaints

- There were 14 complaints in the 12 months prior to this inspection. Eight were fully upheld and five were partially upheld. Complaints had mainly been around loss of patients' personal possessions. The provider informed us that they had introduced an inventory of items for a patient on admission which hadn't been in place before, had reviewed the laundry system and begun checking patient belongings on discharge. The provider advised us they had reimbursed patients or relatives where items had been mislaid and had received no further complaints about this since January 2017.
- At the inspection in February 2016 we found that patients were not offered the opportunity to feedback or complain about the service provision or delivery. At this inspection we found that one patient was able to tell us that although they had had no reason to complain, they would go to the person in charge if they did. Relatives told us they knew who to speak to if they wanted to complain. Relatives gave examples of receiving feedback regarding clothes going missing and of a complaint regarding staff attitudes.
- Staff told us how they responded to complaints made by patients or their family members. There was complaint information displayed around the wards on notice boards in easy read versions for patients to understand. Patients and families were provided with information on how to complain on admission. Staff told us they always tried to resolve complaints informally but would support patients and families to formally complain.
- Formal complaints were logged and filed so that response times were managed to provide a resolution swiftly. The hospital had implemented a walk round to include patient contact by a manager to ensure that the care provided was of good quality. Staff received feedback on complaints through ward based staff meetings.

Are wards for older people with mental health problems well-led?

Good

Vision and values

- The provider's values were: helpful, responsible, respectful, honest and empathetic. Permanent staff we spoke with told us that they were familiar with the values and that they were displayed on notice boards.
- All three agency staff we spoke with told us they felt very much part of Cygnet and all were familiar with the vision and values.
- The new hospital manager and clinical manager provided strong leadership and the staff that we spoke with had embraced the drive to improve the hospital.
- Ward managers held monthly team meetings for staff. Staff told us that they felt their teamwork reflected the organisation's values and they had observed their colleagues reflect the values in their work.

Good

Wards for older people with mental health problems

- All staff we spoke with knew the new hospital and clinical manager and of the plans to improve the hospital since the last inspection. Staff were very positive about the involvement of the new managers. Staff told us that managers were visible on the wards. Some of the staff we spoke with were also aware of regional managers who visited the service.
- One newer member of staff commented that there was no board for managers' photos, and that she had not known who the new clinical manager was initially.

Good governance

- The provider had made improvements since the last inspection in 2016 in a range of key areas. Levels of mandatory training for staff, appraisal and supervision levels for nursing staff, and the proportion of shifts which were covered by a sufficient number of staff were all at acceptable levels. Safeguarding and MHA procedures were followed. The service was able to demonstrate learning from incidents, complaints and relatives' feedback. Staff participated in clinical audits such as drug chart, clinical notes and physical health audits, and the hospital manager had introduced a monthly meeting to review these.
- Ward managers completed monthly key performance indicators on a variety of issues such as, staffing and sickness levels, supervision and appraisal rates use of agency workers, retention and recruitment of staff as well as daily admissions and discharges. This was reviewed at the integrated governance meeting and by the providers' regional operational governance team. Any risks identified throughout the performance report were escalated through to the hospital risk register for monitoring by the hospital manager. We saw the providers' training attendance spreadsheet, the hospital manager told us that this was updated as a live document and monitored twice weekly by the management team.
- The ward managers were able to authorise shifts to be covered by agency staff should they not be filled with bank staff.
- The risk register was managed by the registered manager for the hospital. Members of staff could raise issues for the risk register through their line managers who would take the risks forward to the hospitals integrated governance meeting. The heads of departments also met every week to discuss patient issues and they could forward these to the risk register.
- The new management team had been actively managing the performance of several staff members.

Leadership, morale and staff engagement

- A staff survey across all the providers' sites was running at the time of the inspection. The results were not expected to be ready for analysis until the late spring of 2017. The management team had included incentives to encourage staff to take part in this survey, such as a donation to a national charity for every survey completed.
- Sickness and absence rates were reported monthly on the provider's management monitoring system.
- Although there were no current bullying and harassment cases active at the time of the inspection we saw how these had been dealt with previously in line with the provider's policy.
- All staff we spoke with were familiar with the whistle-blowing process and told us that this information had been communicated to them on induction and on noticeboards in the hospital.
- All of the staff we spoke with including agency staff knew how to raise a concern and were confident that if they needed to raise an issue they would. The agency staff we spoke with were all familiar with the incident reporting system. One nurse told us that they did now feel able to raise concerns and that they would be addressed. They described this as an improvement since our previous inspection when they said that concerns raised had not been appropriately followed up. Staff we spoke with told us they did not feel they would get victimized or bullied if they raised concerns.
- We spoke with agency staff who told us they felt extremely well supported. They commented there was no undue pressure to accept patients who were not appropriate for the hospital or whose needs were too high. We received excellent feedback about the management team who were described as highly visible and approachable.

Good

Wards for older people with mental health problems

- All the staff we spoke with were positive about working at the service. Staff told us that morale had been affected by there not being enough staff two months earlier but had improved now that there were always enough staff.
- Some staff told us that they loved their jobs, that they recognised there had been a lot of changes since the last inspection, and could see that the hospital was going in the right direction.
- The provider had recently engaged an external training company to provide leadership training to senior healthcare workers and nurses. The courses on offer would be arranged on an individual basis, as a result of identified learning needs during the appraisal process.
- The hospital manager has adopted a very open approach in reporting and addressing situations where things had gone wrong. An example of this was that just before the inspection a potential serious error with medication was notified to CQC and the local safeguarding authority, and the notification form recorded that the patient had been made aware of this error.
- Staff that we spoke with were able to give us examples of when they had given feedback or input into service development. Examples given included supervision sessions, a letter being sent to staff inviting their opinion regarding the move of one ward and a nurse developing a system of audit trail for the clinic room. One member of staff we spoke with didn't feel they had been consulted or advised of potential changes to the service however.

Commitment to quality improvement and innovation

- There were no specific improvement methodologies in place at the time of the inspection. However following our last inspection in February 2016 the hospital had drawn up a comprehensive action plan to improve the performance of the hospital.
- The provider did not participate in any national quality improvement programme..
- The hospital had set up guidelines for staff on the dining experience of patients. The guidance was designed to support staff create a therapeutic milieu when taking into account individual patient needs and preferences. The guidance was developed following site visits to other provider sites during mealtimes and in accordance with good practice. It also included advice on ensuring patients would get adequate hydration.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure they document where and why a patient lacks the capacity to directly input into their care plan or treatment and demonstrate they have acted within the Mental Capacity Act when making best interest decisions.
- The provider must ensure that all nurses and healthcare support workers understand the needs of the client group and how best to support and communicate with them. This must include ensuring that patients with dementia have behavioural analysis where appropriate and that staff are familiar with and able to deliver individualised care plans for challenging behaviour. This must include ensuring that staff working with a patient are familiar with and able to support psychologically-informed interventions.
- The provider must ensure that they complete outstanding actions to comply with the requirement notice that the premises are decorated, furnished and have the relevant equipment for the purpose of supporting patients with dementia.

Action the provider SHOULD take to improve

- The provider should ensure that support is provided to all patients to personalise their bedrooms.
- The provider should ensure all clinical staff have adequate training and updates on working with patients with mental illness.

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
Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care Some staff were unable to tell us about the needs of the client group and how best to support them. Psychological interventions were delivered by the psychologist only. Ward staff did not describe using psychologically informed approaches in their interaction with patients. Care plan documents were completed with standard phrases such as 'has dementia and does not have capacity'. In some files it was not clear if assessments of capacity had been reviewed or updated. Staff did not demonstrate knowledge of how the principles of the MCA might influence their day to day interactions with patients or an understanding or the relationship between the MCA and restraint. This was a breach of Regulation 9 (1) (a) (b) (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (part 3)

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment The premises were not decorated, furnished nor had adequate relevant equipment for the purpose of supporting patients with dementia. This was a breach of Regulation 15 (1) (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (part 3)