

Cygnnet Health Care Limited

Cygnnet Hospital Wyke

Inspection report

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Date of inspection visit: 24 to 25 February 2021
Date of publication: 06/05/2021

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

Ratings

Overall rating for this location

Requires Improvement



Are services safe?

Requires Improvement



Are services effective?

Requires Improvement



Are services caring?

Good



Are services responsive to people's needs?

Requires Improvement



Are services well-led?

Requires Improvement



Summary of findings

Overall summary

In June 2019 we placed Cygnet Hospital Wyke into special measures following a comprehensive inspection of the service; including one ward for older people with mental health problems and the acute and psychiatric intensive care service.

We inspected Cygnet Hospital Wyke in February 2021 because we received information giving us concerns about the safety and quality of the services currently provided. We inspected one new service, a high dependency rehabilitation ward for men suffering a mental illness with an additional diagnosis of Autism Spectrum Disorder. In addition, we also inspected the existing acute and psychiatric intensive care wards.

During this inspection the provider demonstrated that improvements have been made. The service is no longer rated as inadequate overall or in any of the key questions. Therefore, this service is no longer in Special Measures.

Our rating of this location improved. We rated it as requires improvement because:

- Since our last inspection, the provider had taken action to increase patient safety and improve the quality of care. However, at this inspection, we identified issues with governance and some areas of practice had deteriorated due to the re-prioritisation of resources during the Covid 19 pandemic.
- Across both core services, staff did not receive regular supervision and all the mandatory training elements required. The climb risk assessments relating to outside space across the hospital did not contain completion dates and the ligature risk assessment for Adarna ward was incomplete.
- Staff on Adarna ward did not always regularly check the resuscitation equipment.
- Staff did not always monitor patients' physical health after administration of medication by injection in line with providers policy and national guidance. On Bennu and Phoenix wards, seclusion records were not in line with the provider's policy or Mental Health Act code of practice.
- Staff and managers did not use the full clinical audit process effectively to identify issues and improve the quality of care.
- On Adarna ward, the understanding and application of the model of care was inconsistent, staff did not plan for patient discharges effectively and did not always record the views of relatives and carers.
- The care environments were not always fully therapeutic. The environmental noise from Bennu ward impacted on patients below on Adarna ward. Patients on Bennu and Phoenix wards had limited dedicated activity and therapy space in the hospital.
- The seclusion room required decoration and repair. On Bennu ward, there was a protruding hinge on a bedroom door.

However:

- Staff provided patients with compassionate and respectful care. Staff had effective de-escalation skills and there was a commitment to reducing restrictive practices.
- Across the hospital, the multi-disciplinary teams were newly established and developing working relationships internal and external to the hospital.
- Leaders were visible and supportive. Staff could raise concerns confidently without fear.
- The hospital was clean and mostly well maintained. Staff followed infection prevention and control measures very well.

Summary of findings

- Staff involved patients in their care and treatment and recorded their views in their care plans. Staff completed comprehensive patient risk assessments and ensured these were regularly updated.
- On Bennu and Phoenix wards, staff managed the beds available well and there were no discharges delayed other than for clinical reasons.

Summary of findings

Our judgements about each of the main services

Service

Rating

Summary of each main service

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

Requires Improvement



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

- Although some elements of the service require improvement, the overall standard of the service had improved since our last inspection.
- At this inspection, staff did not always monitor patients' physical health after administering medication by injection in line with provider's policy. There was a protruding hinge on a bedroom door on Bennu ward and the hospital's seclusion room required redecoration and repair.
- There were lapses in record keeping and governance processes which impacted on the hospital's ability to manage performance and risks. We identified climb risk assessments that were not dated, seclusion records were not always complete and did not always follow the provider's policy or the Mental Health Act code of practice. The service did not monitor leave being cancelled and meaningful activity data provided limited assurance around performance.
- Some areas of practice had deteriorated as a result of re-prioritisation of resources during the COVID 19 pandemic. Staff were not always up to date with mandatory training or did not always receive regular clinical supervision. The provider's audit schedule had been relaxed which meant leaders were unable to effectively identify and manage all risks, issues and performance.
- There were limited dedicated therapy and activity spaces in the hospital which had more impact during national lockdown COVID 19 restrictions because patients could not access the community as often. The multidisciplinary team was in the process of establishing and

Summary of findings

members had had limited time and opportunities due to COVID 19 restrictions to form relationships in the community for therapies and activities.

However:

- The culture of the service had improved considerably. Staff provided compassionate and respectful care to patients. They used effective de-escalation skills to manage conflict and involved patients in their care and treatment. Staff felt supported and valued and could raise concerns without fear of retribution. Leaders were visible and approachable.
- Staff adhered very well to infection control principles and followed the latest government guidance on managing COVID 19. Both wards were clean and well maintained.
- The service provided a range of care and treatment interventions suitable for the patient group in line with best practice guidance, patients had personalised and recovery-oriented care plans. Staff understood and carried out their roles and responsibilities in line with legislation and guidance.
- The service managed beds well and discharges were rarely delayed other than for clinical reasons.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement



We rated it as requires improvement because:

- The service did not always provide safe care. The ward environment was not always safe, as the ligature risk assessment was incomplete, the climb risk assessment was not dated and the recording of observations of patients following rapid tranquilisation was not in line with the providers policy. Staff did not regularly check the wards resuscitation equipment.
- Staff did not always fully complete the clinical audit process to evaluate the quality of care they provided.
- Managers did not always ensure all staff received training and supervision. Relationships between the ward and

Summary of findings

multi-disciplinary team were developing; requiring time to establish effective relationships; including with those outside the ward who would have a role in providing aftercare.

- Staff did not always record in care records family and carer involvement.
- Staff did not plan effectively for the discharge of patients.
- Staff understanding of the service model on Adarna ward was inconsistent and this meant staff did not have a collective approach to the model of mental health rehabilitation.
- Governance processes did not ensure that ward procedures ran smoothly. Leaders were unable to effectively identify and manage all risks, issues and performance.

However:

- The ward environment was clean and staff adhered very well to infection control principles and followed the latest government guidance on managing COVID 19. The ward had enough nurses and doctors. Staff assessed and managed patient risk well. Staff minimised the use of restrictive practices, managed medicines safely and followed good practice with respect to safeguarding.
- Staff developed holistic, recovery-oriented care plans informed by a comprehensive assessment. They provided a range of treatments suitable to the needs of the patients cared for in a mental health rehabilitation ward and in line with national guidance about best practice. The ward team included the full range of specialists required to meet the needs of patients on the ward.
- Staff understood and discharged their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, and understood the individual needs of patients. They actively involved patients in

Summary of findings

care decisions. Staff felt supported and valued and could raise concerns without fear of retribution. Leaders were visible and approachable.

Summary of findings

Contents

Summary of this inspection

Background to Cygnet Hospital Wyke

Page

9

Information about Cygnet Hospital Wyke

9

Our findings from this inspection

Overview of ratings

12

Our findings by main service

13

Summary of this inspection

Background to Cygnet Hospital Wyke

Cygnet Hospital Wyke is an independent mental health hospital provided by Cygnet Healthcare Ltd situated in West Yorkshire. It has been registered with CQC since November 2010.

The hospital is registered to provide care and treatment to up to 50 patients and the following regulated activities:

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

The hospital had three inpatient mental health wards. These were:

- Bennu - a 12-bed psychiatric intensive care unit for male adults of working age.
- Phoenix - a 19-bed acute mental health ward for male adults of working age.
- Adarna - a 15 bed high dependency rehabilitation ward for male adults with autism and/or learning disabilities.

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

We last carried out a comprehensive inspection in June 2019. Following that inspection, we used urgent enforcement powers under Section 31 of the Health and Social Care Act 2008 to impose conditions on the provider's registration in relation to breaches of regulations 9, 10, 11, 12, 13, 17 and 18 of the Health and Social Care Act (Regulated Activities) Regulations 2008. As a result of that inspection, we rated the hospital as inadequate overall and placed it into special measures.

In October 2019, we completed a focussed inspection to check whether the provider had made improvements to meet the enforcement actions.

At this inspection, we inspected all the five key questions in all the wards provided.

What people who use the service say

In acute and PICU services, carers and patients told us that they thought that patients were safe, they felt involved in care and treatment, the food was nice, patients received treatment for physical health issues, there was good communication from the multi-disciplinary team and information was only shared with patients' families and carers with the patient's consent. One carer told us that they had raised some concerns to the ward manager, and they felt their concerns had been listened to, taken seriously and acted upon.

In the high dependency mental health rehabilitation service, carers and patients spoke positively about the quality of the relationships they had developed with the ward team. Patients told us they felt safe, their needs were being met and were supported on the ward. Carers felt the service engaged well with them; one carer told us the approach taken by the service was the most inclusive they had experienced.

How we carried out this inspection

We completed a comprehensive inspection of Cygnet Hospital Wyke, including two days of on-site inspection activity and visited all three wards at the hospital.

Summary of this inspection

During our inspection, we undertook the following inspection activities:

- Toured the care environments and observed how staff were caring for patients
- Reviewed 11 patients' care and treatment records
- Reviewed four episodes of seclusion.
- Received feedback from staff and patients on 15 comment cards.
- Spoke with six patients.
- Spoke with eight carers.
- Interviewed 39 staff including the hospital manager, the clinical manager, a medical director and consultant psychiatrists, ward managers, social workers, a psychologist, an assistant psychologist, an occupational therapist, a registered general nurse, clinical team leaders, registered nurses, support workers, activity co-ordinator and administrations staff.
- Attended and observed three multi-disciplinary team meetings, an operational meeting and an activity session.
- Carried out a specific check of medicines on all wards.
- Reviewed a range of documents, policies and procedures relating to the running of the hospital.

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

Areas for improvement

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

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

We told the service that it must take action to bring services into line with five legal requirements.

These actions related to acute mental health wards and psychiatric intensive care unit services:

- The service must ensure that staff complete physical health monitoring to mitigate the potential risks of medication administered on patients' health and safety. (Regulation 12 (1) (2) (b)).
- The service must ensure that prompt action is taken in response to environmental hazards to mitigate the risks to patients' health and safety. (Regulation 12 (1) (2) (b)).
- The service must ensure that the use of seclusion is in line with the Mental Health Act code of practice 2015 (Regulation 13 (1) (4) (b)).
- The service must ensure that staff record complete, accurate and contemporaneous records of seclusion. (Regulation 17 (2) (c)).
- The service must ensure that environmental risk assessments have a completion date and review date. (Regulation 17 (1) (2) (c)).
- The service must ensure that staff receive appropriate training, supervision and appraisal. (Regulation 18 (1) (2) (a)).

These actions related to high dependency mental health rehabilitation services:

- The service must ensure staff plan and effectively manage the discharge of patients. (Regulation 9 (1) (b) (3) (b)).
- The service must ensure that staff complete physical health monitoring to mitigate the potential risks of medication administered on patients' health and safety. (Regulation 12 (1) (2) (b)).

Summary of this inspection

- The service must ensure environmental risk assessments are current and accurately reflect and rate risk. (12) (1) (2) (a) (b)
- The service must ensure staff check resuscitation equipment at the required weekly intervals. (12) (1) (2) (e)
- The service must ensure staff complete the full audit process; detailing outcomes and progress against action plans. 17) (2) (c)
- The service must ensure that environmental risk assessments have a completion date and review date. (Regulation 17 (1) (2) (c)).
- The service must ensure that staff receive appropriate training, supervision and appraisal. (Regulation 18 (1) (2) (a)).

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

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

- The service should ensure that the premises are properly maintained.
- The service should ensure that staff record patients' views in their risk assessments.
- The service should maintain a record where patient leave has been cancelled and the reason.
- The service should review the space for activities and therapies to ensure this is sufficient.
- The service should ensure daily environmental checks are signed off by the nurse in charge of each shift.
- The service should ensure care plans identify patient specific goals and outcomes.
- The service should ensure that staff record family and carer engagement within care records.
- The service should ensure it develops effective working partnerships and opportunities for patients to access work and education within the wider community.
- The service should ensure it continues to develop and implement the service model of mental health rehabilitation on Adarna ward to meet the specialist needs of all patients.
- The service should ensure it completes the soundproofing improvements to the ward environment.

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Long stay or rehabilitation mental health wards for working age adults	Requires Improvement	Requires Improvement	Good	Requires Improvement	Requires Improvement	Requires Improvement
Acute wards for adults of working age and psychiatric intensive care units	Requires Improvement	Requires Improvement	Good	Good	Requires Improvement	Requires Improvement
Overall	Requires Improvement	Requires Improvement	Good	Requires Improvement	Requires Improvement	Requires Improvement

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement



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

Are Long stay or rehabilitation mental health wards for working age adults safe?

Requires Improvement



We rated it as requires improvement because:

- Staff did not regularly update the ligature risk assessment for Adarna ward, identify all risks to patients and rate those risks.
- Staff did not record the reasons for discontinuation of physical health observations following rapid tranquilisation, this was not in line with the providers policy.
- Staff did not always check the resuscitation equipment regularly; this was not in line with the providers policy.
- Staff completed a climb risk assessment for the ward courtyard; however, this was not dated. This meant it was unclear when staff had completed this and when staff should review the document again.
- Not all staff were up to date with two out of the 35 mandatory training courses. The following courses were not up to date: emergency first aid at work (31%) and the electronic patient record system (65%).
- The decoration of the hospital's seclusion room was worn, and the seclusion door sill was flaking.
- The provider did not keep records of the number of times that escorted Section 17 leave was cancelled and the reason.
- The quality of incident investigations varied and did not always identify clear outcomes.
- Staff completed the daily environmental checks on Adarna ward; however, the nurse in charge of each shift did not always sign these off as complete.

However:

- The environment on Adarna ward was clean, well equipped, well furnished and maintained. The ward only accepted male patients and therefore complied with eliminating mixed sex accommodation guidance. Domestic staff undertook regular cleaning, the ward was visibly clean. Staff adhered very well to infection control principles and followed the latest government guidance in managing the spread of COVID 19.
- The clinic room was fully equipped, with accessible resuscitation equipment and emergency drugs.
- The service used bank and agency staff to ensure there was enough nursing and medical staff, who knew the patients well. This service had five whole time equivalent vacancies for registered nurses. Managers were undertaking ongoing recruitment to fill vacant posts and at the time of our inspection, the service had offered four candidates posts. The service had access to medical cover during the day and the night to ensure a doctor could attend the ward quickly in an emergency.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement 

- Staff assessed and managed risks to patients and themselves well. They achieved the right balance between maintaining safety and providing the least restrictive environment possible in order to facilitate patients' recovery. Staff followed best practice in anticipating, de-escalating and managing challenging behaviour. As a result, they used restraint and seclusion only after attempts at de-escalation had failed.
- Except for the two mandatory training courses which were not up to date, staff in this service had undertaken 94% of the various elements of training the provider had set as mandatory.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.
- Staff had easy access to clinical information and it was easy for them to maintain high quality clinical records. Records remained a mix of paper-based and electronic.
- The service used systems and processes to safely prescribe, administer, record and store medicines. Patients were supported to self-administer medicines where possible, this was kept under review to help ensure medicines were handled safely.
- The wards had a good track record on safety. The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team, the wider service and regionally. This included the recent introduction in the use of the safety cross, a tool to monitor the frequency and type of incidents on the ward.
- When things went wrong, staff apologised and gave patients honest information and suitable support.

Are Long stay or rehabilitation mental health wards for working age adults effective?

Requires Improvement 

We rated it as requires improvement because:

- Staff did not receive regular supervision and this was not in line with national guidance. Only 45% of staff received management supervision and 70% of staff had received clinical supervision (Correct at 24 February 2021). This meant that managers could not be assured that staff had the appropriate support and skills to complete their roles effectively.
- Staff did not always identify outcomes of clinical audits and action plans were not updated to indicate progress. Data on meaningful activity was not accurately recorded, for some patients staff recorded the offer of meaningful activity of over 288 hours each week. The ward was not undertaking any benchmarking and quality improvement initiatives at the time of inspection.
- Care plans did not always identify specific goals and outcomes for patients; particularly relating to timeframes.
- Although the ward team included the full range of specialists required to meet the needs of patients on the ward, members of the multi-disciplinary team were all relatively new in post and were not fully established as a team. The impact of this meant there was potential for risk averse decision making, as not all staff had the experience to lead within the different specialisms of the multi-disciplinary team. However, at the time of this inspection, managers were planning a relaunch of the service model; central to this was a collective multi-disciplinary approach to supporting patients' specialist needs within the rehabilitation service.

However:

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

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement



- Staff provided a range of care and treatment interventions suitable for the patient group and consistent with national guidance on best practice. This included access to psychological therapies, support for self-care and the development of everyday living skills. During the COVID 19 pandemic, patients had limited opportunities to access the community due to national lockdown restrictions and this meant care and treatment interventions were largely ward based. Patients told us they worked in the hospital tuck shop and supported the maintenance and administration team in selected tasks.
- Staff ensured that patients had good access to physical healthcare and supported patients to live healthier lives. The provider had relaxed the hospital's smoke free policy during the national lockdown restrictions during COVID 19 which was welcomed by patients and staff. Following the national lockdown restrictions relaxing, they had plans to reintroduce the smoke free policy. Patients had access to nicotine replacement therapy.
- Staff used recognised rating scales to assess and record severity and outcomes. These included tools specific to each member of the multi-disciplinary team. Although the provider relaxed the clinical audit schedule during the COVID 19 pandemic in the re-prioritisation of resources, staff participated in completing some clinical audit.
- Managers made sure they had staff with a range of skills needed to provide high quality care. They supported staff with opportunities to update and further develop their skills. For example, the service supported ward staff to complete an eight-week training module on autism and introduced a 10 week rolling programme of training for staff to attend. Managers provided an induction programme for new staff.
- Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice and discharged these well. Managers made sure that staff could explain patients' rights to them.
- Staff supported patients to make decisions on their care for themselves. They understood the provider's policy on the Mental Capacity Act 2005 and assessed and recorded capacity clearly for patients who might have impaired mental capacity. We saw several examples of capacity assessments within care records.

Are Long stay or rehabilitation mental health wards for working age adults caring?

Good



We rated it as good because:

- Staff treated patients with compassion and kindness. They respected patients' privacy and dignity. They understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition. We observed staff responding to patients in distress; staff were calm, encouraging and gave patients time and space.
- Staff involved patients in care planning and risk assessment and actively sought their feedback on the quality of care provided. They ensured that patients had easy access to independent advocates.

However:

- Staff did not always record in care records family and carer involvement, although the service did encourage family and carer engagement. Families and carers spoke positively about engagement with staff from the service.

Are Long stay or rehabilitation mental health wards for working age adults responsive?

Requires Improvement



We rated it as requires improvement because:

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement



- Staff did not plan effectively for the discharge of patients. Patients had visual discharge plans, these were limited in detail, outcomes were vague with no specific timeframes or goals identified.
- Staff understanding of the service model on Adarna ward was inconsistent and this meant staff did not have a collective approach to the model of mental health rehabilitation and meeting the specialist needs of all patients. Managers were assured that staff would achieve this through the remodelling of the service that was underway at the time of inspection.
- Staff did not always make sure patients had access to opportunities for education and work; or develop relationships in the wider community. This coupled with the COVID 19 pandemic restrictions meant that working relationships with organisations outside of the hospital in the community for activities were underdeveloped and limited. Staff were unable to identify any current partnership arrangements or how the service were working towards this.
- The design of the ward was not bespoke for the service. Noise from the PICU ward above was loud and persistent; this meant patients with sensory needs were affected. Managers developed a plan to address this and were waiting for the installation of soundproofing tiles across the ward.

However:

- The layout and furnishings of the ward supported patients' treatment, privacy and dignity. Each patient had their own bedroom with an en-suite bathroom and could keep their personal belongings safe. There were areas for privacy. Staff supported patients' sensory needs; this included the use of night vision goggles to complete observations discreetly.
- The food was of a good quality and patients could make hot drinks and snacks at any time.
- Staff helped patients with communication, advocacy and cultural and spiritual support. The advocate provided a regular report to the service to highlight frequency of engagement with both patients and staff.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team. The ward had received two formal complaints since opening in May 2020.

Are Long stay or rehabilitation mental health wards for working age adults well-led?

Requires Improvement



We rated it as requires improvement because:

- Some systems and processes required embedding into practice; such as the discharge process and the full completion of the clinical audit process.
- Our findings from the other key questions demonstrated that governance processes operated at ward level were not always effective and that performance issues and risks were not always identified and managed well. We identified issues with physical health monitoring following the use of rapid tranquilisation, not all staff being up to date with all of the required mandatory training, staff not receiving regular clinical and managerial supervision, completeness of the climb risk assessment and poor discharge planning.
- Areas of practice were not all monitored and the provider's audit schedule had been relaxed which meant that issues with practice were not easily identified and acted upon in a timely way. The hospital did not monitor the number of times escorted leave was cancelled and although hours of meaningful activity were recorded there were limitations in how this data could provide assurance.
- The ward was not undertaking any bench marking or quality improvement initiatives.

However:

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement








- Leaders had the skills, knowledge and experience to perform their roles, had a good understanding of the services they managed, and were visible in the service and approachable for patients and staff. Managers provided staff with the opportunity to openly discuss concerns or positive areas of work during regular informal drop in sessions.
- Staff knew and understood the provider's vision and values and how they were applied in the work of their team.
- Staff reported that the culture of the hospital had improved considerably. They felt respected, supported and valued. They reported that the provider promoted equality and diversity in its day-to-day work and in providing opportunities for career progression. They felt able to raise concerns without fear of retribution.
- Staff had access to the information they needed; this included the 'Wyke Wall', a display of performance information and monthly topics of focus, such as safeguarding and closed cultures.

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

Requires Improvement



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

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

Requires Improvement



Our rating of safe improved. We rated it as requires improvement because:

- Overall, there had been improvements made in the safety of the acute and psychiatric intensive care wards since our last inspection. However, there were areas that required improvement to protect patients from potential avoidable harm.
- Staff did not always review or monitor the physical health of patients who had medicines administered by injection in line with the provider's policy. In two of the records that we reviewed, staff had stopped monitoring physical health observations 24 hours after the administration of an antipsychotic medicine when they should have completed this for 72 hours. In one record, there were gaps in the monitoring post administration of an antipsychotic medicine.
- Staff were not up to date with four out of the 35 mandatory training courses. The following courses were not up to date: suicide and self-harm 31%, emergency first aid at work 59%, the electronic patient record system 60% and start risk assessment 66%.
- There were issues with the accuracy and completeness of two out of four seclusion records. There was no record relating to the termination of one episode of seclusion. In another record, a patient had been secluded in their bedroom and the seclusion care plans referred to both the seclusion room environment and their bedroom in different sections of the care plan. In that record, the 15 minute reviews were not recorded in line with the provider's seclusion policy.
- In two out of four seclusion records, the rationale for seclusion commencing and/or continuing was not in line with the Mental Health Act code of practice. In one record, staff had recorded seclusion was to continue to allow the patient to reflect on incidents and to accept oral medication and in another record, seclusion commenced based on recent risks and because the patient reported to feel safer going into seclusion. The Mental Health Act code of practice state that seclusion should be only be used where it is of immediate necessity to contain severe behavioural disturbance which is likely to cause harm to others.
- On Bennu ward, a bedroom door hinge was protruding. This bedroom was not in use.
- The climb risk assessments in use for the terrace, main courtyard and Phoenix ward courtyard were current but these were not dated. This meant it was unclear when they had been completed and when staff should review these.
- The decoration of the hospital's seclusion room was worn, and the seclusion door sill was flaking. The provider told us that seclusion refurbishment works were due to be completed in May 2021.
- The provider did not keep records of the number of times that escorted leave was cancelled and the reason why.

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

Requires Improvement 

However:

- Both wards environments were safe, clean, well equipped, well furnished, mostly well maintained and fit for purpose. Staff completed annual risk assessments of the care environment and had mitigated the risk of ligature anchor points adequately. The ward only accepted male patients and therefore complied with eliminating mixed sex accommodation guidance. Regular cleaning took place by domestic staff and ward staff undertook additional cleaning tasks to ensure that high touch areas were regularly cleaned. Staff adhered very well to infection control principles and followed the latest government guidance in managing COVID 19.
- The provider had ensured that equipment was clean and calibrated which was an action from our last inspection.
- The service used bank and agency staff to ensure there was enough nursing and medical staff, who knew the patients well. This service had 7.1 whole time equivalent vacancies for registered nurses. Managers were undertaking ongoing recruitment to fill vacant posts and at the time of our inspection had offered 11 candidates posts. The provider had made improvements to medical cover during the day and the night to ensure a doctor could attend the ward quickly in an emergency.
- Except for the four mandatory training courses which were not up to date, staff in this service had undertaken 84% of the various elements of training the provider had set as mandatory.
- Staff assessed and managed risks to patients and themselves well and followed best practice in anticipating, de-escalating and managing challenging behaviour. Staff completed patient observations at intervals required to keep them safe. Staff used restraint only after attempts at de-escalation had failed. The ward staff participated in the provider's restrictive interventions reduction programme and the hospital was planning to complete Safewards. Safewards is a model that involves staff and patients that consists of interventions that aim to reduce conflict and containment.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.
- Staff had easy access to clinical information, and it was easy for them to maintain high quality clinical records using a combination of paper-based and electronic systems.
- The service used systems and processes to safely prescribe, administer, record and store medicines. Apart from the concerns in relation to the monitoring of one antipsychotic medicine on physical health, staff regularly reviewed the effects of medications on each patient's physical health in line with best practice guidance.
- The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Following a pattern of incidents, sessions for staff had been held on procedural, relational and physical security to remind staff to follow policies and procedures in place.

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

Requires Improvement 

Our rating of effective improved. We rated it as requires improvement because:

- The provider had taken action to address all the regulatory actions in relation to this key question and had made improvements in the effectiveness of this core service. However, despite improvements being made there were new areas for improvement identified at this inspection.
- Staff did not receive regular clinical supervision in line with national guidance. The clinical supervision rate was low at 67%.

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

Requires Improvement 

- The provider had relaxed the clinical audit schedule during the COVID 19 pandemic in the re-prioritisation of resources. Although some clinical audits took place, the actions identified did not always lead to improvements being made. The hospital was not undertaking any benchmarking and quality improvement initiatives at the time of inspection. Data on meaningful activity did not take into account admissions part way through the week and averages hid the wide fluctuation of individual patient meaningful engagement hours from week to week.
- Although the ward teams included or had access to the full range of specialists required to meet the needs of patients on the wards, many members of the multidisciplinary teams were new in position and this meant that they were not yet established into a fully effective multi-disciplinary team. This coupled with the COVID 19 pandemic restrictions meant that working relationships with organisations outside of the hospital in the community for activities and therapies were underdeveloped and limited.
- The required Mental Health Act documentation was not in place for the administration of a medicine on one of the records we reviewed. We brought this to the attention of the prescriber, and this was addressed.

However:

- The ward teams had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation including commissioners, case managers and advocates.
- Staff assessed the physical and mental health of all patients on admission. They developed individual care plans, which they reviewed regularly through multidisciplinary discussion and updated as needed. All the care records that we reviewed contained care plans that reflected the assessed needs, were personalised, holistic and recovery oriented. When staff undertook baseline blood tests on admission, they checked vitamin D levels to ensure that patients were not deficient following COVID 19 pandemic restrictions.
- The hospital accepted patients nationally and this meant that patients may not be from the local area. In order to meet their physical health needs, the service had a registered general nurse and staff liaised with their home area GP where needed.
- Staff supported patients to live healthier lifestyle through initiatives including “no meat Mondays” and providing nicotine replacement therapies. The provider had relaxed the hospital’s smoke free policy during the national lockdown restrictions during COVID 19 which was welcomed by patients and staff. Following the national lockdown restrictions relaxing, they had plans to reintroduce the smoke free policy.
- Staff provided a range of care and treatment interventions suitable for the patient group and consistent with national guidance on best practice.
- Staff used recognised rating scales to assess and record severity and outcomes.
- Staff from different disciplines worked together as a team to benefit patients. Managers made sure they had staff with a range of skills needed to provide high quality care. Managers provided an induction programme for new staff.
- Staff received regular managerial supervision and appraisal of their performance.
- Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice and discharged these well. Managers made sure that staff could explain patients’ rights to them.
- Staff supported patients to make decisions on their care for themselves. They understood the provider’s policy on the Mental Capacity Act 2005 and assessed and recorded capacity clearly for patients who might have impaired mental capacity.

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

Good 

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

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

Requires Improvement 

- Since our last inspection, there had been a significant improvement in the way staff treated patients. Staff treated patients with compassion and kindness. They were warm, showed a genuine interest in patients' wellbeing and respected patients' privacy and dignity.
- Staff understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition. They utilised effective de-escalation skills to manage conflict well and confidently.
- Staff involved patients in care planning and actively sought their feedback on the quality of care provided. They ensured that patients had easy access to independent advocates.
- Staff informed and involved families and carers appropriately. During the Covid 19 pandemic, virtual methods had been used well to involve families and carers. One carer told us that they had raised concerns about some issues, and they felt these had been taken seriously and addressed.

However:

- Although staff involved patients in their care and treatment, their views were not recorded in their risk assessments.

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

Good 

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

- The provider had met the actions from our previous inspections and improvements had been made in the responsiveness of this core service.
- Staff managed beds well and there was clear inclusion and exclusion criteria for referrals being accepted. Some beds had been blocked booked on Bennu and Phoenix wards. This meant that a bed was available when needed and that patients were not moved between wards unless this was for their benefit. Discharge was rarely delayed for other than clinical reasons.
- The design, layout, and furnishings of the ward/service supported patients' treatment, privacy and dignity. Each patient had their own bedroom with an en-suite bathroom and could keep their personal belongings safe. There were quiet areas for privacy.
- The food was of a good quality and patients could make hot drinks and snacks at any time.
- The service met the needs of all patients who used the service – including those with a protected characteristic. Staff helped patients with communication, advocacy and cultural and spiritual support.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team and the wider service.

However:

- During the COVID 19 pandemic, patients had limited opportunities to access the community due to national lockdown restrictions and there was limited space for activities and therapies away from the main ward communal areas. This limited how many activities and therapies could be facilitated at the same time for all patients.

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

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

Requires Improvement 

Requires Improvement 

Our rating of well-led improved. We rated it as requires improvement because:

- Overall, there had been improvements made in the leadership and governance of the service. Although the provider had taken action to address issues, increase patient safety and improve the quality of care provided, there continued to be some areas for improvement needed and further embedding of systems and processes required. Some areas of practice had deteriorated as a result of re-prioritisation of resources due to the COVID 19 pandemic.
- Our findings from the other key questions demonstrated that governance processes operated at ward level were not always effective and that performance issues and risks were not always identified and managed well. We identified issues with physical health monitoring not always being completed when it should be, not all staff being up to date with all of the mandatory training required, staff not receiving regular clinical and managerial supervision, issues with seclusion record keeping and completeness of climb risk assessments.
- Areas of practice were not all monitored, and the provider's audit schedule had been relaxed which meant that issues with practice were not easily identified and acted upon in a timely way. Actions identified in clinical audits did not always lead to improvements being made. The hospital did not monitor the number of times escorted leave was cancelled and although hours of meaningful activity were recorded there were limitations in how this data could provide assurance.
- The hospital was not undertaking any bench marking or quality improvement initiatives.

However:

- Leaders had the skills, knowledge and experience to perform their roles, had a good understanding of the services they managed, and were visible in the service and approachable for patients and staff.
- Staff knew and understood the provider's vision and values and how they were applied in the work of their team.
- Staff reported that the culture of the hospital had improved considerably. They felt respected, supported and valued. They reported that the provider promoted equality and diversity in its day-to-day work and in providing opportunities for career progression. They felt able to raise concerns without fear of retribution.
- Ward teams had access to the information they needed.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity

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

Treatment of disease, disorder or injury

Regulation

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

Staff did not always monitor patients' physical health after administering medication by injection in line with provider's policy.

There was a delay in repairing a protruding hinge on a bedroom door on Bennu ward.

The ligature risk assessment for Adarna ward was incomplete.

Staff did not always check the resuscitation equipment regularly, this was not in line with the providers policy.

Regulated activity

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

Treatment of disease, disorder or injury

Regulation

Regulation 18 HSCA (RA) Regulations 2014 Staffing

Staff did not receive regular supervision or appraisal.

Staff training compliance showed that some mandatory training courses were not up to date.

Regulated activity

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

Treatment of disease, disorder or injury

Regulation

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

Staff did not plan effectively for the discharge of patients.

Patients had visual discharge plans, these were limited in detail, outcomes were vague with no specific timeframes or goals identified.

This section is primarily information for the provider

Requirement notices

Regulated activity

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

Treatment of disease, disorder or injury

Regulation

Regulation 17 HSCA (RA) Regulations 2014 Good governance

There were issues with the accuracy and completeness of two out of four seclusion records.

The climb risk assessments were not dated.

Staff did not always identify outcomes of clinical audits and action plans were not updated to indicate progress.

Regulated activity

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

Treatment of disease, disorder or injury

Regulation

Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment

In two out of four seclusion records, the rationale for seclusion commencing and/or continuing was not in line with the Mental Health Act code of practice.