Cygnet Acer Clinic

Quality Report

Worksop Road
Mastin Moor
Chesterfield
South Yorkshire
S43 3DN
Tel:01246 386090
Website: www.cygnethealth.co.uk

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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	Requires improvement
Are services safe?	**Inadequate**
Are services effective?	**Good**
Are services caring?	**Good**
Are services responsive?	**Good**
Are services well-led?	**Requires improvement**

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

Cygnet Acer Clinic provides care and treatment to female patients. Most patients have a diagnosis of emotionally unstable personality disorder and present with challenging behaviours including self-harm.

This was a focussed inspection in response to a serious incident and other safety concerns at the hospital. We did not look at all key lines of enquiry in each of the domains. The overall rating remains requires improvement and the hospital remains in special measures.

The hospital did not have a good track record of serious ligature incidents that resulted in severe harm to patients or death. It was not always clear from staff discussion how they developed and reviewed actions to better manage incidents at the hospital. The electronic incident management system required further development to ensure incidents were recorded and managed correctly.

It was not always clear that governance processes maintained oversight of actions to ensure they improved quality and safety at the hospital. We identified a number of areas where the provider still needed to make improvements.

Staff practice to complete the fire register remained poor. This meant the fire register did not always provide an accurate record of where and when staff were on duty or the staffs whereabouts in the event of an emergency.

Patients raised concerns about staff engagement with them and the way staff provided support, particularly during incidents or periods of distress.

However:

Staff assessed and managed risk well. They minimised the use of restrictive practices and followed good practice with respect to safeguarding. The provider assessed and managed risks associated with the COVID-19 pandemic well.

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.

Staff teams included or had access to the full range of specialists required to meet the needs of patients on the wards. Managers ensured that these staff received training and supervision. Staff worked well together as a multidisciplinary team and with those outside the hospital who would have a role in providing aftercare.

Staff understood the individual needs of patients. They actively involved patients and families and carers in care decisions.

Staff planned and managed discharge well and liaised well with services that would provide aftercare.

Summary of findings

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Requires improvement

Cygnet Acer Clinic

Services we looked at
Long stay or rehabilitation mental health wards for working-age adults

Summary of this inspection

Background to Cygnet Acer Clinic

Cygnet Acer Clinic provides care and treatment for 28 female patients. Most patients have a diagnosis of emotionally unstable personality disorder and present with challenging behaviours including self-harm. Patients may also have a mental illness, learning disability, substance misuse problems or an unrelated physical health condition. Some patients are detained under the Mental Health Act 1983.

The hospital provided 14 beds at Upper House and 14 beds at Lower House. When we inspected the hospital it had 24 patients, 12 at each house. All patients at Upper House and nine patients at Lower House were detained under the Mental Health Act 1983.

Cygnet Acer Clinic is registered to provide:

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

There was a registered manager in post at the time of this inspection.

CQC has inspected Cygnet Acer Clinic six times since 2015. Following our inspection team finding serious safety concerns during a responsive inspection in August 2019, the hospital was placed into special measures. CQC made follow-up inspections in October 2019 and March 2020 to see if the hospital had made improvements. Following the March 2020 inspection, the hospital remained in special measures and no change was made to the rating. We told the provider they must ensure staff follow the provider's policies and procedures for the use of observation.

CQC has completed Mental Health Act Reviews at Cygnet Acer Clinic in October 2017, February 2018 and October 2019. The review in October 2019 identified nine action points for the provider to act on. The provider submitted a plan to address these actions.

Our inspection team

Due to the Covid-19 pandemic, we conducted patient, carer and staff interviews by telephone. A small inspection team visited the hospital site for one day on 27 August 2020 to look at areas that could not be inspected virtually.

In total four CQC inspectors, two CQC inspection managers and two specialist professional advisors, who were nurses with experience of personality disorder hospitals, contributed to this inspection.

Why we carried out this inspection

This was a focussed inspection completed following a notification of concern, a serious incident involving a ligature that resulted in a patient death. This was similar to serious incidents in 2018 and 2019 that also resulted in patient deaths.

CQC had also received information from Clinical Commissioning Groups concerning the safety of patients at Cygnet Acer Clinic.

How we carried out this inspection

This was a focussed inspection and therefore our inspection activity focussed on specific areas. This means we did not look at all key lines of enquiry in each of the domains.

During the remote part of this inspection we completed telephone interviews with patients, staff and family/ carers and reviewed a range of policies, procedures and

Summary of this inspection

other documents relating to the running of the hospital. During the site visit we looked at the hospital environment and reviewed the care and treatment records of patients.

During this inspection, the inspection team:

- completed telephone interviews with nine patients who were using the hospital.
- completed telephone interviews with three family members/carers
- completed a telephone interview with the registered manager
- completed telephone interviews with 19 other staff members including doctors, nurses, support workers, social worker, psychologist, occupational therapy and regional director
- looked at the quality of the hospital environment
- attended one daily multidisciplinary team meeting
- attended the multidisciplinary review meeting for two patients using the hospital
- looked at 10 care and treatment records of patients
- carried out a specific check of the medication management records for both wards
- reviewed feedback from two Clinical Commissioning Groups
- looked at a range of policies, procedures and other documents relating to the running of the hospital.

What people who use the service say

We spoke with nine patients to gather feedback about the hospital. Six of those patients spoke positively about the hospital. This included positive comments about the number of staff at the hospital, feeling safe and being involved in planning their own care and treatment. Patients were also positive about the providers' infection prevention and control arrangements. These helped them to feel safe during the COVID-19 pandemic. However, six of the nine patients reported concerns about how staff spoke to or supported them when they were upset or involved in incidents. They made comments about staff being unsupportive, rude or dismissive. Four patients reported concerns that staff spent too much time in office areas and were not always available to patients when they needed help.

We spoke with three family members or carers. Two of the three spoke very positively about the hospital. This included staff conduct, involvement in meetings and decision making and discussions about discharge. One reported they had received a gift package from the provider for 'Carers Day' and told us how staff at the hospital supported her daughter's interests. One family member found staff to be impolite and did not believe staff always responded to concerns raised by their family member.

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?

Inadequate

Our rating of this hospital stayed the same. We rated it as inadequate because:

- The hospital did not have a good track record of serious ligature incidents that resulted in severe harm to patients or death. It was not always clear from staff discussion how they developed and reviewed actions to better manage incidents at the hospital. The electronic incident management system required further development to ensure incidents were recorded and managed correctly.
- Staff practice to complete the fire register remained poor. This meant the fire register did not always provide an accurate record of where and when staff were on duty or staffs whereabouts in the event of an emergency.
- Staff did not always complete clinical records correctly or record information in the expected place. This included completion of nurse in charge sign off of observation charts and records of patients' physical health measurements.

However,

- Staff assessed risks to patients, themselves and the hospital environment. Staff completed and recorded patient observations. The provider managed risks associated with the COVID-19 pandemic well.
- The hospital had enough nursing and medical staff. Staff received basic training to help keep patients safe.

Are services effective?

Good

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

- Care plans reflected the assessed needs of patients, they were personalised, holistic and recovery-oriented.
- 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, to support for self-care and the development of everyday living skills, and to meaningful occupation. Staff ensured that patients had good access to physical healthcare and supported patients to live healthier lives.
- The hospital had access to the full range of specialists required to meet the needs of patients. Staff from different disciplines worked together as a team to benefit patients. They had

Summary of this inspection

effective working relationships with staff from external organisation that would provide aftercare following the patient's discharge and engaged with them early in the patient's admission to plan discharge.

However:

- Not all meetings followed a clear framework of what must be discussed. This did not ensure staff shared and discussed essential information.
- Staff's completion of one risk management course, suicide and risk training, was below the provider's own target. The provider's completion of staff appraisals was also below their own target.

Are services caring?

Good

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

- Staff understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition.
- Staff involved patients in care planning and risk assessment and actively sought their feedback on the quality of care provided. Staff involved patients to develop and deliver training packages.
- Staff informed and involved families and carers appropriately.

However;

- Patients did not always like the way staff delivered support to them, particularly during periods of distress or following incidents. Patients also reported that some staff were not always available to them when they were needed.

Are services responsive?

Good

Our rating of this hospital stayed the same. We rated it as good because:

- Staff planned and managed discharge well. They liaised well with services that would provide aftercare and were assertive in managing the discharge care pathway. As a result, patients did not have excessive lengths of stay and discharge was rarely delayed for other than a clinical reason.
- The wards met the needs of all patients who used the hospital – including those with a protected characteristic. Staff helped patients with communication, advocacy and cultural and spiritual support.
- Staff treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team and the wider hospital.

Summary of this inspection

Are services well-led?

Requires improvement

Our rating of this hospital stayed the same. We rated it as requires improvement because:

- The provider had established governance processes, but it was not always clear that governance processes maintained oversight of actions to ensure they improved quality and safety at the hospital.We identified a number of areas where the provider still needed to make improvements.
- Not all staff knew who the provider's Freedom to Speak Up Guardian was.

However,

- The provider continued to invest in leadership at the hospital. Staff spoke positively about the introduction and impact of additional leadership roles.
- Staff from the hospital were involved in the provider's Personality Disorder Steering Group. The Steering Group had produced a revised clinical model for personality disorder hospitals, planned to be delivered across the organisation.

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.

The provider made Mental Health Act and Code of Practice training available to staff as part of mandatory training requirements. At the time of our inspection the provider reported that 96% of eligible staff had completed training.

The hospital had a dedicated member of staff to provide administrative support for the implementation of the Mental Health Act and its Code of Practice at the hospital. Staff knew who their Mental Health Act administrator was.

Staff explained to patients their rights under the Mental Health Act in a way that they could understand, staff repeated this as required and recorded that they had done it. Care records and our conversations with patients confirmed this.

Staff adhered to consent to treatment and capacity requirements.

The provider displayed a notice to tell informal patients that they could leave the ward freely.

Mental Capacity Act and Deprivation of Liberty Safeguards

The provider made Mental Capacity Act training available to staff as part of mandatory training requirements. At the time of our inspection the provider reported that 96% of eligible staff had completed training.

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	Inadequate	Good	Good	Good	Requires improvement	Requires improvement
Overall	Inadequate	Good	Good	Good	Requires improvement	Requires improvement

Long stay or rehabilitation mental health wards for working age adults

Requires improvement

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

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

Inadequate

Safe and clean environment

The provider required staff and visitors to sign in and out of Upper and Lower houses. During the COVID-19 pandemic, the provider limited air-lock access to a maximum of two people. The provider required visitors to the hospitals to complete a COVID-19 questionnaire and provide 'track and trace' details.

Upper and Lower House accommodated patients across two floors with patient bedrooms on both floors. The layout of the houses did not allow staff to observe all areas. However, in addition to the placement of staff and routine observation practices, the provider had convex mirrors in place to assist observation.

The provider had closed-circuit television cameras in some communal areas of the hospital and externally. Staff used closed circuit television camera recordings as evidence to review incidents and to audit staff practice. The provider displayed posters advising patients, staff and visitors that closed circuit television cameras operated at the hospital.

The provider regularly risk assessed the hospital environment. The provider had arrangements in place for a range of environmental risk assessments including fire and Legionella water safety.

The provider completed a comprehensive ligature risk assessment using a recognised tool. Ligature points are fixtures to which people intent on self-harm might tie something to strangle themselves. Staff updated the ligature risk assessment annually, following serious incidents and following changes in the environment. In the 12 months prior to the inspection, the hospital manager had updated the assessment eight times. In patient bedroom areas, staff had assessed only the wall mounted thermostat as low risk to ligatures. We saw the provider had actions in place to reduce ligature risks identified by the assessment. Actions by the provider sometimes reduced the risk rating given to an identified ligature point. For example, the installation of reduced ligature taps in patient bedrooms had reduced that risk rating from high to medium. We reviewed the ligature risk assessment, staff described fittings as 'anti-ligature' rather than 'reduced ligature' as the providers policy directed. The provider shared copies of the ligature risk assessment with staff and provided staff with training on ligatures. Staff we spoke with were familiar with the ligature risk assessment and knew where to access it.

In addition to the ligature risk assessment, in September 2019 the provider completed a ligature audit. We saw the provider made changes to the hospital environment to reduce ligature risks following serious incidents. For example, the provider had installed different taps in bedroom en-suite and kitchenette areas to reduce risks around ligature. The audit identified additional work to replace bathroom doors in patients' rooms with an alternative style that reduced ligature risks. However, the provider had not acted quickly to complete the identified work. The COVID-19 pandemic halted production of the alternative doors and this delayed the schedule of installation. Staff recorded the delay on the local risk register and managed risks individually with patients. The

hospitals recent serious ligature incident in August 2020 involved a suspended ligature from a closed bathroom door at Lower House. During the inspection, work to replace bathroom doors in patients' rooms was completed.

The hospital accommodated female patients only. This complied with national guidance about, and expectations governing, the provision of single sex accommodation. Each patient had their own shower, wash basin and toilet.

Staff had access to personal alarms. Staff checked personal alarms daily to ensure they worked safely. During the inspection we saw staff routinely carrying personal alarms and responding promptly to alarm calls. Staff accompanied visitors during visits or issued them with personal alarms on arrival.

Patients had access to nurse call points in bedrooms, corridors and communal areas.

Maintenance, cleanliness and infection control

Communal areas of the hospital were visibly clean, well maintained and had good furnishings. Cleaning records for the hospital were present and demonstrated regular cleaning.

Staff adhered to infection control principles including handwashing. We saw posters demonstrating correct handwashing techniques and hand gel dispensers throughout the hospital. The provider completed quarterly infection control audits.

As part of the response to the COVID-19 pandemic the provider required staff to wear face masks. Staff made face masks available to patients and encouraged appropriate hand hygiene practices. We also saw two metre 'social distanced' floor markings in areas where patents congregated. There was updated cleaning guidance to include increased cleaning frequency of high-touch areas. Staff told us personal protective equipment was well managed and in good supply. When we inspected, the provider had recorded no cases of COVID-19 at the hospital.

Patients and staff we spoke with were satisfied with the providers COVID-19 pandemic response and infection prevention and control practices.

Clinic room and equipment

Both houses had clinic rooms, that were visibly clean, tidy and well ordered. Staff had access to equipment necessary for carrying out physical health checks.

Staff made daily checks of clinic rooms and medicine fridge temperatures.

At both houses, staff stored and maintained the emergency equipment in the main staff office. This ensured all staff had access to emergency equipment. Staff made daily visual checks of automated external defibrillators and emergency grab bags. Staff completed detailed checks of emergency equipment at Upper House on a weekly basis. However, at Lower House we saw staff had missed two weekly checks between July 16 and August 7 2020.

Safe staffing

The provider had planned enough nursing staff of relevant grades to keep patients safe. The hospital had a planned staffing level of 12 substantive whole time equivalent qualified nurse positions. When we inspected, four whole time equivalent qualified nurse positions were vacant. The hospital manager had recruited senior nurses to three of the vacant positions with and were due to commence in October 2020.

In addition to qualified nurses, the provider had a planned staffing level of 44 whole time equivalent support worker positions. When we inspected, 10 whole time equivalent support worker positions were vacant. The provider had a steering group to oversee staff recruitment and retention initiatives in the organisation.

The provider had calculated the number and grade of nurses and support workers required. Staff worked two shifts to cover the 24-hour period. Based on an occupancy of 24 patients, the provider deployed two qualified nurses and eight support workers during the day and two qualified nurses and six support workers during the night. The provider ensured there was always at least one qualified nurse at each of the houses.

We reviewed staff rotas between 23 March and 9 August 2020. We saw the provider consistently planned staffing levels to meet or be above the baseline requirements. For example, the number of qualified nurses on both shifts was planned to be three and the number of support workers was planned to be between seven and twelve.

The provider continued to monitor that staff completed the hospital fire register. At our previous inspection we told the provider they should continue to monitor staff compliance to sign the register when they entered and left the building. The provider monitored the fire register to ensure actual

staffing matched that recorded on the rota. We looked at the fire register audit from 13 July to 19 August 2020. The audit recorded the fire register and staff rota had not matched on eight occasions and recorded 25 occasions when staff had not signed out from the fire register at the completion of their shift. We saw the July 2020 staff meeting included a reminder to staff to use the fire register correctly. Staff practice to not complete the fire register did not provide an accurate record of where and when staff were on duty and created risks in an emergency.

Senior leadership staff and members of the multidisciplinary team worked during the day Monday to Friday and were not included in qualified nursing and support worker numbers. This included the hospital manager, clinical manager, and three clinical team leaders. Two therapy co-ordinators worked supernumerary to staffing levels at evenings and weekends.

Between April and July 2020, the local staff sickness rate was 3.7%. This was lower than 11% sickness rate reported at our previous inspection and within the provider's target rate.

The provider used temporary staff to maintain safe staffing levels and cover sickness, absence or vacancies. Between April and July 2020, the provider recorded 41 shifts filled by bank nurses and 395 shifts filled by bank support workers. In the same period, the provider recorded 180 shifts filled by agency nurses and 40 shifts filled by agency support workers. No shifts were left unfilled where these was sickness, absence or vacancies.

The provider required all bank and agency staff to complete a full induction and understood the hospital before starting their shift. The hospital manager reported that two agency staff had fixed term contracts at the hospital. The provider made training, supervision and access to electronic records available to these staff.

Staff reported the hospital was rarely short staffed and where this occurred, it identified sickness notified at short notice as mainly responsible for this. Two of the patients we spoke with believed the hospital needed more staff, particularly to support incidents or offer support when it was needed.

Staffing levels allowed patients to have regular one-to-one time with their named nurse or with a member of the multidisciplinary team. Six of the nine patients we spoke with confirmed this.

The provider had enough staff at the hospital to carry out physical interventions safely. For example, observations and restraint. The provider made observation and engagement and the management of actual or potential aggression training available to staff.

Medical staff

The provider had adequate medical cover day and night at the hospital and a doctor could attend the ward quickly in an emergency. The provider had recently recruited a second consultant psychiatrist to the hospital. Both consultants contributed to an overnight on-call rota cover.

Mandatory training

The provider ensured mandatory training was available to all staff. The provider monitored compliance rates and reported on them as part of governance indicators. The provider set a target of 85% for completion of mandatory training. As of 1 August 2020, all mandatory training courses recorded a compliance rate in excess of 95%. Mandatory courses included responding to emergencies, dealing with concerns at work and personality disorder training.

The provider delivered infection prevention and control training as part of online training. This included a COVID-19 specific module and personal protective equipment training.

The provider had changed the way it delivered staff training during the COVID-19 pandemic. For example, by delivering training through video conferencing technology. The provider had also extended deadlines for staff completion of face to face training updates. This included the management of actual of potential aggression and basic/ intermediate life support.

Assessing and managing risk to patients and staff

Assessment of patient risk

We looked at 10 care and treatment records. Staff did a risk assessment of every patient on admission and updated it regularly, including after an incident.

Staff reviewed and managed patient risk on a daily basis. Staff used a daily risk assessment specific for female patients presenting with a personality disorder. Staff assessed the patient's presentation in the previous 24 hours and applied a red, amber or green risk rating. Incidents were reviewed as part of the daily assessment and to inform each patient's daily risk rating. Staff recorded

daily risk assessments in care and treatment records. This included the risk rating, observation level and staff escort requirements. Staff reviewed and developed risk management plans for identified risks. Risk management plans were detailed and personalised to manage risks.

Staff used a recognised risk assessment tool. In addition to the daily risk assessment, staff completed the Short-Term Risk Assessment and Treatability tool. The multidisciplinary team completed this assessment and updated it every eight weeks. The tool required a comprehensive psychological formulation of each patient's current behaviours and needs. It included plans to assist staff to support the patients effectively.

Management of patient risk

Staff identified and responded to changing risks to, or posed by, patients. Records identified patients risk rating, recent incidents and management plans for risk behaviours. Staff met daily to discuss risk levels and review management plans for individual patients. Nursing and support workers reviewed patient observation levels throughout the day. Nurses could increase observation levels in response to changing risks but required medical review to reduce an observation level.

The provider had retrained staff in updated observation and engagement practices. This included an online training module and a competency check. Records showed staff were allocated specifically to complete patient observations throughout the day.

Staff followed policies and procedures for the observation of patients. Staff met regularly to discuss patients' observation levels at handover meetings and multidisciplinary meetings . During the inspection we reviewed 12 observation and engagement records. Staff completed and recorded observations in line with the provider's policy and procedures. This had improved since our previous inspection. For example, staff completed and recorded observations in line with the prescribed frequency and at irregular intervals. This meant patients who were at risk of self-harm would find it harder to predict when staff were going to check on them. However, we commonly found that 'Nurse In Charge' sign-offs signatures were missing from completed observation records. However, this had no direct impact on patient safety.

The provider used audits to monitor that staff completed and record patient observations. Audits assessed staff competency to undertake observations and checked if times of recoded observations matched closed circuit television recordings. We reviewed five audits completed between April and August 2020. These audits demonstrated staff were competent and completed observations in line with policy.

Staff applied blanket restrictions on patients' freedom only when justified. Blanket restrictions are restrictions on the freedoms of patients receiving mental healthcare that apply to everyone rather than being based on an individual patient's risk assessment. Staff used restrictive practice audit tools to document the impact of blanket restrictions. The manager reported few hospital wide restrictions. An example was access to the lift where staff escort was required for all patients. We saw individual restrictive practice plans in patient records.

In response to ligature incidents and risks in the hospital, nursing staff carried a bag with two types of ligature cutters and a pair of wire cutters. Bags also contained a first aid pack and a portable radio to call for assistance when needed.

Use of restrictive interventions

The provider had a prevention and management of violence and aggression policy in place to guide staff practice. This included guidance on de-escalation techniques.

Between April and July 2020, the provider reported 101 incidents of restraint. Of these restraint incidents, 18 occurred at Lower House and 83 at Upper House. This was comparable to the number reported at the August 2019 inspection.

Between April and July 2020, the provider reported there were no incidents of restraint which resulted in the patient being facedown or administered with rapid tranquilisation.

Staff told us that restraint was rarely used with patients and only used after other interventions had failed. The provider included training in de-escalation and restraint techniques as part of the management of actual or potential aggression training for staff. As at 1st August 2020, the provider reported this training compliance as 100%.

Between April and July 2020, the provider reported no incidents of seclusion or long-term segregation with patients.

Long stay or rehabilitation mental health wards for working age adults

Requires improvement

Safeguarding

The provider made safeguarding training available to staff, this included the safeguarding of adults and children. The provider required all staff to complete safeguarding level two training, registered professionals to complete level three and safeguarding leads to complete level four. As at 1st August 2020, safeguarding training compliance was 94%.

The hospital's social worker was the identified safeguarding lead who escalated concerns, liaised with external agencies, and ensured feedback to the local authority. Staff regularly met with a member of the local authority to discuss any outstanding concerns and share good practice.

In November 2019 the provider completed a safeguarding self-assessment tool for the hospital. The tool reviewed local systems and governance against Derbyshire wide Safeguarding Standards. The provider's local systems and governance met the required standards.

Staff access to essential information

Staff used a combination of paper and electronic patient records. We saw that using a combination of paper and electronic records sometimes caused a difficulty for staff to record or access information. For example, staff did not always record monthly physical health observations or refusals on both the paper and electronic record. This meant it was not always clear from looking at one record if staff had offered or completed the intervention.

Medicines management

Between April 2020 and when we inspected, the provider recorded five medicines incidents at the hospital. Of these, three involved administration. The hospital was investigating one medicines administration error as a serious incident. We saw the hospital managed medicine administration errors appropriately. Staff assessed the patient's physical health , investigated the incident and communicated the incident internally and externally. The pharmacist reported that staff were transparent when things went wrong and sought guidance when investigating and learning from medicines incidents.

During the inspection, we reviewed 11 medicine charts. All were in good order, contained a complete record of medicine administration, and recorded patient allergies or drug sensitivities.

The provider had a four-stage programme of medicine self-administration available to patients. We saw one example of medicine self-administration in the medicine charts reviewed. This showed staff made and kept a complete record of the prompts or checks required for the stage of the self-medication programme the patient was participating in.

Staff reviewed the effects of medication on patients' physical health regularly and in line with National Institute for Health and Care Excellence guidance.

Track record on safety

The hospital did not have a good track record of serious ligature incidents that resulted in severe harm to patients or death. Between April and July 2020, the provider reported one serious incident at the hospital. However, in August 2020 there had been another serious incident that involved a ligature and resulted in a patient death.

Prior to the August 2020 serious ligature incident, there had been serious ligature incidents at the hospital in 2018 and 2019. Two had resulted in patient deaths and another had left a patient with an acquired brain injury.

Reporting incidents and learning from when things go wrong

Staff we spoke with knew what incidents to report and how to report them. In April 2020, the provider introduced and trained staff to use an electronic incident management system. The system was integrated in the patients' electronic record, we saw links to incident forms from the daily risk assessments and clinical entries. The hospital manager explained the system ensured staff completed all parts of incident reporting and investigations. The system also communicated incidents within the organisation and allowed senior staff to review an incident remotely. Since its introduction, the provider was learning lessons about how staff used the system to ensure incidents were recorded with enough detail and scored correctly. The provider was also learning how the system could be improved. For example, a medicines error had indicated the need to review the medicine incidents scoring tool. Records from the June 2020 incident review meeting identified that staffs' use of the incident management system was not consistent. For example, in the way staff rated or described incidents.

Long stay or rehabilitation mental health wards for working age adults

Requires improvement

Between April and July 2020, the provider reported 2838 incidents at the hospital. Of these, 2255 occurred at Upper House and 583 occurred at Lower House. The most frequently occurring incidents were self-harm and ligature incidents. The hospital recorded 1799 self-harm incidents and 900 ligature incidents. Staff identified the number of patients contributing to the type of incident recorded at the hospital. For example, in June 2020 seven patients contributed to 44 recorded ligature incidents. Staff most commonly categorised the severity of incidents at the hospital as minor harm. The total number of incidents recorded at this inspection was greater than the 1512 in the three months prior to CQC inspection in August 2019. However, the patient group had changed since 2019. The hospital had successfully discharged 14 patients and patients at the start of their treatment journey often presented with greater acuity.

Staff analysed incident data monthly. They specifically considered ligatures including the time of day patients tied ligatures, if ligatures were suspended and if so, where patients tied ligatures from. Staff also worked with the Derby and Derbyshire Clinical Commissioning Groups to monitor, review and learn from incidents at the hospital. Following the serious ligature incident in August 2020, the Clinical Commissioning Group commenced additional daily monitoring of ligature incidents at the hospital. The goal being to generate better understanding of why ligature incidents occurred and what contributed to their occurrence.

Senior and multidisciplinary staff met to discuss all newly reported incidents at the daily multidisciplinary team meeting. They also met monthly to identify and discuss themes and trends of self-harm incidents at the hospital. We reviewed four records of incident review meetings from April to July 2020. It was not always clear from staff discussion how they developed and reviewed actions to better manage incidents or reduce the number of incidents at the hospital. While the records described staff discussions, there was not robust identification or monitoring of action points. Staff did not clearly formulate action points with a measurable outcome or to identify who was responsible for completing them and by when. Records did not identify that staff returned and reviewed actions arising from the previous meeting. For example, the June 2020 record identifies a transition group will be formulated, but the action is not allocated to a staff member, no measurable outcome is identified and no completion or review date for the action is set. The July 2020 record does not identify if staff returned to discuss or review progress towards a transition group.

All staff received feedback from incident investigations, both internal and external to the hospital. Staff identified this happened through emails, minutes of the daily multidisciplinary team meeting and a weekly staff bulletin. Staff met to discuss learning from incidents during handovers and supervisory practices.

We saw evidence the provider made changes to the hospital as a result of learning and feedback from the investigation of incidents. Following a serious ligature incident in July 2019, the provider had made environmental and staff changes to support the reduction of incidents and risks at the hospital. However, incidents remained high at the hospital. Following the August 2020 serious ligature incident, staff updated the hospital ligature risk assessment and increased the potential risk rating to Lower House patients spending unsupervised time in their bedroom. The provider had learned that some patients approaching discharge were at increased risk of incidents in bedroom areas, these being areas without staff presence and not covered by closed circuit television. Staff planned to identify any change to risk prior to discharge with individual patients and risk manage it accordingly. The hospital manager provided us with an example of how this had been implemented.

The provider ensured staff were debriefed and received support after a serious incident. Following a serious incident in August 2020, the provider had a manager, trained in trauma risk management, deliver a debrief to staff. Staff described when patients had been offered support and debrief following a serious incident.

Are long stay or rehabilitation mental health wards for working-age adults effective?
(for example, treatment is effective)

Good

Assessment of needs and planning of care

Long stay or rehabilitation mental health wards for working age adults

Requires improvement

We looked at 10 care and treatment records. All showed that staff completed a comprehensive mental health assessment of each patient either on admission or soon after.

All 10 care and treatment records showed that staff assessed patients' physical health soon after admission and provided ongoing monitoring of physical health needs.

We found care plans present in all the records we viewed. Staff developed care plans that met patients' needs identified during assessment, including needs arising from risk assessments. We found care plans were personalised, had some recovery focus and considered opportunities for discharge.

Records showed staff reviewed and updated care plans with patients.

Best practice in treatment and care

Staff provided a range of care and treatment interventions suitable for the patient group. These included medication, psychological therapies, activities, training and work opportunities intended to help patients acquire living skills. The occupational therapy staff and activity coordinators delivered a timetable of activities. Psychology staff offered a range of interventions appropriate to patients with personality disorders. This included Dialectical Behaviour Therapy, Compassion Focused Therapy, emotional regulation and distress tolerance. Patients spoke positively about one to one sessions with occupational therapy and psychology staff.

Staff ensured that patients had good access to physical healthcare, including access to specialists when needed.

Staff supported patients to live healthier lives. This included stop smoking interventions, a daily walking group and GP, gym referrals. The hospital menu included healthier options and the provider made fresh fruit available for patient snacks.

In response to the COVID-19 pandemic the provider introduced daily temperature checks for patients. We saw these recorded in clinical records and morning multidisciplinary team meeting records.

Staff used a recognised rating scales with patients to assess and record severity and outcomes. For example, the Global Assessment of Progress. Multidisciplinary staff used assessment and outcome tools specific to their professional discipline with patients.

Staff participated in clinical audit and benchmarking initiatives. In addition to the provider's annual clinical audit programme, we found audits present to monitor practice and improvement in the hospital. These included audits of patient observations and the safe management of medicine self-administration practices. Staff reported changes as a result of audit activities. The provider benchmarked their performance against similar hospitals within the region.

Skilled staff to deliver care

In addition to qualified nurses and support workers, the hospital had a multidisciplinary team to meet the needs of patients. This included two consultant psychiatrists, an occupational therapist, an occupational therapy assistant, a social worker, a psychologist, an assistant psychologist, and two therapy coordinators.

The provider had made recruitment changes intended to help ensure staff were experienced and qualified and had the right skills and knowledge to meet the needs of the patient group. This included increased rates of pay and additions to the leadership team. During the inspection we reviewed seven staff records. The provider completed necessary employment checks of staff.

Managers ensured that staff had access to regular team meetings. However, records of meetings showed staff did not follow a set agenda and there was no evidence staff routinely discussed lessons learned during meetings. Staff attendance at team meetings continued to be low. For example, the August 2020 meeting recorded four attendees.

The provider made annual appraisals available to staff. When we inspected, 66% of eligible staff had been appraised. This was lower than the appraisal rate reported at the October 2019 inspection and below the provider's 90% target rate. However, the low appraisal was in part due to the number of new staff working at the hospital. The manager had a plan in place to complete outstanding appraisals by October 2020.

The provider made supervision available to staff. Supervision is a meeting to discuss case management, to reflect and learn from practice and to be offered personal support and professional development. When we inspected, the provider reported a supervision rate of 99%. This was comparable to the rate reported at the October 2019 inspection.

Multidisciplinary staff facilitated fortnightly reflective practice sessions at the hospital. Staff used a recognised model of reflection which encouraged reflection on wellbeing, development, work and practice with patients.

The provider ensured staff received specialist training necessary for their roles. In addition to mandatory training, the provider offered staff training in suicide and risk, observation and engagement and supporting people with autism. Of these, only suicide and risk training 76% completion fell below the provider's target completion rate. However, staff completed other training that included risk management. For example, daily risk assessment training and personality disorder awareness training. Staff we spoke with were satisfied with the quantity and quality of training available to them.

Managers dealt with poor staff performance. For example, the provider required staff involved in medicines errors to have additional supervision and complete a new medicines competency assessment.

Multi-disciplinary and inter-agency team work

Staff held regular multidisciplinary meetings. Senior staff, multidisciplinary team staff and ward nursing staff attended daily meetings to discuss all patients admitted to the hospital. Meetings had a fixed agenda to include incidents, complaints and learning. We observed one morning meeting and saw staff discussed patient risk, observational levels, individual risk management plans, patients' coping strategies and physical health.

Staff met with individual patients every four weeks for a multidisciplinary review meeting. With patients' permission, we observed two multidisciplinary reviews. We saw all staff present contributed to discussion, worked together well and provided useful challenge to colleagues. The hospital allocated patients to a multidisciplinary team that worked with them for the duration of their admission. Patients also met with individual members of their multidisciplinary team outside of review meetings.

Staff shared information about patients at handover meetings within the team. House staff held handover meetings when shifts changed. Staff told us handovers followed a template document. This document included and summarised risk, observation level, incidents, mood and engagement. Staff shared completed handover templates by email and on the hospital's shared computer drive.

Staff had effective working relationships with teams outside the organisation. We observed senior staffs' positive participation in an assurance meeting held after the August 2020 serious ligature incident. This included a number of Clinical Commissioning Groups and Case Managers.

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

The provider made Mental Health Act and Code of Practice training available to staff as part of mandatory training requirements. At the time of our inspection the provider reported that 96% of eligible staff had completed training.

The hospital had a dedicated member of staff to provide administrative support for the implementation of the Mental Health Act and its Code of Practice at the hospital. Staff knew who their Mental Health Act administrator was.

In response to the COVID-19 pandemic, the provider used information technology to assist the application of the Mental Health Act 1983 appeals process. This included facilitating patients' access to video conferencing for legal advice and for participating in tribunal reviews.

The provider had clear, accessible, relevant and up-to-date policies and procedures that reflected all relevant legislation and the Mental Health Act Code of Practice.

Patients had access to information about independent mental health advocacy. We saw evidence patients met with independent mental health advocacy recorded in care and treatment records.

Staff explained to patients their rights under the Mental Health Act in a way that they could understand, staff repeated this as required and recorded that they had done it. Care records and our conversations with patients confirmed this.

Staff adhered to consent to treatment and capacity requirements. We reviewed 11 medicine charts and those

needing legal authorisation had correctly completed forms attached. This meant that nurses administered medicines to patients under the right legal requirements. Staff requested a second opinion appointed doctor in a timely way in accordance with the Mental Health Act Code of Practice.

The provider displayed a notice to tell informal patients they could leave the ward freely. We spoke with an informal patient who told us they had no restrictions to leaving the hospital.

Care plans included information about after-care hospitals available for those patients who qualified for it under Section 117 of the Mental Health Act.

Staff did regular audits to ensure that the Mental Health Act was being applied correctly and there was evidence of improvement from those audits.

Good practice in applying the Mental Capacity Act

The provider made Mental Capacity Act training available to staff as part of mandatory training requirements. At the time of our inspection the provider reported that 96% of eligible staff had completed training.

The provider identified that patients referred to the hospital needed to have capacity to engage with care and treatment. Staff regularly assessed a patient's capacity to consent to treatment.

The provider had a policy on the Mental Capacity Act, including Deprivation of Liberty Safeguards.

The provider had arrangements in place to monitor and audit adherence to the Mental Capacity Act. For example, six monthly audits of capacity to consent to treatment assessments.

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

Good

Kindness, privacy, dignity, respect, compassion and support

Staff took an individualised approach to understand challenging behaviour and support distressed patients.

The multidisciplinary team developed interventions informed by patients and best practice guidance. Senior staff maintained oversight of the approaches staff used and did not support routine use of restrictive practices or disengagement from patients. Staff told us that when a patient raised concerns about staff conduct or behaviour, they acknowledged the concern and worked with the patient to understand and resolve the concern. However, only four gave positive reports about the way staff treated and behaved towards them. Of particular concern, six of the nine patient interviews identified concerns about how staff supported them when distressed or when or after an incident took place.

Four patients reported that staff tended to congregate in office areas. We saw the records of the July 2020 staff meeting reminded staff not to do this, especially at night. The manager made out-of-hours checks to the hospital. They reported six checks had been completed to date in 2020 and no concerns had been identified.

Staff supported patients to understand and manage their care, treatment or condition. Staff spoke about how they worked with patients over time to better understand their perceptions of safety, relationships and emotions. Patients told us staff provided information on medicines and legal status. Patients also talked about one to one sessions with nursing and multidisciplinary staff.

Staff understood the individual needs of patients. Senior staff introduced staff training and sensory strategies to meet the needs of an increased number of patients referred with autism spectrum disorders. Staff met to discuss and understand patients' individual needs. This included at multidisciplinary meetings and reviews, reflective practice sessions and de-briefs. Multidisciplinary staff worked with nurses and support workers to support the delivery of therapeutic interventions.

Involvement in care

Involvement of patients

Staff involved patients in care planning and risk assessments. The records we reviewed, and our observation of the multidisciplinary team review supported this judgement. Six of the nine patients we spoke with reported staff involved them in developing care plans or offered them a copy of their plan.

Long stay or rehabilitation mental health wards for working age adults

Requires improvement

When appropriate, staff involved patients in decisions about the hospital. The provider highlighted an example of an organisational change that occurred as a result of patient involvement from Acer Clinic. We also saw staff involved patients to develop and deliver training packages.

Staff enabled patients to give feedback on the care and treatment they received.

Staff encouraged and supported patients to make advance statements. An advance statement is written preferences, beliefs and wishes about your future care. Staff documented when patients were offered and declined an advance statement. We saw daily risk management records and positive behavioural support plans documented patients' preferences and strategies for managing risk behaviours.

Staff ensured that patients could access advocacy. Patients we spoke with confirmed they had access to advocacy.

Involvement of families and carers

Staff provide examples of how they informed and involved families and carers. For example, with the permission of the patients, staff involved families and carers in risk and clinical reviews. Our conversations with patients confirmed staff involved family and carers. Two of the three carers we spoke with were positive about how staff informed and involved them. This had improved from our previous inspection.

The provider enabled families and carers to give feedback on the treatment they received. However, no families and carers had participated in Cygnet Acer's most recent family/ carer survey. Staff had plans they hoped would improve engagement and feedback.

Are long stay or rehabilitation mental health wards for working-age adults responsive to people's needs?

(for example, to feedback?)

Good

Access and discharge

Cygnet Acer Clinic offered a national hospital, patients were admitted from across England and Wales. The provider's website had clear information on bed availability and how to make a referral. The provider had a central online referral team who processed referrals.The provider had an operational framework and clinical model that documented criteria of which patients would be offered a hospital admission and those that would not. Although staff assessed each referral on an individual case-by-case basis, staff used inclusion and exclusion criteria to inform decisions.

In the 12 months prior to inspection, the hospital received 74 referrals and had accepted 39 of those. Referrals came from community hospitals, acute admission wards and psychiatric intensive care wards. Depending on patients' assessed needs, the hospital admitted patients to Upper House or Lower House. The hospital had an average occupancy of 86%. The provider reported the average length of stay was between 12-18 months. Although sometimes patient admissions exceeded this.

Patients could transfer from Upper to Lower House as part of their care pathway. Upper House was primarily a facility for newly admitted patients who presented with higher risk and staff cared for them with greater restrictions. Patients progressing to Lower House showed greater ability to cope with personal and environmental risks.

The provider had a process to access a psychiatric intensive care unit if a patient required more intensive care.

Discharge and transfers of care

Staff planned for patients' discharge. We saw evidence of discharge planning and liaison in the records we reviewed. Four patients we spoke with identified they had a discharge plan or had been involved in discussions about their discharge.

Since April 2020 the hospital had discharged three patients home or to supported living accommodation. Two further discharges were planned for September 2020, when we inspected these patients were on leave to where they were due to be discharged to. Records demonstrated staff maintained contact with patients during periods of leave.

The facilities promote recovery, comfort, dignity and confidentiality

Patients had their own bedrooms. Bedrooms had a kitchenette area and en suite shower and toilet facilities. Where patients had been individually risk assessed as

suitable they could have their own kettles, toasters and microwaves. Staff could monitor power usage to each room and provide cost of use feedback to patients to assist independent living skills.

Patients had access to their bedrooms during the day. Bedroom doors had viewing panels which opened and closed. This meant staff could observe patients in their bedrooms while also allowing patients' privacy. Staff considered the potential impact to patients dignity when considering strategies to manage risk behaviours.

Patients had somewhere secure to store their possessions.

Staff and patients had access to the full range of rooms and equipment to support care and treatment. Both houses had clinic areas, therapy rooms and activities of daily living kitchens. Where patients had been individually risk assessed as suitable they could access some areas without staff supervision, including the laundry and activities of daily living kitchens.

Both houses had quiet areas and areas designated for visiting. During the COVID-19 pandemic lockdown period the provider stopped visitors to the hospital. At the time of our inspection visiting had recommenced. Staff told us visiting was limited to a maximum of two people and staff cleaned visiting areas before and after visits.

Patients without access to a mobile phone could make calls in private using the hospital's phones.

Both houses had access to secure garden areas. We saw staff allocated to garden observations to supervise patients' access and provide them with therapeutic support. Following a serious incident in July 2020 the provider reviewed climbing risks in garden areas and made changes to reduce risks associated to climbing.

Patients we spoke with provided positive feedback about the choice and quality of the food at the hospital. This included meeting the needs of patients with allergies or special diets.

Patients' engagement with the wider community

Staff ensured that patients had access to education and work opportunities. Some patients participated in volunteering roles locally. The provider offered a therapeutic earnings scheme for patients at the hospital. The provider had also arranged for a tutor to attend for maths, literacy and information technology sessions with patients.

Staff supported patients to maintain contact with their families and carers. Staff regularly checked and updated communication agreements with patients. These identified who information could be shared with and also what information could be shared. During the COVID-19 pandemic, staff supported patients access to information technology for maintaining contact with their families and carers.

Staff encouraged patients to develop and maintain relationships with people that mattered to them, both within the hospitals and the wider community. However, staff identified that relationships between patients were not always helpful and sometimes contributed to increased risks and incidents. For example, borrowing or lending of items between patients. When this occurred, staff worked with patients to better manage associated risks.

Staff promoted understanding of mental health and personality disorders in stakeholder organisations.

Meeting the needs of all people who use the hospital

The hospital was accessible to all who needed it and took account of patients' individual needs. Staff supported patients with restricted mobility. Each house had two bedrooms located on the ground floor adapted with wet rooms and wider door frames to support wheelchair users.

Staff ensured that patients could obtain a range of information, including on treatments, local hospitals, patients' rights and how to complain.

Staff made information available in accessible formats to meet the communication preferences of patients. For example, easy-read formats or information in languages other than English. The provider ensured staff and patients had easy access to interpreters and/or signers.

The provider ensured patients had a choice of food to meet the dietary requirements of religious and ethnic groups.

Staff supported patients to access appropriate spiritual support. The hospital had dedicated multi-faith resources.

Listening to and learning from concerns and complaints

Long stay or rehabilitation mental health wards for working age adults

Requires improvement

Between October 2019 and 24th August 2020, the provider received 27 complaints. This was greater than the number reported during inspection in October 2019. The provider upheld eight complaints and no complaints were referred to the Ombudsman. Senior staff investigated complaints and identified themes. The most commonly categorised complaints involved the quality of care and members of nursing staff.

Patients we spoke with confirmed they knew how to complain or raise a concern. Those who had complained or raised a concern reported the provider had given them feedback. The hospital's compliant log recorded how staff provided feedback to patients.

Staff knew how to handle complaints appropriately. The provider had a policy and procedure in place to guide staff practice.

Staff reported managers provided feedback on outcomes from investigations about complaints. Staff shared this in bulletins, handovers and governance meetings.

Between April 2020 and when we inspected the provider recorded 11 compliments about staff at the hospital.

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

Requires improvement

Leadership

Since our previous inspection, the provider had implemented changes to the leadership structure at the Acer Clinic. Additions included the introduction of a Clinical Manager and three Clinical Team Leaders. The provider expected these roles to provide supervision, guidance and role-modelling to nursing and support staff involved in direct patient care. Staff spoke positively about the introduction and impact of the additional leadership roles.

The provider had changed the leadership structure in an effort to recruit more experienced staff to the hospital. When we inspected the additional roles in the leadership structure had been recruited to.

We spoke with the hospital manager and regional operations director. Both displayed a good understanding of the hospital and could explain how their team worked to provide quality care.

During the inspection, we saw the hospital manager and leadership staff were visible in the hospital. Staff we spoke with confirmed leadership was visible and supportive at the hospital. However, in the providers 2020 staff survey of the Acer Clinic, staff did not always respond positively to questions about being supported, motivated or valued by their manager.

Vision and strategy

Staff were aware of the provider's vision and values and how they were applied in the work of their team. In the providers 2020 staff survey of the Acer Clinic, 82% of the 23 respondents reported they understood the provider's values.

The provider communicated its vision and values to the frontline staff. These were accessible to staff on the provider's intranet and internet. The provider used their vision and values to guide recruitment and supervisory practices.

Staff had the opportunity to contribute to discussions about the strategy for their hospital, especially where the hospital was changing. For example, staff from the Acer Clinic contributed to the provider's Personality Disorder Steering Group and review of the clinical hospital.

Senior staff could explain how they were working to deliver high quality care within the budgets available. We saw the provider was investing in staffing recruitment and environmental changes at the Acer Clinic. The provider did not expect the hospital to have high patient occupancy rates, this gave staff the opportunity to implement change and improvement.

Culture

Staff spoke positively about support and team work in the hospital. In the providers 2020 staff survey of the Acer Clinic, staff responded positively about team spirit, support from colleagues and respect for each other in the workplace.

The provider had a whistleblowing process in place. Staff we spoke with felt able to raise concerns without fear of retribution. In the providers 2020 staff survey of the Acer

Clinic, 83% of the 23 respondents reported they knew how to report a concern. The provider had a Freedom to Speak Up Guardian for the organisation, however staff we spoke did not know who this was. Between April and August 2020, CQC had received no whistleblowing concerns about Cygnet Acer Clinic.

Managers dealt with poor staff performance when needed. The provider had a clear process of escalation. Records showed managers raised performance concerns with staff directly.

The provider promoted equality and diversity in its day to day work. Staff completed equality and diversity training as part of mandatory training requirements. The provider carried out an equality and diversity assessment of all policies and procedures.

Staff had access to support for their own physical and emotional health needs through an occupational health hospital.

The provider had an awards programme that recognised the success of teams and individual staff members. Staff shared and recorded compliments about support or good practice from their colleagues.

Governance

The provider had established governance processes. Staff met locally each month to discuss and review clinical governance at the hospital. This included to review outcomes of the incident review meeting. Senior staff met monthly to discuss operational governance at a regional level. This included staffing, recruitment and audit outcomes. However, it was not always clear governance process maintained oversight of actions to ensure they improved quality and safety at the hospital.

Not all the actions the provider had taken to improve quality and safety had demonstrated positive outcomes. For example, the number of ligature and self-harm incidents had not reduced following our 2019 inspection. It wasn't always clear how staff developed and monitored action points. Records did not demonstrate how staff used their discussions to make improvements and prevent further reoccurrence of incidents at the hospital. We also saw the provider was still learning about and changing its incident management system to ensure incidents were recorded, analysed and managed robustly.

Staff shared essential information in a number of ways. However, we did not always see a clear framework of what must be discussed at team meetings. Other meetings where staff also met did have a clear framework of what must be discussed, and staff we spoke with knew about lessons learned from recent incidents.

Staff undertook or participated in local clinical audits. Senior staff met regularly to discuss the outcomes of audits and identify any actions needed to drive improvements. The providers local quality assurance manager had oversight of audits at the hospital. Audits continued to support improvement at the hospital and, where needed, staff developed actions to improve performance. However, we did see examples where staff's practice to complete documentation remained a concern to safety at the hospital.

We saw the provider continued to implement recommendations from reviews of deaths and incidents at the hospital. This was consistent with our findings from the previous inspection.

Management of risk, issues and performance

The provider had a local risk register in place. We saw it included risks related to recent incidents at the hospital, the COVID-19 pandemic and ongoing action plans for concerns raised by CQC inspections and quality reviews. The risk register included actions for reducing the risk and detailed progress towards the completion of action points.

In response to the COVID-19 pandemic, the provider completed individual risk assessments with staff. This included assessments for staff groups identified as high risk of COVID-19 infection. For example, staff from Black, Asian and minority ethnic groups.

Information management

The hospital used systems to collect data from wards and directorates that were not over-burdensome for frontline staff. However, not all staff completed the hospital fire risk register when signing out of the hospital. Staff identified the electronic incident management tool as helpful to report and track incidents. The tool assisted managers to generate reports for governance processes.

Staff had access to the equipment and information technology needed to do their work. The information technology infrastructure, including the telephone system, worked well and helped to improve the quality of care.

Long stay or rehabilitation mental health wards for working age adults

Requires improvement

Information governance systems included confidentiality of patient records. Staff completed information governance training as part of mandatory training requirements. When we inspected, 98% of staff had completed this training. Staff accessed electronic care records with the use of individual logon identifications and passwords.

The hospital manager had access to information to support them with their management role. This included information on the performance of the hospital, staffing and patient care.

Staff made notifications to external bodies as needed. This included to the local authority Clinical Commissioning groups and CQC. Following a recent assurance meeting with external stakeholders, hospital staff were to review their contact list to ensure they had the right contact details of placing Clinical Commissioning Groups.

Engagement

Staff, patients and carers had access to up-to-date information about the work of the provider and the hospital. This included intranet access for staff and the provider's website.

Patients and carers had opportunities to give feedback on the hospital they received in a manner that reflected their individual needs. For example, through an annual survey.

Managers and staff had access to the feedback from patients, carers and staff and used it to make improvements.

Patients and carers could be involved in decision-making about changes to the hospital. This included through the Peoples Council, advocacy hospitals and complaint processes.

Senior staff engaged with external stakeholders, including commissioners and the local authority. Commissioners completed regular quality visits and safe and well checks. We received feedback from two commissioning leads. One provided positive feedback in relation to staffing, responding to risk and providing patient's an opportunity to give feedback. They believed staff communicated openly about incidents and could demonstrate how they implemented change and learning from incidents. However, they had raised a concern with the provider about their patient's involvement in coproducing care. The other spoke positively about the local leadership team and the success of discharge preparation and packages for patients. We saw another Clinical Commissioning Group's quality visit feedback acknowledged a positive and open approach from the provider.

Learning, continuous improvement and innovation

The provider had removed budget and occupancy expectations in order to allow staff at the hospital to focus on improvements and safety at the hospital.

Improvements were taking place in the hospital. Staff from the hospital were involved in the provider's Personality Disorder Steering Group. The Steering Group had produced a revised clinical model for personality disorder hospitals across the organisation. The model recognised best practice guidance on personality disorder hospitals from a number of organisations including The Royal College of Psychiatry and National Institute for Clinical Excellence. However, the provider had not yet implemented this revised clinical model.

Staff used quality improvement methods. For example, staff had trialled different times for reflective practice sessions to promote and improve attendance.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

The provider must ensure staff develop and review actions to prevent the reoccurrence of incidents and improve the management of incidents at the hospital. Regulation 12 (2) (b) HSCA (RA) Regulations 2014 Safe care and treatment.

The provider must ensure staff comply with requirements to complete the hospital's fire register. Regulation 12 (2) (b) HSCA (RA) Regulations 2014 Safe care and treatment.

The provider must ensure staff monitor progress against plans to improve the quality and safety of the hospital and take appropriate action without delay where progress in not achieved as expected. Regulation 17 (2) (a) HSCA (RA) Regulations 2014 Good Governance

Action the provider SHOULD take to improve

The provider should ensure all staff record information in clinical records correctly and completely.

The provider should continue to monitor and improve the electronic incident management system.

The provider should ensure all meetings follow a clear framework to ensure staff share and discuss essential information.

The provider should ensure the hospital manager completes plans to ensure staff appraisals are completed.

The provider should ensure all staff complete suicide and risk training.

The provider should ensure staff work with patients to better understand how and why their care and treatment plans will be delivered, particularly during times of incidents or distress.

The provider should continue to monitor how nursing and support staff engage with patients, particularly out of hours.

The provider should ensure staff know who their Freedom to Speak Up Guardian is.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance

This section is primarily information for the provider

Enforcement actions

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.