Cygnet Health Care Limited

Cygnet Hospital Wyke

Inspection report

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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?	Inadequate
Are services effective?	Requires Improvement
Are services caring?	Requires Improvement
Are services responsive to people's needs?	Requires Improvement
Are services well-led?	Requires Improvement

Summary of findings

Overall summary

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

- The service did not always provide safe care. The ward environments were not always safe, clean or well-maintained. Medicines were not always managed safely. Emergency equipment was not always accessible.
- A high proportion of patients on all three wards had experienced violence or aggression from a peer and the provider was not taking sufficient action to work towards reducing this.
- Ward teams did not always have access to the full range of specialists required to meet the needs of patients on the wards. Staff were not always receiving regular training updates or appraisals.
- Staff on the specialist rehabilitation ward had not always had training to support them in meeting the specific needs of the patient group on this ward and as a result were not always able to meet patients' needs.
- Staff did not always actively involve patients and their families and carers in care decisions.
- Patients were not always well supported in relation to their cultural and spiritual needs.
- We identified blanket restrictions which were not justified on the basis of risk and these had not always been recognised by the provider.
- Governance processes were in place but these did not always ensure that wards ran smoothly.

However:

- The wards had enough nurses, doctors and support staff. Staff assessed and mostly managed clinical risks well. They minimised the use of restraint and seclusion and followed good practice with respect to safeguarding.
- Ward staff worked well together as a multidisciplinary team and with those outside the ward who would have a role in providing aftercare.
- Staff understood and discharged their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005.
- Staff usually treated patients with compassion and kindness, and respected their privacy and dignity.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Long stay or rehabilitation mental health wards for working age adults	Requires Improvement 	Although this ward falls within the long stay/ rehabilitation core service for CQC inspection purposes we also used our guidance on inspecting services for people with a learning disability and/or autism to inform the inspection because the ward provides specialist rehabilitation services for autistic people including input from a consultant psychiatrist with a special interest in neurodevelopment. We expect health and social care providers to guarantee people with a learning disability and autistic people respect, equality, dignity, choices and independence and good access to local communities that most people take for granted. 'Right support, right care, right culture' is the guidance CQC follows to make assessments and judgements about services supporting people with a learning disability and autistic people and providers must have regard to it. Our rating of this location stayed the same. We rated it as requires improvement because: **Right Support: Model of Care and setting that maximises people's choice, control and independence** • The service did not give people care and support in a safe, clean, well equipped, well-furnished and well-maintained environment that met their sensory and physical needs • All patients were out of area which affected their ability to engage in activities, especially relating to education or employment as there would be difficulty in ensuring this could continue following their discharge. • The discharge plans did not outline progress against an action plan. They did not set out a clear pathway towards discharge and people's families were not involved in discharge planning.

Summary of findings

- The ward had a high use of agency staff and there was a high turnover of staff, particularly healthcare support workers. Some staff had not received training on autism prior to starting work on the ward.
- Staff did not effectively support people to play an active role in maintaining their own health and wellbeing.

However:

- The service supported people to have the maximum possible choice, control and independence and they had control over their own lives.
- The service worked with people to plan for when they experienced periods of distress so that their freedoms were restricted only if there was no alternative.
- Staff did everything they could to avoid restraining people. The service recorded when staff restrained people, and staff learned from those incidents and how they might be avoided or reduced.
- People had a choice about their living environment and were able to personalise their rooms.

Right Care: Care is person-centred and promotes people's dignity, privacy and human rights

- People's care, treatment and support plans did not always fully reflect their range of needs in order to promote their wellbeing and enjoyment of life.
- People could not consistently take part in activities and pursue interests that were tailored to them.
- There had been an ongoing concern over noise levels on the ward that had still not been addressed adequately.
- Although the food menu showed a variety of options for vegetarian and vegan meals, these were not always available. As a result, some people told us they had limited options for their dietary needs.

However:

Summary of findings

- Staff promoted equality and diversity in their support for people. They understood people's cultural needs and provided culturally appropriate care
- Staff understood how to protect people from poor care and abuse. 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 and people cooperated to assess risks people might face. Where appropriate, staff encouraged and enabled people to take positive risks.
- People could communicate with staff and understand information given to them because staff supported them consistently and understood their individual communication needs.

Right Culture: The ethos, values, attitudes and behaviours of leaders and care staff ensure people using services lead confident, inclusive and empowered lives.

- People did not always receive good quality care, support and treatment because trained staff and specialists could not always meet their needs and wishes.
- There was a consistent theme of people not feeling safe and there were a high number of incidents of violence and aggression on the ward.
- The ward had used bedroom seclusion without an environmental audit or checklist to ensure the person was safe in their room.
- Although audit systems were in place, they were not always effective in reducing risk or improving the quality of care.
- The service had not reported all notifiable incidents to the Care Quality Commission.

However:

- Most staff knew and understood people well and were responsive, supporting their aspirations to live a quality life of their choosing.

Summary of findings

- Staff ensured risks of a closed culture were minimised so that people received support based on transparency, respect and inclusivity.
- People and those important to them, including advocates, were involved in planning their care.

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

Requires Improvement

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

- The service did not always provide safe care. The ward environments were not always safe, clean or well-maintained. Medicines were not always managed safely. Emergency equipment was not always accessible.
- A high proportion of patients had experienced violence or aggression from a peer on the ward and the provider was not taking sufficient action to work towards reducing this.
- Ward teams did not always have access to the full range of specialists required to meet the needs of patients on the wards. Staff were not always receiving regular training updates or appraisals.
- Staff did not always actively involve patients and families and carers in care decisions.
- Patients were not always well supported in relation to their cultural and spiritual needs.
- We identified blanket restrictions which were not justified on the basis of risk and these had not always been recognised by the provider.
- Governance processes were in place but these did not always ensure that wards ran smoothly.

However:

- The wards had enough nurses, doctors and support staff. Staff assessed and mostly managed clinical risks well. They minimised the use of restraint and seclusion and followed good practice with respect to safeguarding.
- The ward staff worked well together as a multidisciplinary team and with those outside the ward who would have a role in providing aftercare.

Summary of findings

- Staff understood and discharged their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005.
- Staff usually treated patients with compassion and kindness and respected their privacy and dignity.

Summary of findings

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Background to Cygnet Hospital Wyke

Cygnet Hospital Wyke is an independent mental health hospital provided by Cygnet Health Care Limited, 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 46 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.

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 a learning disability.

The hospital had a registered manager and an accountable controlled drugs officer. At the time of our inspection the registered manager was on long term leave and there was an interim manager in post. The provider had followed the correct procedure to notify us of this.

We have inspected this location 12 times previously. We last carried out a comprehensive inspection of the hospital in February 2021. We rated the hospital as requires improvement overall with requires improvement ratings for all key questions except caring, which was rated good. Following that inspection, we issued requirement notices to the provider in relation to the following breaches:

Regulation 9 (Person-centred care)

Regulation 12 (Safe care and treatment)

Regulation 13 (Safeguarding service users from abuse and improper treatment)

Regulation 17 (Good governance) and

Regulation 18 (Staffing)

Following the inspection, the provider sent us updated action plans setting out how all the concerns leading to these breaches had been addressed.

At this inspection, we inspected all five key questions across all three wards.

What people who use the service say

People on the acute and psychiatric intensive care wards told us that they did not always feel safe at the hospital. Several of the people we spoke with told us that they had been injured in an assault by another patient. People on the

Summary of this inspection

psychiatric intensive care unit told us that they did not have much to do on the ward, staff were not always available and they were bored due to a lack of activities. People who had been granted leave from the hospital told us they were getting this leave and they were able to do the things they wanted to outside the hospital. People mostly said the food was good and they had choices, but some people complained that their specific dietary needs were not met.

Relatives and carers told us that they had not seen the wards where their relation was cared for but the parts of the hospital they had seen were clean and well maintained. Some relatives told us that they did not feel sufficiently informed in relation to their relative's care and most of the relatives we spoke with said they had not had an opportunity to be involved in their relative's care planning.

People on the specialist rehabilitation ward also reported not feeling safe. They complained of the ward being noisy which many of them found particularly distressing due to their sensory needs as autistic people. The patients were not happy with the high use of agency staff and some said the staff did not understand their needs, although some also commented that staff were professional.

The family members we spoke with in relation to the rehabilitation ward were satisfied with the care that was being delivered to their relative and said they found the staff approachable.

How we carried out this inspection

The team that inspected the service included two CQC inspectors, a mental health nurse specialist advisor, a consultant psychiatrist specialist advisor and an expert by experience.

During the inspection, the inspection team:

- visited all three wards
- spoke with 12 patients who were using the service
- spoke with 6 carers/relatives
- spoke with the interim registered manager and the interim clinical manager
- spoke with 2 acting ward managers and 1 permanent ward manager
- spoke with 15 staff members of staff including nurses, doctors, allied health professionals, support workers, housekeepers and administrative staff
- spoke with an independent advocate
- received feedback from 4 external agencies
- looked at 36 care and treatment records for patients
- attended meetings relating to patient care and the running of the service
- spent time on the wards observing care, including carrying out a Short Observational Framework for Inspection (SOFI)
- looked at a range of policies, procedures, and other documents relating to the running of the service.

Visits were unannounced and took place during the day on 6, 7 and 8 September 2022 and in the evening on 6 September 2022.

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.

Summary of this inspection

Areas for improvement

Action the service MUST take is necessary to comply with its legal obligations. Action a provider 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:

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

- The service must ensure that patients have access to the full range of specialists to meet their needs in accordance with the model of care for the service they are receiving. (Regulation 9(3)(b))
- The service must ensure that patients are regularly and consistently supported to undertake regular meaningful activities. (Regulation 9(3)(b))
- The service must ensure that patients receive advice and support in relation to leading a healthy lifestyle. (Regulation 9(3)(b))
- The service must ensure that blanket restrictions are only imposed on the wards where these are justified on the basis of risk, are kept under regular review and are removed as soon as possible. (Regulation 10(2)(b)
- The service must ensure that people have their spiritual and cultural needs assessed on admission, kept under regular review and receive support to ensure these needs are met during their admission as far as possible. (Regulation 10(2)(c))
- The service must ensure that patients who pose a risk to others are supported so that other patients on the ward and staff are protected from physical assault as far as possible. (Regulation 12(2)(b))
- The service must ensure that the care environment is free from avoidable hazards including ligature and infection prevention and control risks. (Regulation 12(2)(d))
- The service must ensure that environmental risk assessments are carried out prior to seclusion including seclusion in bedrooms if required in an emergency situation. (Regulation 12(2)(d))
- The service must ensure that staff can access emergency equipment promptly. (Regulation 12(2)(d))
- The service must ensure that medicines are stored safely. (Regulation 12(2)(g))
- The service must ensure that medicines required on a once only basis are lawfully prescribed prior to administration. (Regulation 12(2)(g))
- The service must ensure that monitoring systems relating to activities taking place on the wards, the management of medicines including consent to treatment, the care environment and the ward based support available to patients are improved to ensure that issues are identified and addressed in a timely manner. (Regulation 17(1))
- The service must ensure that all staff receive regular clinical and managerial supervision and appraisals. (Regulation 18(1))
- The service must ensure that all staff receive regularly updated training to fully support them in their roles. (Regulation 18(1))
- The service must ensure that incidents are reported to CQC in a timely manner in accordance with the requirements of the Care Quality Commission (Registration) Regulations 2009. (Regulation 18 Notification of other incidents)

Long stay or rehabilitation mental health wards for working age adults

- The service must ensure that discharge plans have meaningful action plans and that any lack of progress is evaluated and action is taken to address this. (Regulation 9(3)(b))
- The service must ensure that patients who pose a risk to others are supported so that other patients on the ward and staff are protected from physical assault as far as possible. (Regulation 12(2)(b))

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- The service must ensure that environmental risk assessments are carried out prior to seclusion including seclusion in bedrooms if required in an emergency situation. (Regulation 12(2)(d))
- The service must ensure medicines required on a once only basis are lawfully prescribed prior to administration. (Regulation 12(2)(g))
- The service must ensure that medical checks are carried out in accordance with national guidance when patients receive medication for rapid tranquillisation. (Regulation 12(2)(g))
- The service must ensure that trend analysis is included in its governance systems to ensure incidents are monitored more closely and any underlying themes are highlighted and addressed. (Regulation 17(1))
- The service must ensure that all staff receive regularly updated training to fully support them in their roles, including training in autism in accordance with nationally recognised best practice, prior to working on the ward. (Regulation 18(1))
- The service must ensure that incidents are reported to CQC in a timely manner in accordance with the requirements of the Care Quality Commission (Registration) Regulations 2009. (Regulation 18 Notification of other incidents)

Action the service SHOULD take to improve:

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

- The service should ensure that action is taken to improve staff retention and to continue to explore the reasons for staff leaving their posts so that any trends of concern can be identified.
- The service should ensure that they continue to improve security measures to reduce incidents of illicit substances and other banned items being introduced to the wards.
- The service should ensure that they review the processes for monitoring delayed discharges to ensure that all possible action is being taken to support people to move on to a more suitable alternative placement where their needs can no longer be met at the hospital.
- The service should ensure that systems for monitoring compliance with the Mental Health Act ensure that people only receive medicines which they have consented to, or which have been correctly authorised by a Second Opinion Appointed Doctor.
- The service should ensure that patients who experience verbal abuse from peers on the ward are supported appropriately and a culture is promoted where verbal abuse is challenged as much as possible by staff.
- The service should ensure that efforts to reduce agency staff use continue, baseline staffing levels for each ward are kept under regular review and feedback from a range of ward-based staff is taken into account as staffing levels are adjusted to account for changes in patient risk and need.
- The service should ensure that improved systems are implemented for involving relatives and carers in the care planning process and for gaining regular feedback from relatives and carers.
- The service should consider how the processes for de-briefing staff and patients following incidents can be improved to ensure that input from the psychology team is included and records are kept to enable monitoring of whether de-briefs are taking place effectively.
- The service should ensure that patients are always supported to understand their rights under the Mental Health Act as required by their individual communication needs.

Long stay or rehabilitation mental health wards for working age adults

- The service should ensure that action is taken to improve staff retention and to continue to explore the reasons for staff leaving their posts so that any trends of concern can be identified.
- The service should ensure that patients who experience verbal abuse from peers on the ward are supported appropriately and a culture is promoted where verbal abuse is challenged as much as possible by staff.

Summary of this inspection

- The service should ensure that it carries out work to soundproof the ward taking into account the recommendations of the acoustic engineering report as soon as possible.
- The service should ensure that a plan is put in place to action the environmental improvements identified by the July 2022 autism environment audit as soon as possible.
- The service should ensure that efforts to reduce agency staff use continue, baseline staffing levels for each ward are kept under regular review and feedback from a range of ward-based staff is taken into account as staffing levels are adjusted to account for changes in patient risk and need.
- The service should ensure they continue to carry out regular environmental audits to monitor ongoing compliance with the sensory needs of the patients.
- The service should respond to the feedback from patients about suitable vegan and vegetarian options not always being available even when these are listed on the menus.

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	Requires Improvement	Requires Improvement	Requires Improvement	Requires Improvement
Acute wards for adults of working age and psychiatric intensive care units	Inadequate	Requires Improvement	Requires Improvement	Requires Improvement	Requires Improvement	Requires Improvement
Overall	Inadequate	Requires Improvement	Requires Improvement	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	Requires Improvement
Responsive	Requires Improvement
Well-led	Requires Improvement

Is the service safe?

Requires Improvement

Our rating of safe stayed the same. We rated it as requires improvement.

Safe and clean care environments

People were not always cared for in wards which were safe, clean, well equipped, well furnished, well maintained or fit for purpose.

Safety of the ward layout

Staff completed and regularly updated thorough risk assessments of all ward areas and removed or reduced any risks they identified. Due to its specialist nature the ward required adaptations to make it suitable for people with autism. The autism environment audit completed in May 2022 showed the noise levels on the ward were too high. All six of the of the people we spoke with raised this as an issue. We observed someone who was distressed by the amount of noise on the ward during the inspection. The ward had carried out a sound insulation test through an acoustics engineering company in April 2022. The interim registered manager told us a quote for the work had been requested and work would commence once approved by the corporate team but this had been delayed by five months and the reason for this was not clear.

Staff could observe people in all parts of the wards. The staff office was at an intersection that allowed direct access to all the corridors on the ward. The ward also had CCTV cameras in all patient areas except the bedrooms and the communal bathroom.

Staff knew about any potential ligature anchor points and mitigated the risks to keep people safe. The ward had a board in the staff office that highlighted all the ligature points. It also had an up to date ligature risk assessment.

People had easy access to nurse call systems and staff had easy access to alarms. All staff carried personal alarms. There were call buttons in each room that could be activated by patients. Staff were visible on the ward. Patients were observed approaching staff to have their needs met. The interactions with staff were mainly to meet needs rather than therapeutic.

When people were secluded their basic needs were met, including access to a toilet, food, water and outside space. People who were secluded were able to communicate easily with staff. However, staff did not always ensure that if people were secluded they were kept in a clean and safe environment. We saw evidence that bedrooms were being used for seclusion at times and no environmental risk assessments were being carried out beforehand to make sure people were safe. Staff reported using holds to move people to the seclusion room, which was on the floor above the ward. Some of the corridors were narrow and did not allow safe movement and we saw no evidence to show how this risk was mitigated.

Maintenance, cleanliness and infection control

Ward areas were clean and fit for purpose. Some of the furnishings were not well maintained. Chairs in the main lounge, sensory room and de-escalation room were worn and some of them had ripped covers. The ward staff told us they had carried out an environment review in June 2022 and replacement furniture had been requested through the corporate process in July 2022. The staff we spoke with said they had received no feedback since this time in relation to these requests. However, following the inspection the provider shared evidence that staff were given an update in relation to the furniture replacement programme in the August 2022 heads of department meeting. The hospital manager told us that minutes from this meeting were shared with all staff. The sensory room had an electrical box on the ceiling that had become unfastened. The ward manager told us they had recruited a maintenance worker to complete the repairs required for the hospital.

Staff did not ensure cleaning records were up-to-date. The cleaning schedule showed gaps in cleaning over a six month period. The quarterly infection control audit had not been completed since 5 May 2022. The cleaning audit had also not been completed in accordance with the provider's policy. Staff told us there had been one housekeeper covering the hospital for at least two months, from July 2022. They had only recently recruited additional staff to allocate the ward its own housekeeper.

Staff followed infection control policy, including handwashing. There were handwashing instructions placed above sinks throughout the ward and we observed staff wearing personal protective equipment in line with the provider's policy. Although the ward had not had a regular housekeeper the patients as well as some of the family members we spoke with told us they found the ward environment generally clean. On inspection we found the communal areas generally clean, however equipment did not have 'I am clean' labels in accordance with the provider's policy.

Clinic room and equipment

Clinic rooms were fully equipped, with accessible resuscitation equipment and emergency drugs that staff checked regularly.

Staff checked and maintained equipment. All the clinic equipment had been calibrated in July 2022. However, the provider's policy in relation to the use of "I am clean" stickers as best practice to identify clean equipment was not being followed

Safe staffing

The service had enough nursing and medical staff. However, they did not always receive basic training to keep people safe from avoidable harm.

Nursing staff

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

The service usually had enough nursing and support staff to keep people safe, provide one to one support, provide activities and support community leave. Day and night shifts were fully staffed during our inspection in accordance with the provider's staffing matrix. The ward had two nurses and three healthcare support workers both day and night. The numbers and skills of staff matched the needs of the people using the service and they were able to book extra staff if people's needs changed. The ward manager also reported that in emergencies they were able to request staff from the other wards. Three of the patients told us they were normally taken out in groups including access to local community as they could not always be taken out individually. One of the patients said they did not like this as it was too noisy and they found the shops too bright. As a result, they chose to remain on the ward when others went out. However, when we checked the records we saw that all the patients who had escorted leave approved were accessing regular individual episodes of leave.

The service had low vacancy rates. The provider had recruited an international nurse who was due to start on this ward soon. There were no vacancies for healthcare support workers.

The service had low rates of bank but high rates of agency staff. Agency staff were used daily. The average use for August was 5% for bank and 34% for agency. The highest use of agency in a single day was 62% and lowest in a day was 8% for the same period. The high usage of agency staff was highlighted in the service's risk register from July 2022. The manager linked the high agency use to the high use of enhanced observations on the ward.

Managers did not make sure all bank and agency staff received training to help them to understand the service before starting their shift. The manager reported running a monthly induction programme for all staff. However, three of the staff members who were new to the ward had not completed full induction training and had not received specialist training on autism or learning disabilities. In the patients' community meeting for July some people specifically asked for more staff who are trained to manage challenging situations. Patients we spoke with were not happy with agency staffing and explained there were new faces most of the times. They also told us they found agency staff were not always skilled in attending to their needs and did not engage well with them.

The service had high turnover rates over a 12 month period. This was 23% for nurses and 49% for healthcare support workers. The turnover rate across all staff groups for the 12 month period was 41%.

Levels of sickness were low. They were below 5% over a seven month period this year, except March where it was 7 %. The ward had a healthcare support worker on long-term sick leave.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants for each shift. The manager attended a daily meeting where staffing issues for the day and actions to be taken were discussed. The ward manager could adjust staffing levels according to the needs of people using the service.

People rarely had their escorted leave or activities cancelled, even when the service was short staffed. The people we spoke with told us that they were usually able to take their section 17 leave and they did not frequently have activities cancelled.

The service had enough staff on each shift to carry out any physical interventions safely. Staff told us they were able to request staff from other wards at short notice when required. A patient we spoke with who had recently been restrained explained it was done for their safety. They understood why staff had needed to carry out restraint.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

Staff shared key information to keep people safe when handing over their care to others. We reviewed handover records which showed that key information including risks were discussed for each patient at each morning and evening handover.

Medical staff

The service had enough daytime and night time medical cover and a doctor available to go to the ward quickly in an emergency. The ward had a full time consultant psychiatrist with a special interest in neurodevelopment and a staff grade doctor. Out of hours cover was provided by both the consultant and staff grade doctor. They also had a ward doctor who provided cover twice a week on a Monday and Thursday to cover physical health needs. During our inspection doctors were visible on the ward. We also observed them interacting with patients.

Managers could call locums when they needed additional medical cover.

Mandatory training

Staff had not always completed and kept up-to-date with their mandatory training. The ward was 94% compliant in their mandatory training for all staff groups. The service's threshold was a 90-95% minimum compliance rate. Some of the multi-disciplinary team had low levels of mandatory training compliance when this was analysed by role, for example occupational therapy staff had only 50% compliance with a number of training modules including awareness of self-harm and suicide, reducing restrictive practice, safeguarding and supporting autistic people. However, we saw evidence that this related to 2 of the 4 members of the OT team who both commenced employment in September 2022 and were still completing their induction training.

The mandatory training programme was sufficiently comprehensive to meet the needs of patients and staff. This included e-learning and face to face training on autism awareness and enrolment on an Open University autism awareness course. The ward manager had also completed a train the trainer course on autism which was due to be rolled out to ward staff. However, not all the staff we spoke with had completed all aspects of this training and some told us they had received no training in meeting the needs of autistic people. People using the service had requested staff with improved training in a recent community meeting. When we spoke with people, they told us staff were not always aware of how to meet their sensory needs. They also reported staff were not always able to safely manage challenging situations on the ward. When we checked the training records these showed that 100% of ward staff had completed mandatory e-learning in "supporting autistic people".

Managers monitored mandatory training and alerted staff when they needed to update their training. The manager reported that human resources carried out monthly audits and would send out reminders to staff. The staff we spoke with reported they received email and text reminders for their mandatory training.

Assessing and managing risk to patients and staff

Staff assessed risks to people using the service but this was not managed well. The service did not achieve the right balance between maintaining safety and providing an environment which facilitated people's recovery.

Assessment of patient risk

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

Staff completed risk assessments for each person on admission, using a recognised tool, and reviewed this regularly, including after any incident. The service used the Short Term Assessment of Risk Tool (START) on admission, which is a recognised risk assessment tool. Risk was routinely reviewed every four weeks in ward rounds. Ongoing risks were reviewed daily in morning meetings.

Management of patient risk

Staff knew about risks to each person however the action taken in response did not always prevent or reduce risks. The ward had a total of 850 incidents over the previous 12 months. Most of these incidents were repetitive such as violence and aggression towards staff as well as towards other people using the service. Incidents also included damage to property as well as self-harm. Some of the incidents resulted in injuries to patients or staff. Most of the people we spoke with reported not feeling safe on the ward. Risk assessments were regularly updated and discussed in morning meetings on the ward and the management team also reviewed all incidents five days a week at the hospital wide morning meeting. However, these measures had not resulted in the frequency of incidents of aggression being reduced. On the ward, the risks were looked at individually without adequate linking or monitoring of factors that contributed to the risks to inform risk management plans. However, more action was taken to identify themes of concern at the hospital wide meetings and this had resulted in the pausing of new admissions throughout July and August 2022 in response to the level of enhanced observations and agency use identified immediately prior to this.

Staff did not always identify and respond to all changes in risks to, or posed by, people using the service. We observed staff not paying attention to people they were working with which resulted in some people shouting and becoming agitated. The service's incident records showed that debriefs with the people involved did not always take place in order to inform practice.

Staff followed procedures to minimise risks where they could not easily observe people. The ward had CCTV cameras throughout the communal areas. However, there had been an incident of assault that could not be investigated by the police due to insufficient evidence, as it had not been captured by the CCTV.

Staff did not adequately manage the safety of the living environment and equipment through checks and action to minimise risk. During our inspection unknown tablets that were not prescribed to someone were found in their bedroom. The provider's incident record showed that some people had obtained objects from communal areas such as the activity room and activity of daily living (ADL) kitchen that they hid in their rooms before using them to self-harm.

People's freedom was restricted only where they were a risk to themselves or others, as a last resort and for the shortest time possible. The ward carried out audits of restrictive interventions, most recently in June 2022. Some of the restrictions included limitations to accessing the internet, access to hot drinks and the gym being locked. Staff told us that these were risk assessed and kept under review. However, the restriction on hot drinks was not included on the blanket rules audit for the ward.

Use of restrictive interventions

People were restrained only where evidence demonstrated it was necessary, lawfully justified, used for the minimum period of time, had a justifiable aim, and was in the person's best interest, and that it was used in a safe and proportionate way. People told us that physical restraint happened often on the ward. Data provided by the hospital showed that during the period from August 2021 to August 2022 there had been 75 restraints on the ward. All the people we spoke with told us there were too many incidents on the ward and that they did not feel safe.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

Each person's care and support plan did not include ways to avoid or minimise the need for restricting their freedom.

If a person's freedom was restricted by staff, they received emotional support when needed. The manager told us they did not have a formal debrief process. However, people could be offered follow up with psychology. The case notes of a person who had been secluded showed a brief discussion with psychology had taken place following the termination of seclusion.

Restrictions of people's freedom were not always fully documented or monitored. They did however trigger a review of the person's support plan. The documentation was comprehensive but not always fully completed. Interventions were not always fully implemented and there was no rationale given for this. For example, the addendum to the seclusion booklet (which had been introduced to prompt staff to record what activities where undertaken and when) had not been completed. The schedule for monitoring physical health was not followed according to the provider's guidance.

Staff were trained in the use of restrictive interventions and we saw evidence that their training was certified as complying with the Restraint Reduction Network Training standards

If staff restricted a person's freedom, they took part in post incident reviews. However they did not always adequately consider what could be done to avoid the need for its use in similar circumstances. For example, incidents were reviewed in isolation and did not always address wider issues that could be considered to avoid the need for repeating restrictions on a person's freedom. This was evidenced by repetition of person-to-person violence and aggression on the ward.

Staff participated in the provider's restrictive interventions reduction programme. Staff received training in prevention and management of violence and aggression and 82% of staff were up to date with this. Members of the leadership team attended the Cygnet Positive and Safe Delivery Board and fed back the learning from this to staff.

Staff understood the Mental Capacity Act definition of restraint and worked within it. Capacity assessments were carried out by the responsible clinician. There was one informal patient on the ward at the time we inspected and we saw no evidence that their liberty was being restricted unlawfully.

Staff did not always follow NICE guidance when using rapid tranquilisation. Ward staff did not always follow the provider's own policy when using rapid tranquilisation. The care records showed one person who did not receive physical health checks following rapid tranquillisation in accordance with recommended guidance. The policy recommended physical observations of the pulse, blood pressure, respiratory rate, oxygen saturations as well as levels of consciousness every 15 minutes. In the record seen staff only recorded the respiratory rate twice and reported the person was alert. No other observations were recorded and no rationale was given for those which were not performed.

When someone was placed in seclusion, staff kept clear records but did not follow best practice guidelines. The seclusion booklet and case notes did not always show a record of an adequate conclusion to the seclusion. There was not always a record of a robust mental health or risk assessment prior to termination. There was no record of the decision-making process for using a bedroom for seclusion or a discussion with the person to find out their views in relation to this. Long term segregation had not been used on this ward since our last inspection.

Safeguarding

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

Staff knew people well and understood how to protect them from abuse. However, due to the high level of aggressive incidents on the ward, people were not always kept safe from avoidable harm. 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 received training on how to recognise and report abuse and they knew how to apply it. The staff we spoke with had all received level 3 safeguarding training within the past 12 months and were aware of how to report concerns. The family members we spoke with did not report any concerns regarding abuse.

Staff kept up-to-date with their safeguarding training. The mandatory training record showed that 83% of staff were up to date with their training on safeguarding adults and children at risk at a level appropriate to their role.

People had safeguarding information in a form they could use, and they knew how and when to raise a safeguarding concern. There was information around the communal areas of the ward. People also had access to an advocate that regularly attended the ward.

Staff followed clear procedures to keep children visiting the ward safe. Family with children used a separate entrance and would use the visitor's room in the annex to the ward.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. The service provided a record of their most recent safeguarding incidents. The service had also developed links with their local safeguarding board. The service had a nominated safeguarding lead.

Staff access to essential information

Staff had easy access to clinical information, however it was not easy for them to maintain high quality clinical records – whether paper-based or electronic.

People's notes were not always comprehensive. For example, although there were debriefs following seclusion, these were not always structured and at times did not fully address the incident in a way that would clarify the underlying reasons for the incidents or help to prevent them happening in future. Notes not being comprehensive also made it difficult to corroborate some of the information gathered during the inspection. For example, staff were able to explain the policy around the physical health checks when a person was administered medication while in seclusion and could explain why they were not carried out effectively during a particular seclusion but this was not reflected in the care records.

The service used a combination of electronic and paper records. Staff did not always make sure they were adequately completed. For example, two of the people we spoke with did not agree with the information in their care plan about their rehabilitation needs. Their care plans had not been updated to include this information.

Records were stored securely. Electronic records were password protected. Paper records were stored out of sight in a locked office.

Medicines management

The service usually had effective systems and processes to safely prescribe, administer, record and store medicines. Staff regularly reviewed the effects of medications on each person's mental and physical health.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

Staff followed systems and processes to prescribe and administer medicines safely. However, there was regular practice of staff emailing on call doctors for authorisation to administer medication outside of the prescribed dose times. At times this was five hours outside the dose time. Guidance from NHS Improvement is that most medications are safe to take up to two hours late. After this, certain additional measures will need to be considered. There was no evidence in the emails of such discussions being held with the prescribing doctor before the medicine was administered.

Staff reviewed each person's medicines regularly to monitor the effects on their health and wellbeing and provided advice to people and carers about their medicines. The responsible clinician regularly reviewed the medications. When we reviewed the records we saw evidence that all the patients on the ward had either given valid consent to their treatment or a second opinion had been obtained as required by the Mental Health Act.

Staff completed medicines records accurately and kept them up to date. We reviewed all the medication cards and did not identify any errors.

Staff stored and managed all medicines and prescribing documents safely. Medicines were stored securely within the ward clinic room.

The service ensured people's behaviour was not controlled by excessive and inappropriate use of medicines. Staff understood and implemented the principles of STOMP (stopping over-medication of people with a learning disability, autism or both) and ensured that people's medicines were reviewed by prescribers in line with these principles. Medications were reviewed by the ward doctor as well as the consultant. People told us they received medication when they required it. One person told us medication stopped them from feeling scared.

Staff followed effective processes to assess and provide the support people needed to take their medicines safely. This included where there were difficulties in communicating, and when assessing risks of people taking medicines themselves. The people on the ward received their medication from staff and did not raise concerns with this. None of the people at the unit required their medication to be given covertly at the time of our inspection.

Track record on safety

The service did not have a good track record on safety.

Several of the people we spoke with told us that they had been physically assaulted by another patient during their admission. In the 2022 patient survey 38% of respondents said they had not felt safe during their time in hospital (24% said that they sometimes felt safe and 38% reported that they always felt safe). In the 12 months preceding the inspection we received 45 notifications relating to incidents of violence or aggression between patients and 13 notifications relating to incidents of significant self-harm in relation to Adarna ward.

Reporting incidents and learning from when things go wrong

The service did not always manage patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents effectively. They shared lessons learned with the whole team and the wider service, however the lessons learned did not always identify effective ways to reduce risk.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

Staff knew what incidents to report and how to report them. The service used an electronic incident management system to document all incidents on the ward. The system was highly comprehensive. However, although incident records included details of the actions taken, they did not always include a structured action plan to mitigate any identified risks.

When things went wrong, staff apologised and gave people honest information and suitable support. They were open and transparent and gave people and their families a full explanation when things went wrong. The incident records we saw did not evidence any discussion with family when things went wrong. However, the family members we spoke with told us they were made aware when incidents occurred involving their relatives.

Managers debriefed and supported staff after any serious incident. The staff we spoke with said they had debriefs when incidents took place. However, this was not recorded separately so the provider was not able to monitor this.

Staff received feedback from investigation of incidents, both internal and external to the service. The manager explained that following an incident they would decide if lessons needed to be learned. If this was the case it would then be reviewed by another senior manager and reviewed in governance meetings. We saw evidence in the meeting minutes that this was taking place.

The service recorded any use of restrictions on people's freedom, and managers reviewed use of restrictions to look for ways to reduce them. The provider carried out a blanket restrictions audit and blanket rules were also reviewed with people using the service at community meetings on the ward. Their latest audit dated June 2022 showed that staff gave their reasons for the restrictions and people's opinions were encouraged. The opinions were considered in the action plans.

Is the service effective?

Requires Improvement

Our rating of effective stayed the same. We rated it as requires improvement.

Assessment of needs and planning of care

Staff did not always assess the physical health of all patients on admission. They did however assess their mental health. They developed individual care plans which were reviewed regularly through multidisciplinary discussion and updated as needed. Care plans reflected people's assessed needs and were personalised. They were not always recovery oriented. Some of the identified needs were not always implemented in a timely manner. Care plans were not always evaluated in a way that monitored their effectiveness.

Staff completed a comprehensive mental health assessment of each person either on admission or soon after. The records showed that comprehensive assessments were carried out for each person on admission in relation to their mental health needs.

Not all people had their physical health assessed soon after admission. Of the twelve care records we reviewed, six of them had not received a physical health assessment on admission. Of these six however, two people had refused an assessment at the time. People with identified physical health needs were monitored regularly. The service had recruited a registered general nurse who was waiting to start.

People had care and support plans that were personalised, holistic and strengths-based but did not always reflect their needs and aspirations, including physical and mental health needs. People, those important to them and staff did not always review plans regularly together. Some people told us that they had rehabilitation needs which were not included in their care plans. People that mattered to them told us they were not included in formal care plan reviews.

Care plans reflected an understanding of people's needs, including relevant assessments of people's communication support and sensory needs. Sensory assessments were completed by the lead occupational therapist for the ward. They used the Adult and Adolescent Sensory History (AASH) screening tool to monitor for sensory dysfunction. Communication assessments were completed ty the ward's speech and language therapist.

The pathways to future goals and aspirations, including skills teaching in people's support plans was not always clear. Although all the people on the ward followed a model called 'My Pathway' the individual goals and aspirations were not always clearly reflected or acted on in a timely manner. For example, a person had wanted to access a course but had not been adequately supported in the actions they needed to take in order to successfully enrol. Two other people told us they were taking part in activities set out for them but were not doing what they enjoyed. Staff told us that one of the barriers to this was that people were from out of area which meant it would be difficult to start something on the unit that they could then not complete following discharge.

Staff regularly reviewed and updated care plans when people's needs changed. However the care plans were not constructed in a way that measured current goals and interventions against previous ones. The audit of care plans did not monitor the effectiveness of the care plans. The hospital manager told us that the corporate audit schedule was designed to monitor compliance with paperwork as opposed to effectiveness. Outcomes for patients were monitored through the hospital's governance meetings which included reviews of care plan achievement as well as the provider's Global Assessment of Progress scores.

Best practice in treatment and care

Staff did not always provide a range of treatment and care for people based on national guidance and best practice. Staff supported people with their physical health and encouraged them to live healthier lives. Staff used recognised rating scales to assess and record severity and outcomes. They also participated in clinical audit, benchmarking and quality improvement initiatives.

Staff provided a range of care and treatment suitable for the people using the service. The ward provided a standard model of care that everyone followed which they called the Adarna Pathway. This followed a range of stages in the rehabilitation journey and documented the interventions people would expect during each stage. This was posted on the ward, was pictorial and in an easy to read format. In practice, we did not witness much therapeutic activity on the ward during the period of our inspection. Four out of the seven people we spoke with reported they had no treatment choice and had accepted what they were offered.

Staff delivered care in line with best practice and national guidance. Staff reported using NICE guidance in delivering care. The occupational therapists used the Model of Human Occupation when assessing people's needs and planning care and completed a monthly daily living skills observational scale.

Staff monitored people with established physical health needs and recorded this in their care plans. There were people who required regular monitoring of their bloods as well as other investigations and this was being done regularly. Staff also responded promptly when people complained of physical health issues and this was reflected in the care plans.

Staff were not able to fully support people with their physical health. They were not able to fully encourage them to live healthier lives. The ward did not have a dedicated physical health nurse at the time of our inspection but had recruited one who was due to start. The people and an observation in the community meeting spoke of a lack of variety in vegan options as well as vegetables in their meals. The ward had a small gym within it that was not in use due to a security risk (although people could access the hospital's main gym under staff supervision). The ward did however monitor people's food purchases and encouraged healthier food.

Staff made sure people had access to physical health care, including specialists as required. The ward had recruited a dedicated speech and language therapist. They were newly qualified and acknowledged they required further training to achieve competency for their role. In the meantime they could approach their supervisor for support.

Staff did not always meet people's dietary needs. People had their dietary needs and preferences assessed on admission. However, some people who were vegetarian or vegan told us that they did not have their dietary needs adequately met. We saw menus which showed a range of vegetarian options each day. However, people told us that the kitchen often lacked ingredients or were not able to provide the other meal options on the menu. We observed a community meeting as part of the inspection. It was raised that people required more variety for vegetarian options. People also complained that for meat eaters their meals did not contain enough vegetables. Minutes of the community meetings showed patients had also complained over the quality of food in August 2022. The following community meeting minutes documented this as resolved, but there was no detail included to demonstrate the action taken.

Staff took part in clinical audits, benchmarking and quality improvement initiatives. The lead occupational therapist had completed an autism environmental audit which they co-produced with patients. This identified a number of improvements which were necessary to make the care environment more suitable for autistic people, however we did not see evidence that actions had been clearly identified to take these forward in a timely manner. The speech and language therapist was responsible for putting information into an easy-read format for people who needed this.

Skilled staff to deliver care

The ward team included or had access to a range of specialists required to meet the needs of patients. Managers made sure they had staff with the range of skills needed to provide high quality care. They supported staff with appraisals, supervision and opportunities to update and further develop their skills. Managers provided an induction programme for new staff.

The service had a full range of specialists to meet the needs of people using the service. The ward team was made up of a full time consultant psychiatrist, a staff grade doctor, a ward doctor, occupational therapists, mental health nurses, learning disabilities nurses, a clinical psychologist and assistant, healthcare support workers, social workers, activity co-ordinators and a speech and language therapist.

People were not always supported by staff who had received relevant and good quality training in evidence-based practice. Staff had not all received training in the wide range of strengths and impairments people with a learning disability and or autistic people may have, mental health needs, communication tools, positive behaviour support, trauma-informed care, human rights and all restrictive interventions. Of the six ward staff members we spoke with, three told us they had not received specialist training on autism or learning disabilities. There had been an incident with one

of the staff members where they were unaware of someone's sensory sensitivity, which had resulted in an incident of aggression. However, the staff mandatory training record for the ward showed that compliance for training in supporting autistic people was 100% and training in supporting people with a learning disability was 94%. This raised the concern that completion of the provider's training on autism was not supporting staff to meet the needs of autistic people adequately.

If people were assessed to lack capacity to make certain decisions for themselves or had fluctuating capacity, staff made decisions on their behalf which were in their best interests. This was supported by effective staff training and supervision. Staff on the ward were 100% compliant with their training on consent and mental capacity. A family member we spoke with felt the ward acted in the best interests of their relative who lacked capacity.

People benefitted from reasonable adjustments to their care to meet their needs, and their rights were respected. This was because staff put their learning into practice. People regularly had their rights under the Mental Health Act read to them and the people we spoke with were aware of their detention and their rights under it.

Managers usually gave each new member of staff a full induction to the service before they started work. Some of the staff we spoke with had been recently transferred from another location under the same provider and we saw evidence that these staff members had completed a supernumerary shift as part of their induction. New staff also had access to 'grab and go' sheets for each patient which included summary information about their communication needs and positive behaviour support plans. However, these staff told us that they had not received any autism or learning disabilities training to support them in working with the ward's patient group before commencing work on the ward. The ward had eleven people who were autistic and had a mental illness and one person who had a mild learning disability and a mental illness.

Managers did not always support staff through regular, constructive appraisals of their work. The ward was 69% compliant with appraisals. This was below the service's target of 80%. The manager was aware of this and was taking measures to ensure all staff were complaint.

People received adequate care as managers supported staff through regular, constructive clinical supervision of their work. The compliance rate for clinical supervision was 90%. The staff we spoke with reported having received supervision or were aware of how to request it.

Managers made sure staff attended regular team meetings or gave information from those who could not attend.

Multi-disciplinary and interagency team work

Staff from different disciplines worked together as a team to benefit people using the service. They supported each other to make sure people had no gaps in their care. However, they did not always have effective working relationships with staff from services providing care following a people's discharge.

Staff held regular multidisciplinary meetings to discuss people using the service and improve their care. People received multidisciplinary reviews ever four weeks and commissioner oversight reviews every eight weeks. This was reflected in all the case notes we reviewed.

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Requires Improvement

Staff made sure they shared clear information about people and any changes in their care, including during handover meetings. We were able to observe a handover meeting. Staff discussion included clinical risk, legal issues, presentations during the shift including incidents that had taken place and action taken as a result, risk assessments and mental capacity issues.

Ward teams had effective working relationships with other teams in the organisation. Staff told us they were able to access help and support from other wards in the hospital when needed.

The ward team did not always have effective working relationships with external teams and organisations. The team received visits from commissioners every eight weeks. We reviewed the discharge plans for four people. These did not show a consistent level of effective communication with external teams and organisations.

People did not have health actions plans or health hospital passports that enabled health and social care services to support them in the way they needed.

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

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 people's rights to them.

Staff received and kept up-to-date with training on the Mental Health Act and the Mental Health Act Code of Practice. The provider's training data showed staff were 100% compliant with Mental Health Act training on this ward. All 12 of the care records included the correct Mental Health Act documentation.

Staff had access to support and advice on implementing the Mental Health Act and its Code of Practice. The service had a Mental Health Act administrator who was able to support staff.

The service had clear, accessible, relevant and up-to-date policies and procedures that reflected all relevant legislation and the Mental Health Act Code of Practice. Staff reported they could access this through their intranet.

People had easy access to information about independent mental health advocacy and people who lacked capacity to make decisions for themselves were automatically referred to the service. The service had links with a provider of independent mental health advocates. Information on how to access the advocate was displayed in the communal areas of the ward.

Staff explained to each people their rights under the Mental Health Act in a way that they could understand, repeated as necessary and recorded it clearly in the person's notes each time. Some people told us they were aware of what section they were detained under and what this meant for them.

Staff made sure people could take section 17 leave (permission to leave the hospital) when this was agreed with the Responsible Clinician and/or with the Ministry of Justice. People told us they usually were able to go out on section 17 leave as planned.

Staff requested an opinion from a Second Opinion Appointed Doctor (SOAD) when they needed to.

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Requires Improvement

Staff stored copies of people's detention papers and associated records correctly and staff could access them when needed.

Informal patients knew that they could leave the ward freely and the service displayed posters to tell them this. These were displayed in the communal areas of the ward.

Good practice in applying the Mental Capacity Act

Staff supported people 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 people who might have impaired mental capacity.

Staff received and kept up to date with training in the Mental Capacity Act and had a good understanding of at least the five principles. Compliance for this training was 100%.

Staff knew where to get accurate advice on the Mental Capacity Act and Deprivation of Liberty Safeguards. This was available from the Mental Health Act administrator.

Staff empowered people to make their own decisions about their care and support and obtained people's consent in an inclusive way. People had access to information, including pictorial and easy to read written information, to support them in making decisions about their care.

Staff assessed and recorded capacity to consent clearly each time someone needed to make an important decision. When required there were multidisciplinary assessments of decision making capacity that also involved the person's family if appropriate. The records we looked at showed that capacity assessments took place and people were supported to give informed consent to their care.

When staff assessed people as not having capacity, they made decisions in the best interest of patients and considered the person's wishes, feelings, culture and history. There was evidence of multidisciplinary discussions around capacity, including out of hours when people required urgent treatment but were refusing to go to hospital.

People were not provided with information regarding all aspects of the surveillance, including records management, to enable them to give informed consent. There was no record of discussions in the community meetings or the blanket restrictions audit.

The service monitored how well it followed the Mental Capacity Act and made and acted when they needed to make changes to improve. Compliance with the Mental Capacity Act was monitored through the provider's monthly governance meetings.

Is the service caring?

Requires Improvement

Our rating of caring went down. We rated it as requires improvement.

Kindness, privacy, dignity, respect, compassion and support

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

Staff mostly treated people with compassion and kindness. They respected people's privacy and dignity. They understood the individual needs of people and supported people to understand and manage their care, treatment or condition, however this was not always done in an inclusive and positive way which made people feel valued.

Staff were not always discreet and responsive when caring for people. They were not always attentive to people's emotional and other support needs and sensory sensitivities. Two of the people we spoke with told us staff continued to insist on looking for signs of life by turning lights on or entering the room during the night checks which affected their sleep. As part of the inspection we carried out a Short Observational Framework for Inspection (SOFI). This identified that interactions between staff and the people they were caring for mainly related to the meeting of basic needs.

Staff knew when people needed their space and privacy and respected this. Sometimes following an incident staff maintained distance and privacy to avoid any further escalation.

Staff did not always give people help, emotional support and advice when they needed it. All the people we spoke with reported there was a high number of incidents and fights on the ward and some people said they were concerned that staff did not have the skills to manage this. All the people we spoke with reported not feeling safe on the ward. People also reported a high number of agency staff working on the ward who they were unfamiliar with. Some people said the agency staff did not understand or show interest in their needs.

Staff did not always support people to understand and manage their own care treatment or condition. Some people told us that staff did not understand or respond to their sensory difficulties. For example, one person had a sign on their door stating how staff were to check on them during the night, however this was not being followed. During our inspection the ward was often noisy. We observed people complaining about the noise levels with no action being taken in response to this by staff.

Staff directed people to other services and supported them to access those services if they needed help. People were able to access an advocate who had dedicated time on the ward twice a week. There was also information in communal areas with information regarding other services such as abuse support, Mental Health Review Tribunals and social support services.

Staff did not always follow the provider's policy to keep people's information confidential. We observed a staff member discussing confidential information about a someone's care in the communal lounge. They only moved to a more private area after noticing other people had started to listen to the conversation.

Involvement in care

Staff involved people in care planning and risk assessment and actively sought their feedback on the quality of care provided. They ensured that people had easy access to independent advocates.

Involvement of patients

Staff introduced people to the ward and the services as part of their admission. People received written information about the ward when they were first admitted and this could be provided in an easy reads format if needed.

Staff involved people and gave them access to their care planning and risk assessments. The care records we reviewed showed that everyone had received copies of their care plans.

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Requires Improvement

People were given time and supported by staff to express their views using their preferred method of communication. The speech and language therapist completed an easy read version of written information for people who needed this. People were involved formulating their profile for people who were new to the ward to use.

Staff respected people's choices and wherever possible but were not always able to accommodate their wishes, including those relevant to protected characteristics – for example, due to cultural or religious preferences. The people we spoke with had wanted pastoral care on the ward which had not been facilitated. They also felt the multi-faith room could be better equipped.

Staff involved people in decisions about the service, when appropriate. An environmental audit for autism had been carried out by the occupational therapist who had collaborated with people to complete it.

People were empowered to make decisions about the service when appropriate and felt confident to feed back on their care and support. Decisions about the service were discussed in community meetings. There was also information on how to complain as well as how to contact the Care Quality Commission posted on the walls in the communal areas of the ward.

Staff supported people to make decisions about their care. Records showed that people were supported to understand their care and give informed consent where possible.

Staff made sure people could access advocacy services. There was an advocate available on the ward twice a week. Some of the people we spoke with found this valuable.

Staff supported people to maintain links with those important to them. They had technology in different formats to communicate such as computers, mobile phones and tablets. Those important to them were updated on care and invited to multi-disciplinary meetings.

Involvement of families and carers

Staff informed and involved families and carers appropriately.

Staff supported, informed and involved families or carers. The families we spoke with reported feeling involved in the care provided to their relative. They told us that staff were approachable. They had also been invited to ward rounds and notified when incidents occurred. However, relatives were not aware of what activities had been offered to their family member or how well they engaged. They were not aware of the ward's activities timetable. One relative told us it was unlikely their family member was engaging due to lack of progress with their discharge arrangements which increased their feelings of being let down.

Staff helped families to give feedback on the service. This was done through family and carer surveys.

Is the service responsive?

Requires Improvement

Our rating of responsive stayed the same. We rated it as requires improvement.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

Access and discharge

Staff did not plan or manage people's discharge well. They did not work well with services providing aftercare to manage people's move out of hospital.

Managers made sure bed occupancy did not go above 85%. Bed occupancy at the time of our inspection was 80%.

Managers regularly reviewed length of stay for patients to ensure they did not stay longer than they needed to. At the time of our inspection the average length of stay for Adarna ward was 429 days.

The service had mostly out-of-area placements. All twelve people on the ward were out of area. People and relatives told us this made it difficult to arrange family visits. We found that the ward did not have many links with external agencies to enable people to improve their wellbeing post-discharge. They had not established pathways into education, employment or building on skills. The people we spoke with told us that other than cooking and activities of daily living there was not enough to do that they could build on following discharge.

Discharge and transfers of care

Managers monitored the number of people whose discharge was delayed and knew which wards had the most delays but did not take adequate action to reduce them. The ward's record showed out of the twelve people, five of them had stayed longer than eighteen months. We looked at a sample of four records including their discharge plans. We found that some of the actions did not lead to any meaningful outcome and this was not followed up by staff in a timely way.

This resulted in issues leading to discharge delay not being addressed, in one case for a period of seven months. This had resulted the person missing out on an activity they had planned to complete in the community. Three people told us they felt frustrated with their lack of progress. One person told us that they did not think anyone had taken ownership over the barriers to their discharge. A relative expressed that frustration relating to delayed discharge had resulted in their family member not engaging in therapy on the ward due to a history of being let down and feeling as if this was happening again.

People did sometimes have to stay in hospital when they were well enough to leave. Two of the discharge documents showed that arrangements in the community were affecting discharge. This was reflected by the people we spoke to as above. We did not see evidence that staff were taking an active approach to address these delays.

Although the discharge plans were present and updated according to policy, their content was at times generalised and did not detail or evaluate measures to be taken to achieve discharge. In one person's record there was no clear discharge plan.

The average length of stay on the ward was 429 days. This was in keeping with the provider's target of 18 to 24 months.

Facilities that promote comfort, dignity and privacy

The design, layout, and furnishings of the ward supported people's treatment, privacy and dignity. Each person 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 good quality and people could make hot drinks and snacks at any time. When clinically appropriate, staff supported people to self-cater.

Each person had their own bedroom, which they could personalise. This was individually risk assessed. People were able to choose soft furnishings and accessories for their rooms that were in line with their interests. They were also able to keep some electronic items such as televisions, music, tablets and mobile phones.

People had a secure place to store personal possessions.

The service's design, layout and furnishings supported people and their individual needs. This included noise-reducing furnishings and calm diffused lighting, which supported people with sensory sensitivities. However, the action taken since our previous inspection to try to resolve the high noise levels on the ward had not been effective. People told us they found the noise travelled from the floor above distressing and we observed someone becoming distressed by the noise level on the ward. The ward had made the sensory room accessible throughout the day to support people if they became too distressed by noise.

Staff used a full range of rooms and equipment to support treatment and care. The ward had a small gym, an activities of daily living kitchen, a private lounge area, a sensory room and a de-escalation room that people could use.

The service had quiet areas and a room where people could meet with visitors in private. This room could be accessed through a separate entrance to the main ward. The family members we spoke to were happy with this arrangement. People on the ward did not raise concerns with this either.

People could make phone calls in private. They had access to their own mobile phones.

The service had an outside space that people could access easily. There was a courtyard with seating area that people could utilise. This could be accessed from the ward's communal lounge. We observed people frequently using this to interact with each other or to smoke.

People could make their own hot drinks and snacks and were not dependent on staff. Due to concerns around harm, cups were kept in the staff office. However some people were able to keep a stock of cups in their rooms if individually assessed as safe to do so. This restriction had been evaluated and was also open for further review.

People's engagement with the wider community

Staff did not adequately support people with activities outside the service, such as work, education and family relationships.

Staff did not always support people to take part in their chosen social and leisure activities on a regular basis. The people we spoke with told us they did not always like to engage in ward activities and preferred to be in their rooms. Some of the care records showed that external activities were identified but these were not always carried out in a timely manner. For example, four of the care records showed plans for activities that included visiting places of interest as well as finding suitable accommodation, but these were postponed to the next review date.

Staff did not always ensure people had access to opportunities for education and work or support them to access these. The ward manager reported the earlier lockdowns had an effect on their links in the local community and were working to rebuild these. Their other concern was that all the people using the service were out of area. This made it difficult for the service to support them in starting something that they would have to leave incomplete when they transferred back to their local area.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

People who were living away from their local area were able to stay in regular contact with friends and family using the telephone, online voice or video calls, and social media. People were able to speak to their families using their own phones.

Staff did not always support people to develop and maintain relationships both in the service and the wider community. There was a high number of assaults and we observed the ward to be chaotic at times. However during our inspection a staff member was observed starting a game and encouraging people to join in. The service did not have many close links with other agencies in the community.

Meeting the needs of all people who use the service

The service met the needs of all patients – including those with a protected characteristic. Staff helped people with communication, advocacy and cultural and spiritual support.

Staff used person-centred planning tools and approaches to discuss and plan with people how to reach their goals and aspirations. Plans regarding skills and aspirations were carried out by the lead occupational therapist. They used the Model of Human Occupation as a guide to their practice. People on the ward spoke highly of the occupational therapist and felt they went out of their way to try and support them with their needs.

Staff made sure people could access information on treatment, local service, their rights and how to complain. This was displayed in the communal areas of the ward.

Every person's record contained a clear one-page profile with essential information so that new or temporary staff could see quickly how best to support them.

Staff showed some awareness, skills and understanding of people's individual communication needs. We observed staff communicating effectively with those that had speech difficulties.

The service had information leaflets available in languages spoken by the patients and local community. Staff told us that, for non-English speakers, they could print off online information. Managers told us that they made sure staff and people could get help from interpreters when needed.

People had access to spiritual, religious and cultural support. A room in the annex to the ward was used as a multi-faith room. However, patients and staff told us there were no spiritual leaders attending the ward to support people.

Listening to and learning from concerns and complaints

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team and wider service.

People and those important to them could raise concerns and complaints easily, and staff supported them to do so. People we spoke with were aware of how to raise complaints but did not want to raise concerns about their care during the inspection. They appeared hopeless in achieving outcomes they hoped for. As a result, they declined to bring up the concerns they expressed as complaints. Complaints data showed that complaints were received from patients from Adarna ward, and these were investigated and resolved in a timely manner.

The service clearly displayed information about how to raise a concern in patient areas.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

Managers investigated complaints and identified themes. The manager reported that complaints usually related to the way people were spoken to by staff or issues around their section 17 leave as the concern.

Staff knew how to acknowledge complaints and people received feedback from managers after an investigation into their complaint.

Managers shared feedback from complaints with staff and learning was used to improve the service.

The service used compliments to learn, celebrate success and improve the quality of care.

Is the service well-led?

Requires Improvement

Our rating of well-led stayed the same. We rated it as requires improvement.

Leadership

Leaders had the skills, knowledge and experience to perform their roles. They had a good understanding of the services they managed and were visible in the service and approachable for patients and staff.

Managers were visible in the service, approachable and took interest in what people, staff and family had to say. Staff told us they were supported by managers and felt they were able to raise concerns. Families told us they were able to speak to managers when needed and found them approachable.

Leaders had the skills, knowledge and experience to perform their roles and had a clear understanding of people's needs and oversight of the services they managed. However, we saw some examples of where consideration of the needs of people using the service were not fully embedded in all aspects of the service. For example, the senior management oversight checklist did not include sensory checks that would be specific for people using the service such as lighting and sound. However, we saw evidence that progress had been made since our last inspection towards improving the lighting on the ward and resolving the soundproofing issues which were causing people distress. This was done in collaboration with patients through the people's council meetings. Also a common theme on the ward was people feeling unsafe. This was reflected by the high number of incidents on the ward. The hospital management team reviewed all incidents at the daily morning meeting which took place Monday to Friday. However, there had been no formal audit process or investigation to identify themes arising from incidents of aggression and how they could be mitigated.

Although the leadership team had put in place systems and processes, these were not always effective. For example, their measures to address staffing shortages by using agency staff had not always been effective for people using the service. Some of the people we spoke with complained of unfamiliar staff and their lack of understanding for their needs and agency staff had not always received training in working with autistic people before working a shift on the ward. However, we did also see evidence of efforts by the leadership team to minimise agency use on Adarna ward and the hospital manager told us that every effort was made to book consistent staff to work on Adarna ward when using agency staff, to reduce the impact of this on patients.

Vision and strategy

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

Staff knew and understood the provider's vision and values and how they applied to the work of their team.

The vision and strategy was displayed in all communal areas around the ward. Their model was centred on My Choice, My Voice, My Life. The staff we spoke with were aware of the Cygnet vision and values and told us these were reviewed in their appraisals.

The provider had a clear vision for the direction of the service that demonstrated ambition and a desire for people to achieve the best outcomes possible. They had developed a 'My Pathway' model for rehabilitation with expectations laid out from admission to discharge. Staff referred to this model in the care records. People were generally aware of their stage on the pathway.

Managers set a culture that valued reflection, learning and improvement. The manager had completed a 'train the trainer' course in autism to enable them to train staff as part of their induction. Staff also had access to online autism training and an online Open University Course in relation to autism. In the March 2022 staff survey, staff were given the statement 'I receive training and support to help me deliver a better service user experience' and 79% either agreed or strongly agreed with the statement. However, at the time of our inspection some of the newer staff we spoke with had not completed any training in relation to caring for autistic people.

Culture

Staff did not always feel respected, supported and valued. However, they said the provider promoted equality and diversity in daily work and provided opportunities for development and career progression. They could raise any concerns without fear.

In the 2021 staff survey staff were asked how strongly they agreed with the statement 'The leadership of Cygnet is committed to providing high quality care to our service users' – 10% of staff agreed with this statement compared to 35% in 2021. Those that strongly disagreed had increased from 2% to 8%.

Regarding immediate managers, the staff survey for the same period showed reduced satisfaction. To the statement 'My line manager supports me and motivates me to do my job well, 51% strongly agreed in 2021. This went down to 36% in 2022. However, staff we spoke with reported being happy with their management arrangements.

Staff felt able to raise concerns with managers without fear of what might happen as a result. They felt the manager was visible on the ward and approachable.

Staff felt respected, supported and valued by senior staff, which supported a positive and improvement-driven culture.

Governance

Our findings from the other key questions demonstrated that governance processes did not always operate effectively at team level and that performance and risk were not always managed well.

Records showed that autism training was part of the induction programme. The mandatory training record showed that staff were compliant in their training for autism. However, when we spoke with staff, they told us they had not all received induction training. They also had not all received training in autism prior to starting work on the ward. The incident record showed regular incidents involving people who had become distressed due to sensory overstimulation.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

The care plans did not monitor or evaluate interventions to see if they had worked. As a result the service did not look into alternative methods of addressing needs. The service's latest care plan audit completed in August 2022 looked into whether documentation had been completed correctly, in a timely manner and meeting goals rather than the effectiveness of the interventions.

A number of the incidents recorded on the provider's reporting system met the threshold for notifying the Care Quality Commission but the record stated this had not been done.

The service did not have an environmental audit or checklist to keep people safe when using a bedroom for seclusion.

Management of risk, issues and performance

Teams had access to the information they needed to provide safe and effective care but did not always use that information to good effect.

The clinical risks for each person were detailed in comprehensive risk assessments and discussed at handover and multi-disciplinary meetings. We saw evidence that records were audited to ensure their accuracy and the outcomes of audits were reviewed at the provider's governance meetings. However, some of the governance meeting minutes showed a lack of consideration of potential trends in incidents involving people using the service, for example violence and aggression and self-harm and the incident records showed that some people were involved in repeated similar incidents.

The hospital had a risk register which included a range of key clinical and organisational risks relating to the service. This was kept under regular review and updated as required, with action being taken to mitigate the identified risks.

Senior staff understood and demonstrated compliance with regulatory and legislative requirements. The documentation relating to the Mental Health Act and Mental Capacity Act was comprehensive and up to date. Staff compliance with training was also up to date.

Information management

Staff collected and analysed data about outcomes and performance and used this data to good effect.

The service's electronic incident reporting system was highly comprehensive and could be interrogated to identify themes and trends.

Engagement

Managers engaged actively with other local health and social care providers to ensure that an integrated health and care system was commissioned and provided to meet the needs of the patients. Managers from the service participated actively in the work of the local transforming care partnership.

People and those important to them worked with managers and staff to develop and improve the service. The service had a hospital tuck shop that was run by patients on a rotational basis under the supervision of staff and people spoke positively about their involvement with this.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

The service worked well in partnership with advocacy organisations, which helped to give people using the service a voice and improve their health and life outcomes. People had access to an independent advocate who attended the ward twice a week. The advocate was present and engaged with people during our inspection.

The service worked with the clinical commissioning groups to share information about the patients whose care they were funding. The hospital also had a link worker who liaised with their local authority for safeguarding.

Learning, continuous improvement and innovation

The provider kept up-to-date with national policy to inform improvements to the service. The service was starting to offer staff specialised training. The service was also offering a variety of masterclasses that included compassionate leadership and learning disability, autism and communication, quality improvement among other courses.

The provider invested sufficiently in the service, embracing change and delivering improvements. The service had funded a Postgraduate Certificate in autism that a staff member was due to commence the following year.

The lead occupational therapist had completed an autism environmental audit which they co-produced with patients. The audit was designed so that it could also be completed individually by a person with autism. It covered domains such as;

Sight/visual - colours, patterns, type of clothing worn by staff and lighting

Smell – such as from cleaning materials, fragrances worn by staff/visitors, ventilation

Hearing – sounds from equipment, monitoring of noise levels on the ward

Body Awareness – unnecessary obstructions, adjustments for people with fine motor difficulties for example locks and door handles, navigating steps, kerbs.

Escape – having a system to know when a person with autism needs to leave an environment, having a suitable room in place where a person can use for this purpose

Touch – considering safety for people hyposensitive to touch and how to manage this, appropriate assessment methods to determine where someone likes/dislikes to be touched.

Taste – having a wide range of food available offering different textures and temperatures, clear guidance on what to do when someone eats objects or substances not meant to be eaten.

This was completed annually. The last one had been completed in May 2022.

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

Requires Improvement

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

Is the service safe?

Inadequate

Our rating of safe went down. We rated it as inadequate.

Safe and clean care environments

Wards were not always safe, clean, well equipped, well furnished, well maintained or fit for purpose.

Safety of the ward layout

Staff completed and regularly updated thorough risk assessments of all ward areas. However, timely action was not always taken to address identified risks. Risk assessments were not being carried out prior to using patients' bedrooms for seclusion, which had been happening regularly.

Staff could not observe patients in all parts of the wards. Patients told us that they did not always feel safe and some patients told us they had been assaulted by another patient.

The ward complied with guidance and there was no mixed sex accommodation. The hospital provides care to men only.

Staff knew about any potential ligature anchor points and mitigated the risks to keep patients safe.

Staff had easy access to alarms and patients had easy access to nurse call systems. Staff told us that they felt safe at work and their colleagues responded promptly when alarms were pulled. However, patients told us it was not always easy to get the attention of a member of staff when they needed to.

Maintenance, cleanliness and infection control

Ward areas were mostly clean, however they were not always well-maintained, well-furnished or fit for purpose. On both wards several chairs had ripped coverings, which is an infection prevention and control risk. There were marks on the paintwork on the walls of both wards and Phoenix ward had an unpleasant smell on the first day of the inspection. On Bennu ward one of the televisions and the water cooler were broken and patients told us this had happened several

days ago in both cases. Staff told us that requests for environmental maintenance and refurbishment were not responded to by the provider in a timely manner. In the Phoenix ward clinic room there were electrical boxes which were open with exposed wiring due to the locks on these not working. Following the inspection the hospital manager told us that planned refurbishment of both wards had commenced, on Phoenix ward on 12 September 2022 (completed on 18 October 2022) and on Bennu ward on 1 November 2022.

We observed cleaning taking place on both wards. Patients told us that the wards were usually clean. However, there were gaps in both the general cleaning records and the COVID-19 cleaning records for the weeks preceding the inspection so we were not assured that cleaning was consistently taking place according to the provider's policy. Harder to reach areas, such as underneath equipment and the corners of the floor, were visibly dirty in both clinic rooms.

Staff followed infection control policy, including handwashing. Staff were observed to be wearing PPE (surgical face masks) in accordance with the provider's policy on preventing transmission of COVID-19 within the hospital at the time of our inspection.

Seclusion room

The seclusion room allowed clear observation and two-way communication. It had a toilet and a clock. However, we also saw evidence that patients' bedrooms were being used for seclusion without a documented risk assessment of the suitability of the environment for this purpose.

Clinic room and equipment

Clinic rooms had accessible resuscitation equipment and emergency drugs that staff checked regularly. On one ward the emergency bag did not include tubing for the oxygen. Staff said this was because it had been used three days prior to the inspection and it had not yet been replaced. This was replaced during the inspection from the spare tubing which was available in the hospital's stock cupboard.

We did not see sufficient assurance that staff checked, maintained, and cleaned equipment. The equipment for physical healthcare checks was disorganised in both clinics. The provider had an equipment cleaning policy which stated that staff should mark cleaned equipment by using "I am clean" stickers but these stickers were not being used on either ward. We did see evidence that maintenance and calibration checks had been carried out on all clinic room equipment in the 12 months preceding our inspection.

Safe staffing

The service usually had enough nursing and medical staff, who knew the patients and received basic training to keep people safe from avoidable harm.

Nursing staff

The service usually had enough nursing and support staff to keep patients safe. All day shifts were fully staffed during our inspection in accordance with the provider's staffing matrix. On Phoenix ward there was only one nurse working when we visited during the night shift when there should have been two. There was an additional support worker on this shift to mitigate the impact of this. Most of the staff on both wards told us that the wards were usually fully staffed, with the correct skill mix. Staffing data showed that both day and night shifts are usually staffed up to the identified establishment level on both wards.

However, patients and some staff told us that the staffing levels on Bennu ward were not sufficient to keep people safe. Staff said it was not always possible to increase the numbers of nursing and support staff when patients needed one to one support due to increasing risks. Patients on Bennu ward told us it was difficult to get the attention of a member of staff and we observed a distressed patient on this ward shouting that there was never a staff member available.

The service had low vacancy rates at the time of our inspection in relation to nurses and support workers due to recruitment initiatives which had recently taken place. There were vacant posts for 5 full time equivalent nurses and 5 full time equivalent support workers however 3 of the nurse positions and all of the support worker positions had been recruited to, with new starters due to commence in early 2023. In addition, there were 8 support workers from another Cygnet hospital who were providing cover from September 2022 to February 2023.

As at the date of our inspection the use of agency nurses and support workers was high as many of the new starters were still going through the induction process and there were a number of patients who required enhanced observations due to their risks to themselves or others. In the six months preceding our inspection the average percentage of total staff which were agency workers was 55% for Bennu ward and 35% for Phoenix ward. Managers requested bank and agency staff familiar with the service. Staff and patients told us that when agency staff were used these were usually regular agency workers who the patients were familiar with.

Managers made sure all bank and agency staff had a full induction and understood the service before starting their shift. We saw records which showed that agency staff had a ward induction before starting their first shift on both wards. We spoke with agency staff members who confirmed they had received an induction.

The service had high turnover rates. In the 12 months prior to our inspection the turnover rate for the hospital was 40% for all staff, 23% for nurses and 49% for support staff. We did not see evidence of any initiatives taking place to improve staff retention. The provider asked staff who were leaving to complete a survey but only 3 of the 27 members of staff who left the provider's employment in the six months prior to our inspection completed this so the provider had very limited data on the reasons for the high turnover. Exit interviews with departing staff were not always carried out. In the 6 months prior to our inspection 18 members of staff left the hospital and exit interviews were carried out with 9 of these individuals. The hospital manager told us that it was not possible to complete exit interviews with the other 9 staff members due to them leaving with immediate effect, being dismissed or moving to another Cygnet hospital.

Levels of sickness were low and managers supported staff who needed time off for ill health. An average of 4% of staff were absent due to sickness in the six months preceding our inspection. Staff told us they were able to take paid time off when they were unwell.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants for each shift. A staffing establishment tool was used to calculate the staff required for each ward.

The ward manager could usually adjust staffing levels according to the needs of the patients. At a morning management meeting which took place Monday to Friday, the ward managers for each ward reported the staffing needs and number of staff on shift to senior leaders and any shortfalls in staffing were discussed and action taken to address them. Ward managers were able to request additional staff if the acuity of the patients warranted this. We also heard from some ward-based staff that their experience was that the ward was not always staffed at a level sufficient to keep staff and patients safe and it was not always possible to increase staffing numbers in a timely manner when patients' needs changed. However, we saw no corroborating evidence to support these concerns in the staffing rotas we reviewed.

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

Requires Improvement

Patients did not always have regular one to one sessions with their named nurse. Some patients told us that they only got to spend one to one time with staff if they were receiving enhanced observations due to increasing risks.

Patients rarely had their escorted leave or activities cancelled, even when the service was short staffed. Most patients we spoke with said they had never had their leave or activities cancelled due to a lack of staff.

The service usually had enough staff on each shift to carry out any physical interventions safely. Most staff told us that the staffing numbers were sufficient to respond safely if a patient was aggressive or violent. Some staff on Bennu ward told us that the staffing at night was not sufficient to keep patients and staff safe from harm if there was an incident of violence. Several of the patients told us they did not feel safe on the wards and some of the patients we spoke with had recently been the victim of an assault by a peer. However, we saw no evidence from the rotas and other documents we reviewed to suggest these incidents were caused by inadequate staffing levels.

Staff shared key information to keep patients safe when handing over their care to others. Shift handovers took place twice a day during which key risks relating to each patient (including any incidents they had been involved in on the previous shift) were shared with the new staff team.

Medical staff

The service had enough daytime and night-time medical cover and a doctor available to go to the ward quickly in an emergency. Each ward had a dedicated consultant psychiatrist and a staff grade doctor. Patients told us that their ward rounds were not usually cancelled and took place weekly. Nursing and support staff, including night staff, told us that they could always access a doctor if they needed to.

Managers could call locums when they needed additional medical cover. However, this had not been necessary recently due to the high level of permanent medical staff in place at the hospital.

Mandatory training

Staff had completed and kept up-to-date with most of their mandatory training. Most staff told us that they were able to complete their training within working hours. The provider's training data showed that most e-learning modules were over 90% compliance across all staff groups. However, some modules were at lower rates of compliance, for example pharmacy e-learning at 67% for Bennu ward (although medication competency for nurses was 100% compliant) and ligature rescue training at 71% for Phoenix ward.

The mandatory training programme was comprehensive and met the needs of patients and staff. Staff told us that the mandatory training they received supported them in meeting patients' needs. The training data showed that staff received training on a range of areas relevant to the services being provided at the hospital.

Managers monitored mandatory training and alerted staff when they needed to update their training. Staff told us that they received reminders when their training modules needed to be refreshed.

Assessing and managing risk to patients and staff

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

Requires Improvement

Staff assessed and managed risks to patients and themselves well and followed best practice in anticipating, de-escalating and managing challenging behaviour. Staff used restraint and seclusion only after attempts at de-escalation had failed. The ward staff participated in the provider's restrictive interventions reduction programme.

Assessment of patient risk

Staff completed risk assessments for each patient on admission, using a recognised tool, and reviewed this regularly, including after any incident. All the patients on both wards had a risk assessment which had been completed on their admission to the hospital. We saw evidence that risk assessments were regularly reviewed, including after incidents involving the patient, to reflect any changing risks.

Management of patient risk

Staff knew about any risks to each patient and acted to prevent or reduce risks. Risks were reviewed at each shift handover and during multi-disciplinary team meetings which took place five times a week. All the staff we spoke with were aware of the key areas of risk relating to the patients on their ward. However, the action taken by staff to manage the risks posed by individual patients to others was not always effective in protecting people from harm.

Staff identified and responded to any changes in risks to, or posed by, patients. Changes in risk were highlighted to staff at handover and documented in reviews of the individual's risk assessment.

Staff could not observe patients in all areas of Bennu ward and did not always follow procedures to minimise risks where they could not easily observe patients. Patients on Bennu ward told us that staff were not always visible on the ward and they did not always feel safe. It was easier for staff to observe patients on Phoenix ward and patients on this ward did not raise concerns about staff visibility.

Staff did not always follow the provider's policies and procedures when they needed to search patients or their bedrooms to keep them safe from harm. There had been issues with drugs being smuggled on to both wards via takeaways on multiple occasions in the weeks preceding our inspection. Some of the patients we spoke with said they felt it was easy for people to smuggle restricted items on to the wards. However, we saw that the hospital had taken a robust response to this with increased security measures which resulted in attempts to smuggle drugs being intercepted by staff more frequently.

On Bennu ward a blanket restriction on hot drinks had been imposed due to one patient lacking decision making capacity around fluid intake. This meant all the patients had to request tea and coffee from the ward office which was leading to tensions on the ward. Staff and patients told us this restriction had led to incidents arising due to frustration on the part of patients not being able to make themselves a hot drink. Managers told us that the patients who did not have restricted fluids had tea and coffee in their bedrooms, however our observations did not support this being the case in practice. None of the patients on Bennu ward had a key to their bedroom. This had been identified through the provider's governance systems as a blanket restriction which was not justified on the basis of risk, however this had not been addressed in a timely manner.

Use of restrictive interventions

Levels of physical restraints were high on Bennu ward (185 restraints in the 12 months prior to our inspection, compared to 46 restraints for the same period on Phoenix ward). During this period there were also 41 prone restraints at the

hospital (across all three wards), primarily on to beds to either enable the administration of medication or to enable staff to exit seclusion safely rather than on the floor. We saw evidence that both concerns were identified through the provider's governance systems and assurance was gained that these increases were unavoidable responses to an increase in violent and aggressive behaviour by particular patients.

Staff participated in the provider's restrictive interventions reduction programme, which met best practice standards. Representatives from the hospital attended Cygnet's Positive and Safe Delivery Board meetings and fed back the learning from this to ward based staff.

Staff made every attempt to avoid using restraint by using de-escalation techniques and restrained patients only when these failed and when necessary to keep the patient or others safe. Patients told us that restraint did not frequently happen on the wards and most of them had never been personally restrained. Carers told us that their relative had never been restrained to their knowledge. Staff on both wards told us that restraint was only used as a last resort, when verbal de-escalation was not sufficient to keep people safe.

Staff understood the Mental Capacity Act definition of restraint and worked within it. There were informal patients on Phoenix ward at the time of our inspection. These patients and the staff caring for them were aware of their right to leave the ward and these patients confirmed they were not being inappropriately prevented from leaving the hospital.

Staff followed NICE guidance when using rapid tranquilisation. Records were kept in relation to all instances of rapid tranquillisation which included evidence of the patient receiving physical health monitoring and a medical review following the incident in line with the Mental Health Act code of practice.

In the 12 months preceding our inspection there had been 42 episodes of seclusion on Bennu ward and 3 on Phoenix ward (compared to 72 for Bennu and 14 for Phoenix in the 12 months preceding our previous inspection). When a patient was placed in seclusion, staff kept clear records and followed best practice guidelines. Seclusion reviews were carried out at the intervals required by the Mental Health Act Code of Practice and these were documented in a seclusion booklet which also included documentation of the patient's views. We identified two isolated occasions where the two hourly nursing reviews were late and one where the review was carried out by one nurse and one support worker, and staff had documented on the records on all three occasions that this non-compliance with the Mental Health Act code of practice was due to staffing pressures.

Staff followed best practice, including guidance in the Mental Health Act Code of Practice, if a patient was put in long-term segregation. A patient had been in long-term segregation in the months prior to our inspection but was no longer at the hospital when we inspected. We saw evidence that the Mental Health Act Code of Practice guidance on long-term segregation was followed in relation to this individual during the time they were separated from the main wards.

Safeguarding

S**taff 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, however this was not always effective in keeping people safe from physical and/or verbal abuse from other patients.**

Staff received training on how to recognise and report abuse, appropriate for their role. The staff we spoke with had all received level 3 safeguarding training within the past 12 months and were aware of how to report concerns. However, patients told us they did not always feel safe on the ward and they felt that action was not always taken by staff to respond to abuse, particularly verbal abuse.

Staff kept up-to-date with their safeguarding training. On Bennu ward 83% of staff were up to date with safeguarding training and on Phoenix ward 100% of staff were up to date.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. We did not see any evidence of patients experiencing discriminatory abuse at the hospital. Equality, diversity and inclusion training formed part of the mandatory training staff completed and over 90% of staff were up to date with this on both wards.

Staff knew how to recognise adults and children at risk of or suffering harm and worked with other agencies to protect them. The staff we spoke with were able to describe how they would identify and report safeguarding concerns.

Staff followed clear procedures to keep children visiting the ward safe. When children visited their relatives this took place away from the main ward and visits were supervised when this was justified because of risk.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. The staff we spoke with were familiar with their role in the reporting procedure and were able to describe how they would promptly escalate concerns, including out of hours.

Managers took part in serious case reviews and made changes based on the outcomes. We saw evidence of regular partnership working between the senior leaders at the hospital and the local safeguarding adults team.

Staff access to essential information

Staff had easy access to clinical information and it was easy for them to maintain high quality clinical records – whether paper-based or electronic.

Patient notes were comprehensive and all staff could access them easily. All patient records were electronic except for medication records. Staff could access the records for the patients they worked with via a secure online account.

When patients transferred to a new team, there were no delays in staff accessing their records. Records for all patients at the hospital were accessible by all staff who needed to view them.

Records were stored securely. Staff had individual accounts which were password protected and they could only access records for the patients they worked with. Temporary log in details could be set up quickly for agency staff and permissions could be changed if people worked on a different ward to usual. Medication cards were stored securely in the treatment room on each ward, which was kept locked when not in use.

Medicines management

The service used systems and processes to safely administer and record medicines. Staff regularly reviewed the effects of medications on each patient's mental and physical health. However medicines were not always safely prescribed or stored securely.

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

Requires Improvement

Staff did not always follow systems and processes to prescribe and administer medicines safely. We saw evidence that it was common practice on both wards for staff to request once only doses of medication to be authorised by email without the prescriber attending the ward. On two occasions the prescriber had not retrospectively signed to confirm the prescription, which should have been done within 72 hours in accordance with the provider's policy, but the medicine had been administered to the patient. Patients' own medicines were identified by handwritten stickers with the patients' initials on them rather than a printed label, which posed a potential risk that a patient could receive a medicine that was not prescribed to them if two patients on the ward had the same initials. Issues relating to the labelling of patients' own medicines had also been identified by recent medicines audits carried out by the hospital's pharmacy provider. One patient had been prescribed a medicine which he had not consented to and had not been authorised by a Second Opinion Appointed Doctor, which is not compliant with the requirements of the Mental Health Act.

Staff reviewed each patient's medicines regularly and provided advice to patients and carers about their medicines. Most of the patients we spoke with told us that they had received information about their medicines which they understood.

Staff completed medicines records accurately and kept them up-to-date. We reviewed all the medication charts on both wards and did not identify any errors other than those detailed above.

Staff did not store and manage all medicines safely. We found loose tablets of two different types on the floor of Phoenix ward clinic room. These were handed to staff and safely disposed of as soon as they were identified. Loose tablets in the medication trolley of Bennu ward had been identified in the September 2022 medication audit.

Staff followed national practice to check patients had the correct medicines when they were admitted or they moved between services. The records showed that people's medicines were reviewed as part of their admission assessment.

Staff learned from safety alerts and incidents to improve practice. In the months prior to our inspection the provider had identified an increase in medication errors on both wards and had carried out some improvement work to reduce the rate of incidents involving medication. We saw evidence of the implementation of this work during our inspection, for example posters displayed in both clinic rooms to remind staff of the additional procedures to follow when administering controlled drugs.

The service ensured people's behaviour was not controlled by excessive and inappropriate use of medicines. The use of 'as required' medicines was audited and most patients told us they had no concerns about their medicines.

Staff reviewed the effects of each patient's medicines on their physical health according to NICE guidance. Where people were prescribed high dose anti-psychotics they were receiving all the necessary physical healthcare checks.

Track record on safety

The service did not have a good track record on safety.

Several of the patients we spoke with told us that they had been physically assaulted by another patient during their admission. Five complaints were submitted by patients in relation to being verbally or physically abused by a peer in the 12 months preceding the inspection. In the 2022 patient survey 38% of respondents said they had not felt safe during their time in hospital (24% said that they sometimes felt safe and 38% reported that they always felt safe). In the August

2022 staff newsletter it was highlighted to staff that incidents of violence and aggression accounted for 68% of the reported incidents on Bennu ward. In the 12 months preceding the inspection we received 67 notifications relating to incidents of violence or aggression between patients on Bennu ward and 28 notifications of violence and aggression on Phoenix ward.

Reporting incidents and learning from when things go wrong

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. However, we identified repetition in the incident data, particularly relating to incidents of violence and aggression, which suggested that lessons learned from incidents were not always being fully addressed.

Staff knew what incidents to report and how to report them. All the staff we spoke with were aware of what should be reported as an incident and they were familiar with the incident reporting system.

Staff raised concerns and reported incidents and near misses in line with the provider's policy. We reviewed the provider's incident records and saw that staff on both wards were regularly reporting incidents.

The service had no never events on either ward.

Staff understood the duty of candour. They were open and transparent, and gave patients and families a full explanation if and when things went wrong. The patients and relatives we spoke with said they felt that staff were open and honest with them including if something had gone wrong.

Managers debriefed and supported staff after any serious incident. Staff who had been involved in serious incidents told us they had been well supported. However, at the time we inspected the psychology team was not contributing to post-incident de-briefs with patients, which would have been good practice. We did see evidence of reflective practice sessions being offered to staff on a referral basis by the psychology team.

Managers investigated incidents thoroughly. However, patients and their families were not always involved in these investigations. Some of the patients we spoke with had been involved in incidents and told us that they had not been offered a de-brief afterwards. Staff said de-briefs took place but separate records were not kept of these sessions so we were not able to see how often this was happening in practice or who was involved.

Staff received feedback from investigation of incidents, both internal and external to the service. Staff told us that they received information about lessons learned from serious incidents across the Cygnet group in a monthly email. We saw examples of these information sharing emails which did include information about lessons learned from incidents at other Cygnet hospitals.

Staff met to discuss the feedback and look at improvements to patient care. We reviewed minutes of team meetings which showed they were taking place regularly and learning from incidents was a standing agenda item. However, we saw limited evidence in the meeting minutes that trends in incidents involving individual patients were being identified and addressed.

There was evidence that changes had been made as a result of feedback. The provider maintained a lessons learned log which outlined the action taken in response to incidents which occurred at the hospital and elsewhere, for example

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Requires Improvement

improved security in relation to takeaway food coming on to the ward due to concerns about illicit substances being smuggled in and improvements to medication management as outlined above. We saw evidence during the inspection of these changes being embedded on the wards. However, we also saw that some patients were involved in repeated, similar incidents which suggested that lessons learned from incidents were not always used to inform individual care planning effectively.

Managers shared learning with their staff about never events that happened elsewhere. Serious incidents which occurred at other Cygnet hospitals and other comparable services were shared through the provider's governance systems.

Is the service effective?

Requires Improvement

Our rating of effective stayed the same. We rated it as requires improvement.

Assessment of needs and planning of care

Staff assessed the physical and mental health of all patients on admission. They developed individual care plans which were reviewed regularly through multidisciplinary discussion and updated as needed. Care plans reflected patients' assessed needs, however they were not always personalised, holistic and recovery-oriented.

Staff completed a comprehensive mental health assessment of each patient either on admission or soon after. Records on both wards showed that all patients had an assessment of their mental health as soon as possible following their admission.

Patients had their physical health assessed soon after admission and regularly reviewed during their time on the ward. All but one of the records showed that the individual had their physical health assessed as part of their admission assessment and we observed the multi-disciplinary team discussing patients' physical health at handovers and ward rounds.

Staff developed a comprehensive care plan for each patient that met their mental and physical health needs. Each patient had a documented plan of care which was reflective of their health needs.

Staff regularly reviewed and updated care plans when patients' needs changed. We saw evidence on the records that people's care plans were reviewed and updated, for example following incidents and as changes in their needs were identified.

Care plans were not sufficiently personalised, holistic and recovery-orientated. Care plans did not include details of the individual's social, occupational or cultural needs. Some patients told us that some aspects of their needs, for example spiritual needs or cultural dietary needs, were not always taken into account.

Best practice in treatment and care

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Requires Improvement

Staff did not provide a full range of treatment and care for patients based on national guidance and best practice. Staff used rating scales to assess and record severity and outcomes.

Staff did not provide a full range of care and treatment suitable for the patients in the service. Patients on Bennu and Phoenix wards told us that they were not receiving any psychological therapies or other input from psychologists. The lead psychologist was a locum and staff and patients on Bennu ward particularly said they did not have any input from the psychology team. We observed two multi-disciplinary team meetings on this ward which did not have any input from psychology or occupational therapy staff. The hospital manager told us that there hade been vacancies immediately prior to our inspection for occupational therapists and an assistant psychologist. They confirmed that an occupational therapist, a preceptor psychologist and two assistant psychologists started work at the hospital in the week of our inspection.

The wards followed the Cygnet hospital's acute and PICU model of care which was developed in line with national guidance. Updates to national guidance were fed back to the service through the provider's governance systems. However, as noted above due to the lack of psychology input to the patients' care pathway this was not being fully complied with in practice at the time of our inspection.

Staff identified patients' physical health needs and recorded them in their care plans. Patients had care plans in relation to specific physical health conditions, they had regular physical observations taken and these were reviewed daily by the multi-disciplinary team on both wards.

Staff made sure patients had access to physical health care, including specialists as required. We saw evidence on the records that patients received support in relation to their physical health both with routine appointments such as dental checks and urgent care where needed. Patients told us they felt well supported in relation to their physical health needs.

Staff met patients' dietary needs, and assessed those needing specialist care for nutrition and hydration. Menus included nutritious food options and patients at risk of harm relating to nutrition or hydration were being appropriately supported.

Staff did not help patients live healthier lives by supporting them to take part in programmes or giving advice. A new physical health nurse had been recruited but had not yet commenced in post at the time of our inspection. In the absence of this role there was no one at the hospital who was providing any formalised support to patients in relation to healthy living. We observed the patients on Bennu ward continually asking staff to escort them to the courtyard to smoke. Patients on this ward told us that they had not been offered any smoking cessation advice or nicotine replacement therapy. There was no information relating to healthy living displayed on either ward.

Patients on both wards told us that they were bored and there were not many activities for them to take part in. We observed a game of Monopoly taking place on Phoenix ward but other than this we did not see any activities taking place on either ward during our inspection.

Staff used recognised rating scales to assess and record the severity of patients' conditions and care and treatment outcomes. Both wards used the Global Assessment of Progress scores which are used across all Cygnet Hospitals. These were reviewed regularly and used to share information with commissioners about the progress of the patients they were funding.

Managers used results from audits to make improvements. Findings from audits were reviewed at the hospital's monthly governance meetings and the completion of action plans was monitored by the leadership team.

Skilled staff to deliver care

The ward teams had access to the full range of specialists required to meet the needs of patients on the wards, however the psychology team was not providing any input to the care of patients at the time of our inspection. Managers made sure they had staff with the range of skills needed to provide high quality care. They supported staff with supervision and opportunities to update and further develop their skills. Managers provided an induction programme for new staff. However, not all staff were receiving a regular appraisal.

The service had access to a full range of specialists to meet the needs of the patients on the ward. However, as noted above, patients on Bennu and Phoenix wards were not receiving meaningful input from the hospital's team of clinical and assistant psychologists at the time of our inspection.

Managers ensured staff had the right skills, qualifications and experience to meet the needs of the patients in their care, including bank and agency staff. Staff told us they were up to date with their mandatory training and the provider's training data showed this to be the case in relation to most courses.

Managers gave each new member of staff a full induction to the service before they started work. Staff told us they had undertaken an induction before working their first shift on the ward. Agency staff told us they had a ward-based induction the first time they worked at the hospital.

Managers did not always support staff through regular, constructive appraisals of their work. The provider's data showed that 56% of staff on Bennu ward and 59% of staff on Phoenix ward were up to date with their appraisals at the time of our inspection. Not all the staff we spoke with were up to date with their appraisal.

Managers supported non-medical staff through regular, constructive clinical supervision of their work. The provider's data showed that both nursing and support staff received clinical supervision and that 99% of staff on Bennu ward and 96% of staff on Phoenix ward were up to date with their supervision. Most of the staff we spoke with told us they had recently had supervision and they felt supported by this.

Managers supported medical staff through regular, constructive clinical supervision of their work. The provider's data showed that 100% of medical staff were up to date with their clinical supervision at the time we inspected.

Managers made sure staff attended regular team meetings or gave information from those who could not attend. Staff told us that they were able to attend team meetings and some staff who consistently worked nights told us that information from meetings was shared with them.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Staff told us that they felt well supported by the provider in relation to training and development. Managers made sure staff received any specialist training required for their role.

Managers recognised poor performance, could identify the reasons and dealt with these. The provider's records showed that appropriate action was taken in relation to staff performance and misconduct issues.

Multi-disciplinary and interagency team work

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Requires Improvement

Staff from different disciplines worked together as a team to benefit patients, although at the time we inspected we saw no evidence of the psychology team making a meaningful contribution to the multi-disciplinary team discussions. The ward teams had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation.

Staff held regular multi-disciplinary meetings to discuss patients and improve their care. A morning multi-disciplinary team meeting was held daily Monday to Friday on each ward at which each patient was reviewed. We observed three of these meetings which were attended by representatives of the full multi-disciplinary team, however on Bennu ward the psychology and occupational therapy representatives did not contribute to the discussions during the meetings we attended.

Staff made sure they shared clear information about patients and any changes in their care, including during handover meetings. Handover meetings took place at each shift change during which information was shared and recorded in relation to all patients on the ward.

Ward teams had effective working relationships with other teams in the organisation. We observed effective partnership working between teams across the hospital, with staff supporting the delivery of care on other wards where needed.

Ward teams had effective working relationships with external teams and organisations. We received feedback from commissioners who told us that staff on the wards involved them and shared information effectively. The independent advocate told us that they were well supported by staff on both wards.

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

Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice and usually discharged these well. Managers usually made sure that staff could explain patients' rights to them.

Staff received and kept up-to-date with training on the Mental Health Act and the Mental Health Act Code of Practice. The staff we spoke with told us they had received training on the Mental Health Act recently and were aware of the Code of Practice overarching principles, for example the principle of providing the least restrictive care possible. All staff on both wards were up to date with their Mental Health Act awareness e-learning at the time we inspected.

Staff had access to support and advice on implementing the Mental Health Act and its Code of Practice. The hospital had a full time Mental Health Act administrator who ward staff said was accessible if they needed advice or support.

The service had clear, accessible, relevant and up-to-date policies and procedures that reflected all relevant legislation and the Mental Health Act Code of Practice. Staff were able to access these from the ward via the hospital's intranet.

Patients had easy access to information about independent mental health advocacy and patients who lacked capacity were automatically referred to the service. An Independent Mental Health Advocate attended the hospital two days a week and was on the wards during our inspection. Several of the patients we spoke with told us that they did not know who the advocate was and had never used the advocacy service, however the advocate told us how she ensured she was accessible to all patients as needed.

Staff usually explained to each patient their rights under the Mental Health Act in a way that they could understand, repeated as necessary and recorded it clearly in the patient's notes each time. Records demonstrated that patients were

being reminded of their rights at the intervals required by the Mental Health Act. However, one patient told us that they were not able to understand their rights because staff went through the information too quickly for them. Not all the patients had English as a first language and some of these patients told us that they were not being provided with an interpreter to support them in understanding their rights under the Mental Health Act, which they would have found helpful. However, the hospital manager told us that interpreters are frequently booked for patients who require them due to language needs. We also saw evidence that staff can download leaflets in 24 languages on the Mental Health Act if patients need written information in their first language.

Staff made sure patients could take section 17 leave (permission to leave the hospital) when this was agreed with the Responsible Clinician and/or with the Ministry of Justice. Patients told us that they were usually able to take their section 17 leave, including when they needed a staff escort to facilitate this.

Staff requested an opinion from a Second Opinion Appointed Doctor (SOAD) when they needed to.

Staff stored copies of patients' detention papers and associated records correctly and staff could access them when needed.

Informal patients knew that they could leave the ward freely and the service displayed posters to tell them this. Informal patients told us that they were aware of their rights and that they were not subjected to inappropriate restrictions on the ward.

Care plans included information about after-care services available for those patients who qualified for it under section 117 of the Mental Health Act. We saw that after-care was discussed in ward rounds when patients were nearing discharge.

Managers and staff made sure the service applied the Mental Health Act correctly by completing audits and discussing the findings. Mental Health Act compliance was audited and monitored at the hospital's monthly clinical governance meetings. However, we identified some occasions where the Mental Health Act code of practice was not being followed, for example in relation to seclusion monitoring, which had not been identified and addressed through the provider's systems.

Good practice in applying the Mental Capacity Act

Staff supported patients to make decisions on their care for themselves. They understood the trust policy on the Mental Capacity Act 2005 and assessed and recorded capacity clearly for patients who might have impaired mental capacity.

Staff received and kept up-to-date with training in the Mental Capacity Act and had a good understanding of at least the five principles. The staff we spoke with told us they had received training on the Mental Capacity Act within the last 12 months and demonstrated an understanding of the key principles to consider when assessing an individual's decision-making capacity. On both wards there were patients who had been assessed as lacking capacity in relation to making certain decisions. The staff were aware of who these people were and the reason for the restrictions being in place. All staff on both wards were up to date with their Mental Capacity Act and deprivation of liberty safeguards training.

There were no patients at the hospital at the time we inspected who had a deprivation of liberty safeguard in place in relation to their care.

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Requires Improvement

There was a clear policy on Mental Capacity Act and deprivation of liberty safeguards, which staff could describe and knew how to access. These policies were also available to ward staff via the hospital's intranet.

Staff knew where to get accurate advice on the Mental Capacity Act and deprivation of liberty safeguards. The Mental Health Act administrator was also available to staff in relation to any queries they had about the Mental Capacity Act.

Staff gave patients all possible support to make specific decisions for themselves before deciding a patient did not have the capacity to do so. We saw evidence in the records of how patients were supported to make informed decisions about their care where this was needed.

Staff assessed and recorded capacity to consent clearly each time a patient needed to make an important decision. Records showed that capacity assessments and best interests decision making were appropriately documented.

When staff assessed patients as not having capacity, they made decisions in the best interest of patients and considered the patient's wishes, feelings, culture and history.

The service monitored how well it followed the Mental Capacity Act and acted when they needed to make changes to improve. Compliance with the Mental Capacity Act was audited and monitored through the provider's monthly governance meetings.

Is the service caring?

Requires Improvement

Our rating of caring went down. We rated it as requires improvement.

Kindness, privacy, dignity, respect, compassion and support

Staff treated patients with compassion and kindness. They respected patients' privacy and dignity. However, staff did not always provide care which met individual the needs of patients.

Staff were discreet, respectful, and responsive when caring for patients. When patients were being observed due to risks to self or others it was identified whether it was possible to allow them bedroom and bathroom privacy and we observed staff respecting this where relevant.

Staff did not always give patients help, emotional support and advice when they needed it. Patients on both wards told us that staff were often not available if they needed support. Patients said staff were too busy to spend time with them if they were not on enhanced observations.

Staff supported patients to understand and manage their own care treatment or condition. Patients told us that they had been given information about their diagnosis by the doctor.

Staff directed patients to other services and supported them to access those services if they needed help. We saw evidence of partnership working with other services, for example substance misuse services, when patients were nearing discharge. Where patients had physical healthcare needs they were supported to access appropriate services in a timely manner.

Patients said staff treated them well and behaved kindly. The patients we spoke with said that staff were usually friendly and respectful towards them.

Staff usually understood and respected the individual needs of each patient. All the staff we spoke with told us that they were aware of the individual needs of the patients on their ward. The patients we spoke with said that staff treated them as an individual. However, some patients with protected characteristics said that not all their individual needs were respected.

Staff felt that they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards patients. All the staff we spoke with said they would feel comfortable raising concerns and they knew the procedure for doing this.

Staff did not always follow policy to keep patient information confidential. We observed a member of staff discussing a patient's care plan with them in a communal lounge in front of other patients on Bennu ward. Some patients told us that they had been given a paper copy of their care plan but they did not have anywhere secure in their bedroom to store items. The hospital manager told us that all patients should have locked drawers in their bedrooms but a number of these had been broken at the time of our inspection. They confirmed that a plan was in place to install safes in each patient's bedroom to replace the drawers and we were informed following the inspection that these were fitted on 19 September 2022. Patients did not have keys to their bedrooms on either ward and bedroom doors were often left open. However, we did not identify any concerns in relation to how the service handled patients' electronic records.

Involvement in care

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.

Involvement of patients

Staff introduced patients to the ward and the services as part of their admission. Patients received a written booklet on admission including a summary of key information relating to their ward.

Staff involved patients and gave them access to their care planning and risk assessments. Patients told us that they had been involved in their assessments and in developing their care plans. We observed a member of staff discussing a care plan with a patient on the ward. The care plans included notes of the patient's comments verbatim at each care plan review. However, the records did not indicate whether patients had been offered a copy of their care plan and some patients told us they had not been offered a copy.

Patients whose first language was English told us that staff had explained their care and treatment to them in a way they could understand. However, some patients who did not speak English as their first language told us that they struggled to understand some of the information staff gave them and said they had not been offered an interpreter.

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Requires Improvement

Staff involved patients in decisions about the service, when appropriate. Community meetings were taking place on both wards. Patients told us they were able to attend the meetings and share their views, for example about activities they would like to do on the ward.

Patients could give feedback on the service and their treatment and staff supported them to do this. Community meetings were regularly held on both wards and the provider carried out an annual survey to seek more formal feedback from patients.

Staff supported patients to make advanced decisions on their care. Patients told us they had received support from staff in making advanced decisions about how they wished to be cared for if their mental health deteriorated.

Staff made sure patients could access advocacy services. An Independent Mental Health Advocate (IMHA) attended the hospital two days a week and visited every ward. Most of the patients we spoke with, particularly on Bennu ward, told us that they had never spoken to the advocate and they were not aware that this service was available to them. However, we saw that efforts were made by the advocate and staff to make the service accessible to all patients.

Involvement of families and carers

Staff did not always inform and involve families and carers appropriately.

Staff did not always support, inform or involve families or carers. Most of the relatives we spoke with said they had not been involved in care planning for their relative. Some relatives told us it was difficult to get information from staff about how their relative was doing and it was difficult to visit due to the hospital being far from their home.

Staff did not help families to give feedback on the service. None of the relatives we spoke with said they had been given the opportunity to give feedback on the service.

Staff did not give carers information on how to find the carer's assessment. Most of the relatives we spoke with said that no one at the hospital had discussed this with them.

Is the service responsive?

Requires Improvement

Our rating of responsive stayed the same. We rated it as requires improvement.

Access and discharge

Staff managed beds well. A bed was available when a patient needed one. Patients were not moved between wards except for their benefit. However, sometimes patients had to stay in hospital when they were well enough to leave because there was no suitable service for them to move on to.

Bed management

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Requires Improvement

Managers regularly reviewed length of stay for patients to try and ensure they did not stay longer than they needed to. Each patient's length of stay was clearly highlighted on their care records and was discussed in multi-disciplinary team meetings and ward rounds. We identified some patients on both wards who were ready to move on from the service but this had been delayed due to the non-availability of a suitable bed elsewhere. However, we saw evidence that the provider's staff were proactively following up these alternative placements and doing what they could to facilitate patients' discharge from the hospital.

The service had mostly out-of-area placements. All the beds on Phoenix ward and most of the beds on Bennu ward were commissioned by an out-of-area NHS trust and most of the patients originated from outside the West Yorkshire area. Relatives told us this made it difficult to visit their family member regularly. Patients told us that they were able to keep in regular contact with their relatives through phone and video calls and staff facilitated home visits for patients when this had been risk assessed as safe.

Managers and staff worked to make sure they did not discharge patients before they were ready.

When patients went on leave there was always a bed available when they returned.

Patients were moved between wards only when there were clear clinical reasons or it was in the best interest of the patient. We saw no evidence of patients being moved between wards at the hospital for inappropriate reasons.

Staff did not move or discharge patients at night or very early in the morning. The staff we spoke with told us that when patients left the ward this happened during daytime hours unless there were unavoidable reasons for a transfer or discharge to happen at other times.

Discharge and transfers of care

Managers monitored the number of patients whose discharge was delayed, knew which wards had the most delays, and took action to reduce them. We saw evidence that delayed discharges were kept under regular review by the senior management team through the provider's governance meetings.

Patients did not have to stay in hospital when they were well enough to leave. We did not identify any patients who had been assessed as ready for unsupported discharge to the community who remained at the hospital at the time of our inspection.

Staff carefully planned patients' discharge and worked with care managers and coordinators to make sure this went well. We observed effective partnership working with the commissioners of patients' care and their community mental health teams where appropriate during the ward rounds we attended. Patients had discharge care plans on their records which were being regularly reviewed and updated.

Staff supported patients when they were referred or transferred between services. Where it had been identified that a patient's needs would be better met at another service this was discussed with them during ward rounds.

Facilities that promote comfort, dignity and privacy

The design, layout, and furnishings of the ward supported patients' treatment, privacy and dignity. Each patient had their own bedroom with an en-suite bathroom. There were quiet areas for privacy. The food was of good quality. However, patients could not always make hot drinks and snacks.

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Requires Improvement

Each patient had their own bedroom, which they could personalise. However, patients on both wards did not have keys to their own rooms. The provider had identified that this was a blanket restriction that was not justified on the basis of risk, however timely action had not been taken to address this.

Patients did not always have a secure place to store personal possessions on Bennu ward. Staff told us that some patients did not have secure storage facilities in their room and patients did not have keys to their own rooms. We observed multiple patient bedrooms with the doors open during our time on the ward.

Staff did not use a full range of rooms and equipment to support treatment and care. The clinic rooms on both wards did not have an examination couch. Staff told us that if a patient needed physical healthcare which required them to be lying down this would be carried out in their bedroom, including dressing a wound.

The service had quiet areas and a room where patients could meet with visitors in private. Relatives told us that the facilities for visiting their relative were of a good standard.

Patients could make phone calls in private. Patients had access to their own mobile phones unless it had been specifically risk assessed that this was not safe.

The service had an outside space, however patients on Bennu ward could not access this easily as they could only do so when escorted by staff as the ward was on an upper floor. Some patients complained about the small size of the covered walkway where they could go for a cigarette, which represented the majority of the time most patients on Bennu ward were able to leave the ward. Some of the patients on Bennu ward told us they needed more access to fresh air.

Patients could not always make their own hot drinks and snacks. On Bennu ward the tea, coffee and hot chocolate were kept in the locked nursing office and patients had to specifically request this if they wanted a hot drink. Staff told us this was to keep one patient safe due to fluid restrictions. The patients we spoke with on this ward expressed their frustration about this arrangement.

The service offered a variety of good quality food. We saw menus which included a variety of nutritious meal choices. Patients and relatives mostly told us the food was of a good standard and they had a good choice of options. However, some patients who needed Halal meals told us that they were not confident that these were always provided. The provider's menus had options marked "H" for Halal options on some days but not others (although vegetarian options were always available). Following the inspection the provider clarified that all meat with the exception of pork at the hospital is Halal to allow more choice for people eating Halal meals. They also shared their butcher's Halal certificates to evidence this.

Patients' engagement with the wider community

Staff supported patients with activities outside the service, such as work, education and family relationships.

Staff made sure patients had access to opportunities for education and work. We saw evidence that patients on Phoenix ward were being supported to access opportunities as part of their discharge pathway. Patients on this ward told us that they were happy with the level of community access they had.

Staff helped patients to stay in contact with families and carers. Relatives told us that they were able to speak to their family member regularly.

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Requires Improvement

Staff encouraged patients to develop and maintain relationships both in the service and the wider community. Patients told us that they were able to keep in contact with friends and family as much as they wanted to.

Meeting the needs of all people who use the service

The service did not always meet the needs of all patients, particularly those with a protected characteristic. Staff helped patients with advocacy but not always with communication and cultural and spiritual support.

The service did not always support and make adjustments for those with communication needs or other specific needs. Patients whose first language was not English told us that they were not able to always understand the information staff shared with them about their care and their rights under the Mental Health Act and they had not been offered an interpreter.

Staff made sure patients could access information on treatment, local services, their rights and how to complain. Information was displayed on the wards, however this was not always kept up to date.

The service did not have information leaflets available in languages spoken by the patients and local community. Patients whose first language was not English did not have access to written information in their first language.

The service did not always provide food to meet the dietary and cultural needs of individual patients. Some patients told us that they had not been able to access food to meet their cultural and religious needs at the hospital. However, we did see evidence that a variety of food was usually available for patients to meet a range of dietary preferences and cultural needs.

Patients did not always have sufficient access to spiritual, religious and cultural support. Some patients told us that they had not been able to access spiritual support during their admission and that they had not been supported in relation to their religious observance on the wards. The hospital had a multi-faith room but some patients on Bennu and Phoenix wards said they were not being supported to access this. There were also some religious resources available for patients on the wards.

Listening to and learning from concerns and complaints

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team and wider service.

Patients, relatives and carers knew how to complain or raise concerns. Patients and relatives told us that they had been given information on how to make a complaint about the hospital. We saw that there was information about the hospital's complaints process in the written information provided to patients on both wards. There had been 74 formal complaints and 10 informal complaints in the 12 months preceding our inspection (across all three wards). Of the 82 formal complaints, 34 were partially upheld, 5 were fully upheld, 30 were not upheld, 3 were withdrawn and 2 were still under investigation. All the informal complaints had been resolved to the patient's satisfaction.

The service clearly displayed information about how to raise a concern in patient areas. There was information about the complaints process on the noticeboards on both wards.

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Requires Improvement

Staff understood the policy on complaints and knew how to handle them. The staff we spoke with were aware of how to support a patient who wished to complain about their care and described how they would support a patient who wished to complain.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint. The patients we spoke with who had raised concerns about their care confirmed that they had received a response to this.

Managers investigated complaints and identified themes. The senior management team monitored complaints through the provider's regular governance meetings and this included the identification of themes of concern.

Staff protected patients who raised concerns or complaints from discrimination and harassment. We saw no evidence of patients experiencing discrimination as a result of having complained about their care.

Managers shared feedback from complaints with staff and learning was used to improve the service. Lessons learned from complaints were discussed in staff meetings.

The service used compliments to learn, celebrate success and improve the quality of care. The provider kept a log of compliments received and these were shared in staff meetings.

Is the service well-led?

Requires Improvement

Our rating of well-led stayed the same. We rated it as requires improvement.

Leadership

Leaders had the skills, knowledge and experience to perform their roles. They had a good understanding of the services they managed and were visible in the service and approachable for patients and staff.

The hospital had a registered manager in post at the time of our inspection although they were on long term leave. The provider had correctly notified us of this and there was an interim manager in post who was appropriately skilled and qualified. The senior management team had a good understanding of the services being provided across the hospital and were a visible presence on the wards.

Vision and strategy

Staff knew and understood the provider's vision and values and how they applied to the work of their team.

The staff we spoke with were aware of Cygnet's values of integrity, trust, empowerment, respect and caring. They were able to describe how they implemented these in their day to day work with patients, for example supporting people to be as independent as possible and developing a trusting rapport with the patients they worked with.

Culture

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

Requires Improvement

Staff said the provider promoted equality and diversity in daily work and provided opportunities for development and career progression. They could raise any concerns without fear. However, not all staff felt respected, supported and valued.

Some staff told us that they did not feel well supported at work. Staff described a challenging working environment where incidents of violence and aggression on the ward were commonplace and some staff said they did not always feel sufficiently supported in relation to this. Some staff said that the senior managers were not accessible and they did not think the management team understood what it was like on the wards. However, most of the staff we spoke with told us that they felt well supported by their colleagues on the ward and they said there was an open culture at the hospital where concerns could be raised in a blame-free environment.

In the provider's 2022 staff survey 58% of respondents either disagreed or strongly disagreed with the statement "there are enough staff at the hospital to enable me to do my job properly", a 6% increase in negative responses from the 2021 survey. Also 49% of respondents stated they had felt unwell in the past 12 months with work related stress, an increase of 11% from the 2021 survey. Of the 46 free text comments about what staff would change about their job, 13 commented about lack of support from senior management and 10 commented about staffing pressures.

Governance

Our findings from the other key questions did not always demonstrate that governance processes operated effectively at team level and that performance and risk were managed well.

We saw that there were governance processes in place including a range of audits, environmental checks and reporting processes for incidents, complaints, compliments and whistleblowing concerns. A morning managers' meeting took place Monday to Friday at which key information was reviewed including staffing information and incidents occurring on each ward. Regular governance meetings were taking place at which information from the governance processes was reviewed. However, the issues we identified during the inspection across multiple areas of the service were not always being identified by these quality monitoring systems.

Management of risk, issues and performance

Teams had access to the information they needed to provide safe and effective care but did not always use that information to good effect.

The clinical risks for each patient were detailed in comprehensive risk assessments and discussed at handover and multi-disciplinary meetings. We saw evidence that records were audited to ensure their accuracy and the outcomes of audits were reviewed at the provider's governance meetings. However, some of the governance meeting minutes showed a lack of consideration of potential trends in incidents involving patients for example violence and aggression and self-harm and the incident records showed that some patients were involved in repeated similar incidents.

The hospital had a risk register which included a range of key clinical and organisational risks relating to the service. This was kept under regular review and updated as required, with action being taken to mitigate the identified risks.

The provider informed us during the inspection of incidents which had met the threshold for notification to the Care Quality Commission but which had not been notified to us as required. This was due to the unexpected absence of ward managers and the notifications were subsequently submitted following the inspection.

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

Requires Improvement

Information management

Staff collected and analysed data about outcomes and performance, however we saw no evidence they were engaged actively in local or national quality improvement activities.

Data about outcomes was monitored using the Cygnet wide Global Assessment of Progress score and this was regularly reviewed in the hospital's governance meetings.

Engagement

Managers engaged actively with other local health and social care providers to ensure that an integrated health and care system was commissioned and provided to meet the needs of the local population.

We received mostly positive feedback from the representatives of commissioners we spoke with in relation to how the management and clinical teams engaged with them. We saw positive engagement with commissioners at the ward round we observed.

Learning, continuous improvement and innovation

The service had been recognised at Cygnet's north region Positive and Safe Delivery Board as an example of good practice in relation to the 'grab and go' books they had developed for agency staff working with people on enhanced observations. An example of these was shared with us and they included relevant information including activities the individual enjoys which may distract them if they become distressed.

We identified a shortfall in how lessons learned from incidents involving individual patients were monitored to ensure changes were made to reduce the likelihood of recurrence. This meant that people were involved in repeated similar incidents which put them at risk of harm.

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 18 HSCA (RA) Regulations 2014 Staffing **Acute wards for adults of working age and psychiatric intensive care units:** The service must ensure that all staff receive regular clinical and managerial supervision and appraisals. (Regulation 18(1)) The service must ensure that all staff receive regularly updated training to fully support them in their roles. (Regulation 18(1)) **Long stay or rehabilitation mental health wards for working age adults** The service must ensure that all staff receive regularly updated training to fully support them in their roles, including training in autism in accordance with nationally recognised best practice, prior to working on the ward. (Regulation 18(1))

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents **Acute wards for adults of working age and psychiatric intensive care units** The service must ensure that incidents are reported to CQC in a timely manner in accordance with the requirements of the Care Quality Commission (Registration) Regulations 2009. (Regulation 18 Notification of other incidents) **Long stay or rehabilitation mental health wards for working age adults**

This section is primarily information for the provider

Requirement notices

The service must ensure that incidents are reported to CQC in a timely manner in accordance with the requirements of the Care Quality Commission (Registration) Regulations 2009. (Regulation 18 Notification of other incidents)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care **Acute wards for adults of working age and psychiatric intensive care units:** The service must ensure that patients have access to the full range of specialists to meet their needs in accordance with the model of care for the service they are receiving. (Regulation 9(3)(b)) The service must ensure that patients are regularly and consistently supported to undertake regular meaningful activities. (Regulation 9(3)(b)) The service must ensure that patients receive advice and support in relation to leading a healthy lifestyle. (Regulation 9(3)(b)) **Long stay or rehabilitation mental health wards for working age adults:** The service must ensure that discharge plans have meaningful action plans and that any lack of progress is evaluated and action is taken to address this. (Regulation 9(3)(b))

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect **Acute wards for adults of working age and psychiatric intensive care units:**

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
	The service must ensure that blanket restrictions are only imposed on the wards where these are justified on the basis of risk, are kept under regular review and are removed as soon as possible. (Regulation 10(2)(b) The service must ensure that people have their spiritual and cultural needs assessed on admission, kept under regular review and receive support to ensure these needs are met during their admission as far as possible. (Regulation 10(2)(c))
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 **Acute wards for adults of working age and psychiatric intensive care units:** The service must ensure that patients who pose a risk to others are supported so that other patients on the ward and staff are protected from physical assault as far as possible. (Regulation 12(2)(b)) The service must ensure that the care environment is free from avoidable hazards including ligature and infection prevention and control risks. (Regulation 12(2)(d)) The service must ensure that environmental risk assessments are carried out prior to seclusion including seclusion in bedrooms if required in an emergency situation. (Regulation 12(2)(d)) The service must ensure that staff can access emergency equipment promptly. (Regulation 12(2)(d)) The service must ensure that medicines are stored safely. (Regulation 12(2)(g)) The service must ensure that medicines required on a once only basis are lawfully prescribed prior to administration. (Regulation 12(2)(g)) **Long stay or rehabilitation mental health wards for working age adults:**

This section is primarily information for the provider

Requirement notices

The service must ensure that patients who pose a risk to others are supported so that other patients on the ward and staff are protected from physical assault as far as possible. (Regulation 12(2)(b))

The service must ensure that environmental risk assessments are carried out prior to seclusion including seclusion in bedrooms if required in an emergency situation. (Regulation 12(2)(d))

The service must ensure medicines required on a once only basis are lawfully prescribed prior to administration. (Regulation 12(2)(g))

The service must ensure that medical checks are carried out in accordance with national guidance when patients receive medication for rapid tranquillisation. (Regulation 12(2)(g))

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 **Acute wards for adults of working age and psychiatric intensive care units:** The service must ensure that monitoring systems relating to activities taking place on the wards, the management of medicines including consent to treatment, the care environment and the ward based support available to patients are improved to ensure that issues are identified and addressed in a timely manner. (Regulation 17(1)) **Long stay or rehabilitation mental health wards for working age adults:** The service must ensure that trend analysis is included in its governance systems to ensure incidents are monitored more closely and any underlying themes are highlighted and addressed. (Regulation 17(1))