Cygnet Hospital Beckton

Quality Report

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This report describes our judgement of the quality of care at this location. It is based on a combination of what we found when we inspected and a review of all information available to CQC including information given to us from patients, the public and other organisations

Ratings

Overall rating for this location	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive?	Good
Are services well-led?	Good

Mental Health Act responsibilities and Mental Capacity Act and Deprivation of Liberty Safeguards

We include our assessment of the provider's compliance with the Mental Capacity Act and, where relevant, Mental Health Act in our overall inspection of the service.

We do not give a rating for Mental Capacity Act or Mental Health Act, however we do use our findings to determine the overall rating for the service.

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

Summary of findings

Overall summary

We rated this service as good because:

- During this most recent inspection, we found that the services had addressed the issues that had caused us to rate safe and effective as requires improvement following the July 2015 inspection.
- Following the last inspection in July 2015, we also made a number of recommendations for the service to consider improving. At this inspection we found that these improvements had been made.
- The hospital provided good care in challenging and complex circumstances. Staff sought to minimise incidents of self-harm, aggression, violence and other challenging behaviour in a caring and supportive way.
- Staff consistently responded to patients with care and compassion. They said that morale within their teams was good and that they felt supported by their managers.
- Staff knew which patient safety incidents to report and how to report them. Senior managers monitored incidents through the clinical governance process. Through this monitoring, managers looked for trends and ways to reduce the number of incidents.
- The service had introduced a programme to reduce restrictive practices. As a result, patients had unrestricted access to dining rooms, activity areas and quiet rooms. Patients were also now able to make hot drinks whenever they wished.
- Senior managers demonstrated a strong culture of seeking improvements to the service.
- Staff assessed risks to patients using standard risk assessment tools. Staff updated risk assessments during patients' admission, either at regular multidisciplinary team meetings or after incidents.
- The services used evidence-based therapies to work with patients across the wards.
- Cygnet Health Care had appointed an Expert by Experience Lead. At this hospital, they had established meetings to promote the views of patients across and facilitating further service user involvement.
- The hospital had achieved national quality accreditation for the psychiatric intensive care unit, the forensic ward and the ward for people with learning disabilities.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Acute wards for adults of working age and psychiatric intensive care units	Good 	We gave an overall rating of good because: • Staff supported patients' recovery from acute episodes of mental illness. The ward also facilitated creative and recreational therapeutic activities to support patients' personal development. Staff worked hard to provide a safe environment by ensuring patient observation levels were appropriate to assessed risks. Changes were made on the ward based on lessons learned from previous incidents. • At the last inspection in July 2015, we issued requirement notices for the service to minimise risks from ligature anchor points and blind spots. We also issued other requirement notices. These related to secluding patients in the de-escalation room and inconsistent recording of restraint. There had also been a lack of physical health checks after staff had administered rapid tranquilisation and an inconsistent response to safeguarding concerns. During this inspection, we found that the service had dealt with those concerns. • Patients were positive about the care and treatment they received from staff. Patients said they felt safe on the ward. Patients were involved in decisions about their care and treatment and they all received a copy of their care plan. Care plans we reviewed were person-centred and mostly written in the patients' voice. • Staff reported the ward presented a challenging environment, but morale on the ward was good and had improved since our previous inspection. • The ward is a member of the national association of psychiatric intensive care and low secure units (NAPICU).

Summary of findings

Forensic inpatient/ secure wards

Good

We gave an overall rating of good because:

- The ward proactively supported patients with complex mental health needs. The service provided medicine and psychological therapies, including using motivational interview techniques to support patients achieve positive changes. The service facilitated creative and recreational therapeutic activities to support patients' personal development. The service also supported patients to address substance misuse needs.
- Staff worked hard to provide a safe environment. Comprehensive risk assessments specifically for patients with a forensic history were completed and updated. Staff were trained to identify 'relapse signatures' that could be a sign of a deterioration in the patient's health and increased risks.
- At the last inspection in July 2015, we issued a notice requiring the service to take action to safely identify and assess ligature points. During this inspection, we found that the service had dealt with this concern.
- Patients said that the ward was clean and that staff were kind, friendly and caring. We observed positive, caring interactions between staff and patients during the day of our inspection. Patients were fully involved in planning and decision making through care planning with their primary nurse and attending the weekly ward round. Patients were involved in making decisions about leave. Patients were given choices about which groups to attend and were able to negotiate the times that suited them.
- There was a good level of morale and staff supported colleagues within the team.
- Bewick Ward was a member of the Quality Network for Forensic Low Secure Services. It had achieved the 'Star Ward' status following an independent review of therapeutic activities offered.

Summary of findings

Wards for people with learning disabilities or autism

Good

We gave an overall rating of good because:

- The service demonstrated care and commitment in supporting patients with complex mental health needs with their recovery. The service provided psychological therapies, including an adapted dialectical behavioural therapy for people with a learning disability, trauma therapy and mindfulness groups. The service also facilitated creative and recreational therapeutic activities to support patients' personal development. Staff worked hard to provide a safe environment by ensuring observations levels were appropriate to assessed risks and by making changes to the ward based on lessons learned from incidents.
- At the last inspection in July 2015, we issued a requirement notice for the service to take action to ensure there was a clear plan to address the risks presented by ligature anchor points. We also issued a requirement notice for the service to ensure staff administered all medicines appropriately within prescribed guidance. During this inspection, we found that the service had dealt with all those concerns.
- Staff designed the service to meet the specific needs of people with learning disabilities. Care plans produced in an easy-read format. Each patient had a 'communication passport' with details of the best ways to communicate with them. Each patient also had a personal positive behaviour support plan.
- Staff interacted with patients in a caring and compassionate way. They responded to people in distress in a calm and respectful manner. Staff appeared interested and engaged in providing good quality care to patients. Patients spoke positively about staff and said they were kind, respectful and supportive.
- All staff we spoke to said morale was high on the ward and that it was a good place to work. Staff reported they sometimes worked under pressure due to the challenging group

of patients. However, they felt well supported by their team and the rest of the organisation. Staff also participated in monthly reflective practice groups. Team meetings took place every month.

- In November 2016, the Quality Network for Inpatient Learning Disability Services awarded Hansa Ward accreditation for inpatient learning disability mental health services.

Tier 3 personality disorder services

We do not rate specialist personality disorder services:

- The ward supported patients with diagnoses of personality disorder in their recovery with the aim of patients sustaining less restrictive placements in community settings. The ward provided medicine and psychological therapies, with a focus on dialectical behavioural therapy (DBT). Nurses were trained in DBT to ensure that day-to-day engagement and support was consistent with the therapeutic process. The service also facilitated creative and recreational activities to support patients' personal development.
- Staff worked hard to provide a safe environment by ensuring observations levels were appropriate to assessed risks and by making changes to the ward based on lessons learned from incidents.
- At the last inspection in July 2015, we issued three requirement notices for improvements to this service. One notice was for the service to take action to ensure there was clear plan to address the risks presented by ligature anchor points. Another notice was for the service to ensure there was sufficient emergency equipment was on the ward. A further notice was for the service to ensure that staff had specialist training in working with people with personality disorders. During this inspection, we found that the service had dealt with all those concerns and this had improved.

Summary of findings

- Staff displayed a positive and caring attitude toward patients. Patients found the DBT programme helpful. Patients gave very positive feedback about the occupational therapy team.
- Although the ward could be a challenging environment to work in, morale amongst staff was good. Staff were supported in their work.

Summary of findings

Contents

Good

Cygnet Hospital Beckton

Services we looked at

acute wards for adults of working age and psychiatric intensive care units; forensic inpatient/secure wards; Wards for people with learning disability or autism; Tier 3 personality disorder services.

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Background to Cygnet Hospital Beckton

Cygnet Hospital Beckton is one of 19 locations operated by Cygnet Health Care, an independent provider of mental health and social care services. Cygnet Hospital Beckton provides services for women with complex mental health needs.

There are four wards at Cygnet Hospital Beckton:

New Dawn Ward is an 18 bed personality disorder ward offering dialectic behaviour therapy (DBT) interventions in a locked environment.

Bewick Ward, is a 15 bed low-secure unit for complex care and recovery

Hooper ward is a 15 bed psychiatric intensive care unit (PICU)

Hansa ward is a 13 bed locked learning disability ward that provides care and treatment to detained and informal patients.

Cygnet Hospital Beckton is registered to provide assessment or medical treatment for persons detained under the Mental Health Act 1983 and treatment of disease, disorder or injury.

There was a registered manager in place.

We have inspected the provider five times previously, most recently in July 2015

Our inspection team

The team that inspected the service comprised CQC inspectors, an assistant inspector and an inspection manager. The team also included five specialist advisors. Four specialist advisors had a professional background in mental health nursing. One specialist advisor was a pharmacist.

Why we carried out this inspection

We undertook this inspection to find out whether the Cygnet Hospital Beckton had made improvements to its services since our last comprehensive inspection in July 2015. At that inspection, we rated the hospital as requiring improvement overall.

At the last inspection in July 2015, we rated the forensic patient/secure ward as good. We rated the psychiatric intensive care ward, ward for people with learning disabilities and autism and the ward for people with personality disorders as requiring improvement.

Following the July 2015 inspection, we told the provider it must take the following actions to improve its services:

- The provider must ensure that sufficient emergency medical equipment is available on New Dawn ward, so that patients can receive prompt emergency medical treatment whether located on New Dawn 1 or New Dawn 2.
- The provider must ensure that all ligature anchor points are clearly identified in the ligature risk assessment. Where works to address potential ligature anchor points are required, a date for the completion of these works must be identified. The provider must also ensure that where there are blind spots on the ward (for example Hooper) appropriate steps are taken to address these.
- The provider must ensure that where patients are prevented from leaving de-escalation rooms this is recognised as a period of seclusion and that the appropriate safeguards for patients nursed in seclusion, as outlined in the Mental Health Act Code of Practice are followed.
- The provider must ensure that where patients are administered rapid tranquilisation they receive appropriate health checks afterwards.
- The provider must ensure that where patients are restrained, these incidents are appropriately recorded,

Summary of this inspection

including the hold, the staff involved and the length of time that the restraint hold was maintained. The provider must ensure that it uses available data to identify any trends or themes in the use of restraint.
- The provider must ensure that all staff are trained to recognise safeguarding concerns and that appropriate actions are taken to address safeguarding concerns.
- The provider must ensure that all medicines are administered appropriately and within the prescribed guidelines. The provider must ensure that maximum doses of medication over 24 hour periods are not exceeded and that as required medicines are not used as night time sedation.
- The provider must ensure that all relevant pre-admission assessment information is available to staff and included in the initial risk assessment along with the measures to manage and mitigate these risks.
- The provider must ensure that on specialist wards such as New Dawn, nursing staff and health care support workers receive specialist training in DBT and CBT approaches to better understand patients' needs and support the delivery of the therapeutic programme.

We also told the provider that it should consider taking the following action:

- The provider should ensure that consistency of care is provided on New Dawn 1 and New Dawn 2 ward by monitoring the deployment of bank staff over the unit.
- The provider should ensure all care plans are holistic and contain patients' views on their care and treatment.
- The provider should ensure that staff understand how to apply the MCA to their role and that robust systems are in place to monitor the use of the MCA.
- The provider should ensure that patients are able to access drinks and snacks on all wards without having to ask staff to open the dining room for them.
- The provider should ensure that all staff follow the provider's confidentiality policy and procedure and do not discuss sensitive patient information in communal areas of the ward.
- The provider should ensure that staff do not talk to patients through a closed door when they based in the nursing office.
- The provider should ensure that learning from complaints is shared with all staff.
- The provider should ensure that following incidents of self-harm a doctor reviews the patient.
- The provider should ensure that robust systems are in place to share learning from incidents and complaints between staff and across wards.

We issued the provider with requirement notices at the previous inspection. These related to the following regulations under the Health and Social Care Act (Regulated Activities) 2014.

Regulation 12 Safe care and treatment

Regulation 13 Safeguarding service users from abuse and improper treatment

Regulation 17 Good governance

Regulation 18 Staffing

How we carried out this inspection

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

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

Before the inspection visit, we reviewed information that we held about the location.

During the inspection visit, the inspection team:

- visited all four wards at the hospital, looked at the quality of the ward environment and observed how staff were caring for patients;
- spoke with 17 patients who were using the service;
- spoke with the managers or acting managers for each of the wards;
- spoke with 29 other staff members; including doctors, nurses, occupational therapist, psychologist and social worker;

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- spoke with the hospital manager, clinical services manager, safeguarding lead, regional lead for reducing restrictive practices and the expert by experience lead for Cygnet Health Care
- spoke with an independent advocate;
- spoke with the commissioner for two of the wards;
- spoke with the local authority safeguarding team;
- attended and observed three multi-disciplinary meetings;
- collected feedback from 28 patients using comment cards;
- looked at 16 care and treatment records of patients;
- carried out a specific check of the medication management on all four wards; and

looked at a range of policies, procedures and other documents relating to the running of the service

What people who use the service say

Across the four wards, patients' views of staff were positive. Most patients said that staff were caring and listened to them. Negative comments referred to specific incidents or specific members of staff.

Patients on New Dawn Ward found the dialectical behavioural therapy (DBT) programme helpful. There was very positive feedback about the occupational therapy team who one patient described as excellent, providing fun and interesting activities. The negative comments focussed on specific incidents such as when staff asked a patient to wait for their medication.

Patients on Hansa Ward said staff were kind, respectful and supportive. Patients knew who their named nurse were and enjoyed positive relationships with them.

On Bewick Ward, patients said they valued the support they received from staff to help them visit their families. Some patients also said the hospital was better than other services they had been to.

On Hooper Ward, patients were positive about the care and treatment provided by staff. Patients said staff were attentive and respected their wishes and requests.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Good

We rated safe as **good** because

- In July 2015, sufficient emergency equipment was not available on New Dawn Ward. At this inspection, we found this had improved. Emergency resuscitation bags were stored in both clinic rooms on New Dawn Ward. Staff checked these bags each day.
- In July 2015, ligature anchor points were not clearly identified in the ligature risk assessment along with measures to manage or mitigate these risks. At this inspection, we found this had improved. The service had installed anti-ligature bathroom fittings where necessary. Staff recorded a list of remaining ligature anchor points in an environmental audit.
- In July 2015, medicines were not being administered appropriately and within prescribed guidance. We found that a patient had received medicines exceeding the prescribed dose. At this inspection, we found this had improved.
- In July 2015, when staff administered rapid tranquilisation patients were not receiving appropriate health checks afterwards. At this inspection, we found this had improved. Records showed that staff recorded physical health checks after administering rapid tranquilisation.
- In July 2015, the pre-admission patient information was not available to staff including the initial risk assessment along with measures to manage and mitigate these risks. At this inspection, we found this had improved.
- In July 2015, not all staff followed the safeguards for patients set out in the Mental Health Act Code of Practice when patients were been secluded in their rooms. At this inspection, we found this had improved.
- In July 2015, not all staff were able to recognise safeguarding concerns and take appropriate actions to address these. At this inspection, we found this had improved. We found that all staff had received training in safeguarding and safeguarding concerns were escalated appropriately.
- At the last inspection, we recommended that staff deployment on New Dawn 1 and New Dawn 2 be monitored to ensure consistency of care. At this inspection we founds this had improved.
- The hospital had embarked on a project to reduce restrictive practices. The service assigned a nurse on each ward as the lead for reducing restrictive practice. This is had led to specific

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improvements and reduction of blanket restrictions. The service took a proactive approach to reducing incidents. Staff were encouraged to understand patients risks and triggers. Staff used recognised evidence based tools to monitor this.
- The wards were sufficiently staffed and the turnover of staff was low.

However,
- Compliance with mandatory training on awareness of cardiopulmonary resuscitation and automated external defibrillators was only 73%.

Are services effective?

Good

We rated effective as **good** because:

- In July 2015, staff on New Dawn ward were not receiving specialist training to meet patient needs and provide therapeutic interventions. At this inspection, we found that staff had received specific training to deliver a specialist service to patients on the ward.
- At the last inspection, we recommended care plans should be holistic and contain patient views. At this inspection, we found this had improved.
- At the last inspection, we recommended staff should understand how to apply the Mental Capacity Act (MCA) and that robust systems were in place to monitor the use of the MCA. At this inspection, we found that staff had a good understand of the MCA.
- At the last inspection, we recommended doctors should review patients following an episode of self-harm. At this inspection, we found this had improved.
- Medical and nursing staff assessed patient's physical and mental health on admission. Patients' care plans were comprehensive, personal to individual patients, and up to date.
- Patients had access to a range of psychological therapies including dialectical behaviour therapy (DBT), cognitive behaviour therapy (CBT), and the SPELL framework (structure, empathy, low arousal and link). Nursing staff worked closely with a psychologist to ensure that care and emotional support was consistent with the therapeutic programme.
- Staff received supervision every month and an appraisal once a year and had access to facilitated reflection practice sessions.
- Staff had completed mandatory training on the Mental Health Act and the Mental Capacity Act and we saw evidence of staff understanding how to implement this training and knowledge.

However,

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- Care plans did not include arrangements for aftercare under section 117 of the Mental Health Act 1983 where it was an identified need.

Are services caring?

Good

We rated caring as **good** because:

- At the last inspection, we recommended staff maintain patient confidentiality and not discuss patient information in communal areas. At this inspection, we found this had improved.
- At the last inspection, we recommended staff do not talk to patients through a closed door when in the nursing office. At this inspection, we found this had improved.
- Staff interacted with patients in a caring and compassionate way. Patients spoke positively about staff and said they were kind, respectful and supportive.
- Patients were fully involved in planning and decision making through care planning with their primary nurse and attending the weekly ward round.
- The service displayed a 'You said, we did' board showing how changes had been made as a result of patient feedback. The service also displayed information about its performance on a notice board for patients and visitors.
- Cygnet Health Care had recently appointed an expert by experience lead to facilitate the involvement of patients in developing services. The expert by experience lead regularly attended the hospital to support patients across all four wards. They ensured the service was meaningfully developing a strategy to involve service users in service delivery.

However,

- Patients told us that they had been upset or concerned when they felt staff had not responded quickly and effectively to some incidents.

Are services responsive?

Good

We rated responsive as **good** because:

- At the last inspection we recommended that patients have access to drinks and snacks on all wards without asking staff for assistance. At this inspection we found this had improved.
- Patients had the opportunity to personalise their bedrooms and many chose to do so in bright and creative styles.
- The hospital provided an extensive programme of activities throughout the week. An area on the ground floor of the

Summary of this inspection

hospital had been designated as the recovery college. This offered courses on personal development, skills development and health living. Patients were very positive about the groups and activities available.
- Complaints were dealt with in a timely manner and thorough investigations had taken place. The service provided evidence of changes that had been made as a result of complaints.

However,

- Not all of the responses to complaints included information about how to contact the parliamentary health service ombudsman.

Are services well-led?

Good

We rated well-led as **good** because:

- In July 2015, incidents were not appropriately and comprehensively recorded following restraint of patients. At this inspection, we found the provider was recording incidents of restraint appropriately and accurately.
- In July 2015, data on the use of restraint was not used to identify trends or themes in the use of restraint to improve the quality of the service. At this inspection, we found this had improved. Governance systems were used to monitor use of restraint.
- At the last inspection, we recommended systems be put in place to share learning from incidents and complaints between staff across the wards. At this inspection we found this had improved. The hospital circulated a daily report to all senior nurses with details of incidents from all ward. Staff discussed these incidents in team meetings and reflective practice.
- At the last inspection, we recommended learning from complaints was shared with all staff. At this inspection we found this had improved.

Detailed findings from this inspection

Mental Health Act responsibilities

Almost all patients at the hospital were detained under the Mental Health Act 1983.

Across the hospital, 84% of staff had completed mandatory training on the Mental Health Act (MHA) and the MHA Code of Practice.

The service attached consent and authorisation certificates to patients' medicines charts. Staff spoke to detained patients about the provisions of the MHA they were detained under and about the effect of these provisions. These discussions included details of the patient's right to apply to the Mental Health Review Tribunal. Staff recorded these discussions. Staff told us they carried out these discussions once a month and we saw that these were documented

Statutory documents relating to the MHA were stored securely in the MHA office. The MHA administrator reviewed consent to treatment and capacity forms as part of a regular MHA audit.

Mental Capacity Act and Deprivation of Liberty Safeguards

Across the hospital, 81% of staff had completed mandatory training on the Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS). Staff we spoke with had a good understanding of the MCA.

A doctor and nurse assessed each patient's capacity to consent to admission and treatment when patients were admitted. Staff updated these assessments when it was appropriate. Staff recorded assessments of patients' capacity to consent to treatment and stored these in the patient's records.

One patient was subject to a DoLS authorisation. A comprehensive DoLS application had been completed, was in date and had a best interests assessment attached.

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Acute wards for adults of working age and psychiatric intensive care units	Good	Good	Good	Good	Good	Good
Forensic inpatient/ secure wards	Good	Good	Good	Good	Good	Good
Wards for people with learning disabilities or autism	Good	Good	Good	Good	Good	Good
Tier 3 personality disorder services	N/A	N/A	N/A	N/A	N/A	N/A
Overall	Good	Good	Good	Good	Good	Good

Notes

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

Good

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

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

Good

Safe and clean environment

- At the last inspection in July 2015, staff could not readily observe all areas of the ward and would need to leave the nursing office to view corridors. At this inspection, we found that the service had mitigated the blind spots by installing mirrors. Staff assessed patients throughout their stay to ensure an appropriate and safe level of observation. CCTV was used similarly in the communal areas of each ward to improve safety. Staff could access recordings when needed. For example, staff used recordings during investigations of incidents and complaints. Patients were aware that CCTV was in use. Patients had signed a form to confirm they were aware that CCTV recordings were being made.
- In July 2015, we found that the risks from potential ligature anchor points had not been addressed. At this inspection, we found that a ligature risk assessment had taken place in August 2016. This had identified potential areas of risk. Work was due to start in March 2017 to address some of the remaining ligature anchor points. On each shift, the ward manager designated a member of staff as being responsible for security. The purpose of the role was to continually view areas of the ward that were not readily observable. Staff were aware of the areas that presented a higher risk to patients. A member of staff walked around the ward every hour to check the environment was safe. The service carried out an environmental risk assessment each week.
- The clinic room was clean, tidy and well equipped. The room was small and did not have an examination couch. As a result, physical health checks took place in patient's bedrooms to maintain privacy and dignity. The room was equipped with emergency equipment including a defibrillator. Staff checked emergency equipment each day. Staff had access to ligature cutters and knew where to locate them. Staff had completed checks of emergency equipment and emergency medicines. Medicine fridge and room temperatures were checked daily.
- The ward did not contain a seclusion room but did have a de-escalation room. At our previous inspection in July 2015, we identified that staff restrained and detained patients in the de-escalation room. During this inspection, we reviewed patients' care records, incident records, restraint records and spoke with both staff and patients on their experiences of de-escalation. Staff had a good understanding of seclusion and we found that staff were not secluding people without the proper checks in place.
- Arrangements for infection control were the same across all four wards. The hospital conducted an infection control audit each month. An infection control programme for 2017 included plans to ensure that every ward appointed a nurse as infection control champion, to develop guidelines for early notification of potential outbreaks of infections and to continue to develop the

infection control audit programme. Guidance and information about handwashing was displayed for staff and visitors to follow. Staff used appropriate personal protective equipment such as gloves when needed.

- The ward was clean, well maintained and moderately furnished. The décor consisted of a blend of both newer and older furniture.
- Information about environmental risks was the same for all services at the hospital. There service carried out a number of environmental checks. For example, there were monthly checks of drain covers and water guttering. The hospital carried out weekly checks of oxygen, water softeners and smoke and heat detectors. Records for the control of substances hazardous to health (COSHH) showed that staff had carried out risk assessments for each substance stored on the premises. Records showed that the service checked the fire alarm system twice each year. The service checked emergency lighting, fire extinguishers and fire blankets once a year. All these records were up to date.
- Information about alarms and nurse call systems also applies to all services at the hospital. The service issued personal alarms to all staff. Staff checked their alarms when they received them at the start of each shift. The hospital carried out additional checks each month to ensure that the system indicating where a member of staff activated an alarm showed the correct location. There were no alarms in patients' bedrooms.

Safe staffing

- Staffing levels on the ward were appropriate. The ward had an establishment level of 12.6 whole-time equivalent (WTE) qualified nurses and 26.9 WTE health care assistants.
- At the time of our inspection, there were two vacancies for qualified nurses and two for health care assistants. The ward manager had access to a pool of additional bank staff to cover additional shifts for extra observation, sickness or leave. Hooper ward had the highest use of bank staff at the hospital but no shifts on the ward went unfilled. In the last 12 months, bank or agency staff filled 394 shifts to cover sickness, absence or vacancies. Twenty-one (5%) of these shifts were filled by agency staff.
- The provider estimated levels of staff required for each day shift depending upon occupancy levels and acuity of the ward. At night, the service provided two nurses and three health care assistants. The ward manager was able to adjust staffing levels to meet the requirements of patients' needs, for example, patients who required one to one observations.
- Staff rarely cancelled patient's leave. Patients said that meetings with named nurses happened regularly. Staff did not raise any concerns about the number of staff available to carry out physical interventions such as restraint safely, if required.
- The ward had a doctor on the ward during the week from 9 am to 5 pm. An on-call doctor was available outside these hours.
- Information about mandatory training also applies to all the services at the hospital. The service provided 23 mandatory training courses for staff in clinical or therapeutic roles. These courses included prevention and management of violence and aggression, health and safety, safeguarding and fire safety. Nurses were required to complete a further five courses on the management of medicines. Nurses' compliance with mandatory training across the hospital was above 95%. Compliance for all clinical staff was above 90%. However, compliance with training on awareness of cardiopulmonary resuscitation and automated external defibrillators was only 73%.

Assessing and managing risk to patients and staff

- The ward used restrictive practices such as restraint as a last resort. The ward did not place patients in seclusion and did not have a seclusion room. Between 1 May 2016 and the end of November 2016, there were 49 incidents of restraint. Of the incidents of restraint, 12 required the use of prone restraint with nine resulting in rapid tranquilisation. The hospital had an ongoing least restrictive practice project taking place across all wards. The project included carrying out surveys in relation to staff understanding of least restrictive practice, discussions of restraint in staff meetings and additional training in the prevention and management of violence and breakaway techniques. There was also service user input into training sessions. At our last inspection in July 2015, we found that staff did not appropriately record incidents of restraint. At this inspection, we reviewed the ward's records of incidents of restraint. We found that staff had completed records of restraint appropriately and comprehensively. A factor of the least restrictive

practice project was to improve recording of restraints and we saw that this was happening in practice. The hospital audited records of restraint on a regular basis and implemented actions to reduce the use of restraint.

- Staff used the short-term assessment of risk and treatability (START) tool to assess potential risks. Staff undertook a risk assessment of all patients on admission. We reviewed five patient records and saw that risk assessments were comprehensive, up to date and specific to each individual patient. For example, one risk assessment gave examples of incidents a patient had been involved in. This risk assessment specified that female staff should always provide care during restraint. Patients had restraint care plans when they were necessary. This included details of the patients preferred methods of de-escalation. These plans demonstrated that patients were involved in risk assessments and care planning, and that their needs and preferences were taken into account.
- The hospital had introduced a programme of promoting least restrictive practice across all four core services. This followed analysis carried out by the clinical services manager that showed most incidents began by staff say 'no' to patients. This led to initiatives such as ensuring facilities were available to patients whenever they needed them. An example of this was the installation of equipment for patients to make hot drinks whenever they wanted to. The ward had designated a nurse and patient as the least restrictive practice leads. Following the introduction of these initiatives, the number of incidents of restraint on most wards had declined.
- Staff had a good understanding of the provider's observation policy. We reviewed observation records on the wards. Staff had completed these comprehensively.
- The ward only accepted patients detained under the Mental Health Act (MHA). Staff searched patients returning from community leave in accordance with the hospitals policy and procedure.
- In July 2015, we found that patients were not receiving appropriate physical health checks after being administered rapid tranquilisation. At this inspection, we observed that staff recorded physical health checks after administering rapid tranquilisation.
- In July 2015, staff did not recognise all safeguarding concerns or take the appropriate action to follow these up. At this inspection, we found that staff had received training in adults and child safeguarding and were able to give us examples of safeguarding alerts they had raised. For example, a patient had made an allegation against a staff member. A safeguarding care plan had been put in to place to ensure the patient's safety. The hospital had a safeguarding lead and staff were aware of how to contact them.
- Staff provided patients with information about their medicines. Pharmacist and ward staff discussed medication with patients during ward rounds and reviews. Pharmacists visited the wards regularly.
- The ward stored medicines securely. Staff recorded the temperatures for the medicines fridge and clinical room in which medicines were stored. This meant that medicines were stored at the correct temperature and would remain effective.. The ward doctor checked patients' medication on admission and the pharmacist ensured reconciliation of medication.
- The provider had a policy and procedure in place for children to visit the ward. Visits from children only took place after a multidisciplinary discussion had determined that the visits were in the child's best interest. There were rooms in the hospital to accommodate visits.

Track record on safety

- Between 7 November 2015 and October 29 2016, Hooper ward reported 16 serious incidents requiring investigation. The majority related to disclosures of historic abuse that had taken place before the patient had been admitted to the hospital. Some alleged abuse concerned assaults by staff during restraint. The service thoroughly investigated these incidents. Investigations included a review of CCTV footage. None of these allegations had been upheld.

Reporting incidents and learning from when things go wrong

- Staff knew how to report an incident and demonstrated a good understanding of what constituted an incident. The ward manager reviewed incident reports to identify themes and trends. This meant that there was a robust framework for learning from incidents to be embedded.
- Staff gave examples of incidents that had occurred on the wards and changes in response to these. For

example, a patient had concealed a lighter and taken it on the ward. The ward had made changes in procedural security and conducted additional searches. Metal detectors were used on the ward as a result of this.

- The approach taken to learning from incidents was similar across all wards. The clinical services manager carried out analysis of all incidents. This included looking at the circumstances leading up the incident, the staff involved, the time of day and the type of intervention used. Some individual members of staff were identified as being involved in a high number of incidents. Ward managers supported these staff to reflect on their practice and consider other ways of responding to situations. Senior staff reviewed all serious incidents in the monthly clinical governance meetings. The minutes of these meetings included details of the lessons learned from each incident. Standing items at team meetings in the ward included lessons learned from serious incidents, feedback from clinical governance meetings and risk assessments. Staff confirmed that they discussed incidents team meetings, including incidents that had occurred on other wards. Incidents were also discussed individual supervision and reflective practice sessions.
- Staff and patients were given the opportunity to debrief after incidents occurred. This was recorded in incident reports.

Duty of candour

- Duty of candour is a legal requirement, which means providers must be open and transparent with clients about their care and treatment. This includes a duty to be honest with clients when something goes wrong. The incident records we reviewed demonstrated that staff were open and transparent with patients when incidents took place

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

(for example, treatment is effective)

Good

Assessment of needs and planning of care

- We reviewed five patient records including progress notes and care plans. Staff had completed timely and comprehensive nursing and medical assessments. The assessments were holistic, individualised and included information relating to areas such as mental health, physical health, social context, family and recovery.
- The provider separated care plans into specific domains, for example, “stopping my problem behaviours” and “Recovery”. Staff worked collaboratively with patients to review warning signs and triggers for distressed behaviour. This meant staff based patient care plans on best practice guidelines from the National Institute of Health and Care Excellence (NICE). The care plans we reviewed demonstrated patient involvement and were in the patient’s own voice.
- Staff documented patients’ physical health needs in a separate care plan. The ward doctor completed a physical health assessment for all patients on admission. Regular monitoring of patients’ physical health took place. For example, we saw that for one patient who had high blood pressure, staff developed a care plan to manage this.
- Patients’ information was stored securely and staff were able to access patient records when they needed.

Best practice in treatment and care

- Staff followed NICE guidance when prescribing medication. A pharmacist visited the ward once a week to provide advice and support to staff and patients. The pharmacist also undertook audits to ensure that medication was being administered correctly.
- Patients had access to psychological therapies. The ward had a psychologist and assistant psychologist who conducted weekly drop-ins and ran groups that patients could attend as a part of their recovery programme. The psychologists also conducted groups for patients from all the wards. These groups helped to integrate therapeutic involvement across the hospital and to ensure that patients had greater opportunities for a broad range of input.
- The ward had a full time doctor who provided routine healthcare to patients. Out-of-hours an on-call doctor was available. Doctors reviewed patients after episodes of self-harm.

- Staff used the Health of the Nation Outcome Scales (HoNOS) to assess and record severity outcomes.
- Staff participated in clinical audits of record keeping, restraints, rapid tranquilisation and medication.

Skilled staff to deliver care

- The ward had access to a multi-disciplinary team including doctors, nurses, occupational therapists, psychologists, activities co-ordinators and a social worker.
- New staff received an induction over a period of six weeks. Staff were supernumerary for their first week to allow time for them to work closely alongside experienced members of staff. Staff induction also included training on the organisation's policies.
- The provider supported and encouraged staff to undertake specialist training. Staff gave examples of undertaking dialectical behavioural therapy training, motivational interviewing and positive behavioural support training.
- Staff received regular clinical and managerial supervision. From January 2016 to the end of December 2016, 96% of staff had received supervision on a monthly basis. The provider monitored supervision rates and had a target of 80% for all staff to be supervised monthly. The majority of staff had undertaken an annual appraisal with a completion rate of 81% recorded in December 2016. This meant that staff on the ward were receiving regular supervision and had access to annual appraisals which focussed on professional development and learning needs.
- Staff met on a monthly basis for team meetings. Team meetings gave staff the opportunity to discuss issues specific to the ward such as complaints, incidents, referrals and feedback. Staff also had access to regular facilitated reflective practice sessions.
- Managers addressed poor staff performance through supervision and, where necessary performance management. Managers also received support from senior managers when addressing any issues relating to sickness or conduct.

Multi-disciplinary and inter-agency team work

- The nursing staff had three handovers for each shift and the multi-disciplinary team attended the morning handovers. Staff used handovers to update each other on incidents that had occurred as well as patients' general wellbeing. Staff also attended monthly team meetings and reflective practice sessions.
- The ward accepted admissions from across the country. Staff had good relationships with external organisations including commissioning groups and NHS trusts they accepted patients from. The ward manager was confident in contacting different organisations regarding bed management and discharging patients.
- Staff liaised with patients general practitioners (GPs) on a regular basis. Staff knew how to contact patients' care co-ordinators and invited them to ward reviews and care programme approach meetings. Ward staff ensured meetings were followed up with information especially if care coordinators had not been present.
- The provider attended regular meetings with the local safeguarding lead in the local authority. A police liaison officer also gave staff advice and support when patients went absent without leave.

Adherence to the MHA and the MHA Code of Practice

- Across the hospital, 84% of staff had completed mandatory training on the Mental Health Act (MHA) and the MHA Code of Practice.
- MHA documentation was stored in paper files. There were records of leave arrangements, relevant capacity assessments and detention paperwork. The ward had attached consent and authorisation certificates to patients' medicine charts.
- Most patients told us that staff had made them aware of their rights. Staff recorded the occasions when they explained patients' rights in care plans.
- The ward displayed information about independent mental health advocates (IMHA) who attended the ward on a weekly basis.
- The hospital conducted regular audits of the MHA to ensure staff applied it appropriately. Relevant information following these audits was fed back on a ward level during meetings and during supervision where appropriate.

Good practice in applying the MCA

- Mental Capacity Act training was mandatory for staff. At the time of our inspection, 81% of staff had completed this training. In July 2015, staff were unable to describe the five statutory principles of the MCA and could not tell us how they would implement the MCA while

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

Good

providing care and treatment for patients. At this inspection, staff had a good understanding of the MCA and its principles. We saw evidence of this in the records where a member of staff had reassessed a patient's capacity when it fluctuated.

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

Good

Kindness, dignity, respect and support

- We spoke with four patients on the ward as well as receiving feedback from four comment cards. We observed staff delivering care in a kind, respectful and supportive manner. We observed many interactions between staff and patients that demonstrated both the staff skills and their abilities to adapt to situations through communication.
- Patients were positive about the care and treatment they received from staff and felt the ward was safe. Patients told us that staff were attentive and respected their wishes and requests.

The involvement of people in the care they receive

- Staff had developed a welcome pack for patients to receive upon admission. The welcome pack included basic information for new patients to orientate themselves to the ward, for example, mealtimes and the days that ward rounds took place. Occupational therapists completed an assessment of patients on admission, which helped with planning activities.
- Patients said they felt involved in their care and treatment and had received copies of their care plans. Care plans were person-centred and mostly written in the patients' voice. Staff held regular ward round and reviews. Patients we spoke with said they were able to participate in discussions about their care and treatment.
- Patients had regular access to advocacy. An advocate visited the ward once a week and the ward displayed information about advocacy services available to them.
- Staff invited families and carers to ward rounds and reviews. Families and carers were involved in patients' care and treatment.
- Staff and patients held weekly community meetings. Patients used the meetings to raise concerns and give feedback about the ward. The ward had a "you said, we did" noticeboard that showed the changes the service had made to address issues raised by patients. For example, after patients requested pet therapy, the hospital provided a therapy dog that visited the ward on a regular basis.
- Each ward held community meetings each week. A more formal user council for the whole hospital was held once a month. Cygnet hospitals had recently appointed an expert by experience lead to facilitate user involvement across the organisation. Patients were familiar the expert by experience. The expert by experience lead had supported patients to raise a number of concerns with the managers.
- The hospital conducted a patient satisfaction survey once each year. Through this survey, the hospital asks patients for their views on the environment, care and treatment, therapies and information and rights. Between October and December 2016, the hospital received 47 responses. Overall, 70% of respondents gave positive answers to questions about care and treatment. This score was 62% for the environment, 55% for therapies and 70% for information and rights. The service received six compliments during in the 12 months prior to November 2016.

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

Good

Access and discharge

- The ward accepted referrals from across the UK. The ward achieved its target time of one hour from referral to initial assessment. This involved triage assessment of

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

Good

the patient carried out over the telephone. The service also achieved its target of one day from assessment to treatment. At the time of the inspection, the average length of stay on the ward was 49 days.

- From 1 June 2016 to 30 November 2016 the average occupancy level was 96%.
- In the six months from October 2016 to March 2017, five patients' discharges were delayed due to non-clinical reasons. Patients' discharge from the ward was sometimes delayed due to difficulties in arranging ongoing care for patients.

The facilities promote recovery, comfort, dignity and confidentiality

- The ward had adequate facilities for patients which were welcoming and comfortable. This included a communal lounge, dining room/kitchen, quiet room and therapy room. Clinic rooms did not contain a treatment couch and patients did not access to the clinic room. Where patients required physical health checks or monitoring, staff carried these out in patient bedrooms which maintained privacy and dignity.
- Patients had unrestricted access to a secure garden. The garden area was large, open and did not feel like a confined space.
- Patients were able to use mobile phones supplied by the ward which did not have access to cameras, to make personal phone calls in private.
- Patients had access to hot drinks and snacks at all times in the dining room.
- Patients reported the food was of good quality.
- Patients had access to different activities every day. Timetables for activities were displayed on the ward and included pampering, bingo and movie nights. However, some patients reported there were fewer activities at weekends and this could cause them to be bored.

Meeting the needs of all people who use the service

- The ward was located on the ground floor and accessible for patients who required disabled access. There were pictures on doors to communicate information, for example a picture of a shower to indicate it was the shower room.
- The ward did not display information leaflets in other languages. At the time of inspection, all patients' first language was English. The manager could request leaflets in other languages from the provider if needed. Staff could also book interpreting services if required.
- The service provided information on patients' rights, local services and how to make a complaint.
- Patients had access to appropriate spiritual support. Patients said they were aware of this spiritual support and a chaplain visited the ward each week.

Listening to and learning from concerns and complaints

- From April 2016 to March 2017 there had been 40 complaints about the hospital overall. There had been 14 complaints about nursing staff and eight complaints about the quality of care. Some of these complaints had not been upheld or contained allegations that could not be substantiated. The service monitored themes of complaints. The most prominent theme was complaints about staff and their relationship with patients. When complaints were upheld, the service took action to address the concerns raised and supported staff with training if required. The ward provided patients with information on how to make a complaint. All patients we spoke with were aware of this procedure and felt comfortable making a complaint.
- The ward had received eight complaints in the last 12 months. Two of these were partially upheld and one was fully upheld. Patients and relatives had complained about injuries sustained during restraint and delays in arranging leave.
- Staff were aware of the complaints procedure, and were able to describe the process to follow if patients wished to make a complaint.

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

Good

Vision and values

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

Good

- Staff were aware of the organisation's values of empathy, caring, respect and honesty. We observed staff displaying these values in their work.
- Staff told us well supported by their line manager. Staff knew the senior managers within the service. The hospital manager frequently visited the ward and met with staff and patients at least once a month.

Good governance

- In July 2015, we found the provider did not use available restraint data to identify trends or themes in the use of restraint. At this inspection, we found that staff on the ward completed incident reports comprehensively which were reviewed by managers. Information relating to the times that incidents took place was also analysed so that the service management could determine areas of strength and weakness. For example, managers analysed the data and found that particular members of staff had higher levels of incidents. Managers then used this information to understand whether this was due to better recording or different practices and provide support if needed.
- The hospital manager, the clinical services manager, the general manager and the medical director were responsible for leadership and governance at the hospital. The heads of occupational therapy, social work and psychology attend monthly clinical governance meetings, along with the senior managers and ward managers. Clinical governance meetings included a review of complaints, serious incident reports, restraints, risk registers and service user engagement. In addition, there were monthly meetings of the audit committee and the heads of departments.
- The ward manager had sufficient authority and support to fulfil their role.
- The ward manager had access to a dashboard of data that monitored key performance indicators including mandatory training, supervision, appraisals and staffing levels. The ward manager discussed these with staff in team meetings and the clinical service manager met ward managers to discuss areas of concerns and actions.
- The ward manager attended several meetings including clinical governance meetings, contract review meetings and ward manager meetings.
- In July 2015, we found that there were insufficiently robust systems to share learning from incidents and complaints across hospital wards. At this inspection, we found that the hospital promoted sharing information and learning from other wards. The hospital sent a daily report to managers. This contained information about incidents, safeguarding concerns and alerts and admissions for all the wards. Staff discussed all complaints and incidents at team meetings and in reflective practice sessions.
- Staff at all levels, had the opportunity to lead certain aspects in the service. For example, the service assigned a nurse to the role of least restrictive practice champion to work alongside a patient who the service also designated to this role. The service also assigned another nurse to the role of Mental Health Act champion.
- Staff members could raise concerns with the ward manager regarding risk on the ward. Ward managers would escalate this to clinical service director who would make the decision on whether to add to the hospital risk register.

Leadership, morale and staff engagement

- The staff survey for the whole hospital in 2016 received responses from 132 employees. The overall level of positive responses within the survey was 81%. Within the overall scores, 90% of respondents said that patients were the hospital's top priory and 80% said they enjoyed working for Cygnet. Negative scores reflected the high number of incidents. For example, 42% of respondents said they had personally experienced bullying, harassment or abuse from patients. The service had introduced an action plan to address these concerns. This included introducing the 'safe wards' programme, reducing conflict through minimising blanket restrictions and settings target to reduce incidents of violence and aggression by 50%.
- Staff were positive about the ward manager on Hooper ward. Staff were supported in their work and morale within the team was good.
- Staff had not experienced bullying or harassment. Staff were aware of how to whistle blow and were confident they could raise a concern without fear of harassment.
- Staff said the team worked hard and dealt with situations enthusiastically and with commitment.
- Sickness and absence rates were low at 2.3% during the year to October 2016
- The provider had an agreement with a local university regarding training courses so staff had access to additional training.

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

Good

- Staff had the opportunity to feedback in staff surveys and team meetings.

Commitment to quality improvement and innovation

- The hospital operated a continuous improvement cycle. This involved monitoring policies and procedures, training, reviews and audits, feedback from patients and staff, and identifying themes and trends.
- The ward is a member of the national association of psychiatric intensive care and low secure units (NAPICU). Staff attended NAPICU general meetings and conferences. The service had achieved accreditation for inpatient mental health services (AIMS) for psychiatric intensive care units.

Good

Forensic inpatient/secure wards

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

Are forensic inpatient/secure wards safe?

Good

Safe and clean environment

- The service had fitted anti-ligature features throughout the ward. Staff recorded details of the remaining ligature points in the ligature audit along with details of how they mitigated these risks. The service had installed convex mirrors to improve sight lines along corridors. CCTV was used similarly in the communal areas of each ward to improve safety. Staff could access recordings when needed. For example, staff used recordings during investigations of incidents and complaints. Patients were aware that CCTV was in use. Patients had signed a form to confirm they were aware that CCTV recordings were being made.
- The clinic room was small and did not have facilities for the physical examination of patients. However, the room was clean and well organised. Staff recorded checks of all equipment, including the resuscitation equipment and emergency drugs, every day.
- All areas of the ward were clean and brightly decorated. Furniture was all in good condition.
- Arrangements for infection control were the same across all four wards. The hospital conducted an infection control audit each month. An infection control programme for 2017 included plans to ensure that every ward appointed a nurse as infection control champion, to develop guidelines for early notification of potential outbreaks of infections and to continue to develop the infection control audit programme. Guidance and information about handwashing was available for staff and visitors to follow. Staff used appropriate personal protective equipment such as gloves when needed.
- The facilities department was responsible for the maintenance of equipment. Records showed that staff calibrated equipment and contractors carried out portable appliance tests.
- Housekeeping staff completed a duty sheet to show which areas of the ward they had cleaned. Housekeepers also completed a weekly record to show when bedding and towels were changed. Records showed housekeepers carried out a deep clean of bedrooms and areas of the ward on a rotational basis.
- Information about environmental risks was the same for all services at the hospital. There service carried out a number of environmental checks. For example, there were monthly checks of drain covers and water guttering. The hospital carried out weekly checks of oxygen, water softeners and smoke and heat detectors. Records for the control of substances hazardous to health (COSHH) showed that staff had carried out risk assessments for each substance stored on the premises. Records showed that the service checked the fire alarm system twice each year. The service checked emergency lighting, fire extinguishers and fire blankets once a year. All these records were up to date.
- Information about alarms and nurse call systems also applies to all services at the hospital. The service issued personal alarms to all staff. Staff checked their alarms when they received them at the start of each shift. The hospital carried out additional checks each month to ensure that the system indicating where a member of staff activated an alarm showed the correct location. There were no alarms in patients' bedrooms.

Good

Forensic inpatient/secure wards

Safe staffing

- The service allocated 21 nursing staff, including nursing assistants to Bewick Ward. There was one vacancy for a nurse. In the 12 months up to 31 October 2016, the staff turnover rate was 9.5%. The sickness rate was 2.3%
- The service operated two shifts each day. During the day, the service allocated five staff to the ward including at least two qualified nurses. At night, the service allocated four staff, including at least two qualified nurses.
- In the 12 months prior to 30 November 2016, the service had used bank staff to cover 101 shifts. This was the lowest use of bank staff across the four wards at the hospital. The service had used agency staff to cover 10 shifts. Bank staff were familiar with working on the ward.
- Staff were able to book additional bank nurses and health care assistants if the clinical needs of patients required more staff. For example, the ward manager allocated additional staff if patients needed to be accompanied to external appointments or if there was an increase in the number of patients requiring enhanced observations.
- A member of staff was present in communal areas at all times.
- The service allocated sufficient staff to the ward to facilitate escorted leave, individual discussions with patients and activities. None of the patients we spoke with raised concerns about the availability of staff.
- The service allocated sufficient staff to the ward to carry out physical interventions.
- A doctor on the ward provided medical cover between 9am and 5pm from Monday to Friday. Outside these hours, a duty doctor was available on-call. This doctor was not based on site, but was required to attend within an hour of being called.
- Information about mandatory training also applies to all the services at the hospital. The service provided 23 mandatory training courses for staff in clinical or therapeutic roles. These courses included prevention and management of violence and aggression, health and safety, safeguarding and fire safety. Nurses were required to complete a further five courses on the management of medicines. Nurses' compliance with mandatory training across the hospital was above 95%. Compliance for all clinical staff was above 90%. However, compliance with training on awareness of cardiopulmonary resuscitation and automated external defibrillators was only 73%.

Assessing and managing risk to patients and staff

- Between 1 May 2016 and 31 October 2016, there were two incidents of staff using restraint on patients. These incidents involved two patients. Neither of these restraints was in the prone position or resulted in rapid tranquilisation.
- Across the whole hospital, 99% of staff had completed the mandatory training on preventing and managing violence and aggression.
- The multidisciplinary team completed an assessment of patient needs following all referrals to ensure that the service could safely meet the needs of the patient. When NHS trusts and clinical commissioning groups referred a patient to the service, they were required to provide a full risk assessment to support the assessment. Staff undertook a risk assessment of patients when they arrived at the ward using the short-term assessment of risk and treatability (START) model. Areas of risk identified within this assessment include risk to others, self-harm, self-neglect unauthorised leave and victimisation.
- Staff updated assessments throughout the patient's time on the ward. We saw evidence of risk assessments being updated after incidents took place. Care plans for the management of risk included details of specific triggers to incidents, indicators of heightened risk and planned responses to incidents. Staff worked with patients therapeutically to help them understand and management their risks. In addition, the service completed, or updated a Historical Clinical Risk management assessment, known as an HCR-20, in the first three months of admission. The HCR-20 form documents the patient's forensic history in detail. The service updated this assessment every six months.
- The hospital had introduced a programme of promoting least restrictive practice across all four core services. This followed analysis carried out by the clinical services manager that showed most incidents began by staff say 'no' to patients. This led to initiatives such as ensuring facilities were available to patients whenever they needed them and installing equipment for patients to make hot drinks whenever they wanted to. The ward

had designated a nurse and a patient as the least restrictive practice leads. Following the introduction of these initiatives, the number of incidents of restraint on most wards had declined.

- Staff followed the hospital's policy on observations. Staff used four levels of observation ranging from observing patients every 15 minutes to two nurses being with the patient at all times. If a patient was admitted having been on one-to-one observations at a previous hospital, this was continued. Staff reviewed observation levels at handovers and MDT meetings. Staff could only reduce the level of observation after a review by a doctor. The service did not permit patients to have items that could cause harm such as sharp objects, drugs, alcohol or cigarette lighters. Staff searched each patient's property when they were admitted to the hospital and when they returned from leave. Patient could store some restricted items in their own box. Nurses stored these boxes in the nursing office.
- All staff were trained in de-escalation. Staff told us that they knew patients well and that staff worked together to identify early indicators of patients becoming distressed or agitated. Staff explained that when patients were very unsettled they would talk to them about what was causing them to be worried. Patients could also use the quiet room to be in a lower stimulus environment.
- Across the hospital, 96% of clinical and therapy staff had completed mandatory training in safeguarding adults and 95% had completed the training for safeguarding children. On Bewick Ward, there had been nine safeguarding concerns reported during the year from December 2015 to December 2016. Nurses and nursing assistants reported all allegations or suspicions of abuse to the safeguarding lead for the hospital. The hospital held a safeguarding meeting every month to track the progress of all safeguarding concerns that staff had raised. The safeguarding lead, hospital manager, advocacy services, police and a representative from the local authority safeguarding team all attended this meeting.
- The hospital had a service level agreement with a pharmacy to supply medication to the wards. There was a named pharmacist attached to the hospital who conducted a weekly audit of medication. The pharmacy also provided a weekly report to alert staff to any errors identified and provided advice on action required to address any errors. Managers presented a report on medicines management to the monthly governance meeting.
- When children visited patients, they met in a specifically designated room in the hospital that was not on the ward.

Track record on safety

- There were 11 serious incidents requiring investigation on the ward between November 2015 and October 2016. Four of these incidents involved alleged abuse of a patient by a third party and two involved allegations of abuse of patients by staff. Four incidents involved unauthorised absence that met the serious incident criteria. One incident involved violent, aggressive or disruptive behaviour.
- The service had embarked on a number of initiatives to improve safety. The service had installed anti-ligature fittings throughout the ward. Staff said they had adopted an approach of identifying 'relapse signatures.' This approach involved identifying early signs of mood changes that could indicate deterioration in the patient's health and a heightened risk of incidents. Staff said this approach had had a positive effect in reducing incidents of restraint. Figures showed that incidents of restraint had fallen from 21 in 2014/15 to eight in 2015/16.

Reporting incidents and learning from when things go wrong

- Staff told us about different examples of incidents that they needed to report and details of how they would report these. Staff discussed all incidents during handover meeting ensuring that important information was shared amongst staff.
- Staff recorded all incidents using the Cygnet Incident and Accident Reporting log. The policy stated that the hospital should report all incidents to the relevant NHS commissioning authority within 24 hours.
- The approach taken to learning from incidents was similar across all wards. The clinical services manager carried out analysis of all incidents. This included looking at the circumstances leading up the incident, the staff involved, the time of day and the type of intervention used. Some individual members of staff were identified as being involved in a high number of incidents. Ward managers supported these staff to

reflect on their practice and consider other ways of responding to situations. Senior staff reviewed all serious incidents in the monthly clinical governance meetings. The minutes of these meetings included details of the lessons learned from each incident. Standing items at team meetings in the ward included lessons learned from serious incidents, feedback from clinical governance meetings and risk assessments. Staff we spoke with confirmed that incidents were discussed at team meetings.

- The hospital held debriefing sessions after incidents and facilitated reflective practice sessions for staff each month. Reflective practice sessions were based on the 'Map and Talk' model. This structure enabled staff to organise discussions in a way that reflected their feelings, patterns of thought, roles and relationships.

Duty of candour

- Duty of candour is a legal requirement, which means providers must be open and transparent with clients about their care and treatment. This includes a duty to be honest with clients when something goes wrong. Staff informed each patients nominated close relative if the patient was involved in a serious incident.

Are forensic inpatient/secure wards effective?

(for example, treatment is effective)

Good

Assessment of needs and planning of care

- The service admitted most patients from the local NHS trusts in East London, often from the local psychiatric intensive care units. The service completed medical assessments, nursing assessments, occupational therapy assessments and psychology assessments during the first days of admission. The MDT used these assessments to formulate an initial treatment plan.
- A comprehensive physical assessment was undertaken by the doctor and nurse within 24 hours of admission. This included a medical history and physical examination, blood tests, measuring vital signs, and assessing general health and lifestyle.
- Care records were up to date, holistic and personalised. Care plans included details of the patient's understanding of their condition. Recovery care plans included goals and milestones that patients and staff had agreed.
- Staff completed care records on paper and stored these documents in folders in the nurses' office. The ward was piloting the use of an electronic system for some patient records.

Best practice in treatment and care

- The psychiatrist prescribed medication in accordance with guidance published by the National Institute of Health and Care Excellence (NICE). One patient was receiving a high dose of antipsychotic medication. Staff had clearly marked the patient's record using a red sticker to indicate that the patient required regular physical health checks. A second opinion appointed doctor had authorised this dose of medication on the appropriate certificate. Records showed that staff carried out regular physical health checks of this patient.
- Care plans showed that the service provided psychological therapies in accordance with NICE guidance. The service employed a full-time psychologist. The psychologist completed an initial assessment of each patient during the first weeks of the admission. Individual psychology sessions used motivational interviewing techniques to support patients achieve positive changes. Psychological interventions also reflected that 80% of patients had a history of substance misuse that compounded their poor mental health. Substance misuse had often been a causative factor in patients' index offences. The psychologist worked with patients to facilitate change and also facilitated a relapse prevention group on the ward. In addition, the hospital provided well-being groups and mindfulness sessions.
- A GP attended the ward twice each month. When the GP was not available ward doctors provided assistance with physical healthcare. Patients were referred to specialist services at the local general hospital and staff supported patients to attend appointments.
- The hospital employed a dietician to support patients with specific dietary needs.

- The service used the Health of the Nation Outcome Scales (HoNOS) to measure patients' progress. Staff carried out a HoNOS assessment when they admitted each patient and repeated this every quarter thereafter.
- Clinical staff participated in audits of clinical notes, infection control and clinical effectiveness.

Skilled staff to deliver care

- The staff team on Bewick Ward included nurses, nursing assistants, a consultant psychiatrist, a specialist doctor, psychologist, occupational therapist, social therapist, and a social worker. A dietician worked across all four wards at the hospital.
- New staff received an induction over a period of six weeks. Staff were supernumerary for their first week to allow time for them to work closely alongside experienced members of staff. Staff induction also included training on the organisation's policies.
- The hospital policy stated staff should receive one supervision session each month. Information from the hospital showed the rate of compliance with this requirement was 96%. Staff spoke positively about the supervision and support they received. In addition, to individual supervision with their manager, staff attended a monthly reflective practice session.
- Information provided by the hospital showed that 89% of staff on Bewick Ward had received an appraisal in the last 12 months.
- Staff had received specialised training for their role. This included training in cognitive behavioural therapy and security in low secure settings.
- Poor staff performance was addressed through the supervision process.

Multi-disciplinary and inter-agency team work

- The service held a multidisciplinary ward round each week. During the ward round we observed there were very detailed discussions with patients about progress, physical health, risks and coping strategies. The patient was fully involved in all discussions. The doctor offered the patient choices about medication and encouraged the patient to make suggestions. The patient was able to negotiate with staff about which groups they wanted to attend. All the staff at the meeting contributed to the discussion and encouraged the patient to be involved in decisions about care and treatment.
- Handover meetings took place at the start and end of each nursing shift. The multidisciplinary handover took place once a day. At the end of each shift, the nurse in charge of the hospital circulated a handover report to all managers and senior nurses giving details of all admissions, discharges and incidents that had taken place during the shift.
- There service had good relationships with other organisations. Most patients came to the ward from local NHS trusts. This meant the service had regular contact the psychiatric intensive care wards at the local mental health hospitals.

Adherence to the MHA and the MHA Code of Practice

- Across the hospital, 84% of staff had completed mandatory training on the Mental Health Act (MHA) and the MHA Code of Practice.
- MHA documentation was stored in paper files. There were records of leave arrangements, relevant capacity assessments and detention paperwork. The ward had attached consent and authorisation certificates to patients' medicine charts.
- Most of the patients we spoke with told us that staff had made them aware of their rights. Staff recorded the occasions when they explained patients' rights in care plans.
- The ward displayed information about independent mental health advocates (IMHA) who attended the ward on a weekly basis.
- The hospital conducted regular audits of the MHA to ensure staff applied it appropriately. Relevant information following these audits was fed back on a ward level during meetings and during supervision where appropriate.

Good practice in applying the MCA

- Across the hospital, 81% of staff had completed mandatory training on the Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS). In July 2015, staff were unable to describe the five statutory principles of the MCA and could not tell us how they would implement the MCA while providing care and treatment for patients. At this inspection, staff had a good understanding of the MCA and its principles.
- A doctor and nurse assessed each patient's capacity to consent to admission and treatment when patients

were admitted. Staff updated these assessments when it was appropriate. Staff recorded assessments of patients' capacity to consent to treatment and stored these in the patient's records.

- Nurses provided examples of occasions when patient's mental capacity has been in doubt. Nurses explained that when capacity fluctuates, they ensured that regular assessments were carried out.

Are forensic inpatient/secure wards caring?

Good

Kindness, dignity, respect and support

- We observed positive, caring interactions between staff and patients during the day of our inspection. Staff responded to patient promptly and respectfully.
- We interviewed three patients and received 12 completed comment cards. Nine of these responses were positive. Patients said that the ward was clean and that staff were kind, friendly and caring. Two patients said they valued the support they received in visiting their families. One patient said that the service had supported them with both their mental health and with recovering from their drug addiction. Negative comments referred to specific incidents or specific members of staff. The patients we spoke with had all been patients at other mental health services. They said that the ward was better than many other hospitals they had been to. Patients spoke positively about the staff, saying that staff always listened to them. One comment card and one patient we spoke with mentioned bullying from other patients. The patient we spoke with said that staff had dealt with this.
- Staff had a good understanding of patients' individual needs. We saw staff chatting with patients throughout the day. During these conversations, staff showed that they knew about patients' interests, their families, their care and treatment plans and the activities they enjoyed. The service encouraged all staff to get to know patients well as part of the 'relapse signature' programme of identifying the early signs of patients' moods changing.

The involvement of people in the care they receive

- On arrival, staff showed patients to their room and supported them to settle in. Staff gave patients information about the activities and routines on the ward.
- Patients were fully involved in planning and decision making through care planning with their primary nurse and attending the weekly ward round. At the ward round we attended, the patient was present throughout the meeting. The staff involved in the patient's care did not have any discussion without the patient being there. The patient was involved in decision making about leave from the ward. The patient decided which groups they wanted to attend and was able to negotiate the times that suited them. Staff gave the patient information and encouragement to make choices about the medicines that the doctor prescribed. Staff and the patient also discussed risks and coping strategies. Patients told us that they were fully involved in care planning and had monthly meetings with their primary nurse to update their care plan. All patients said they had copies of their care plans. The patient records that we reviewed all contained care plans that were person centred and signed by the patient.
- An independent advocate visited the ward each week. The advocate explained that they supported patients with complaints. They also helped patients to contact their solicitors and supported patient to express their views at ward rounds. The advocate felt that the hospital was supportive of their service and was good at promoting advocacy.
- Families and carers could be involved in patients care if the patient wanted this. The service provided patient's with leave from the ward to maintain contact with their families.
- The service displayed a 'You said, we did' board showing how changes had been made as a result of patient feedback. One patient told us that there was a daily 'debriefing' session with staff and patients each evening. This meeting gave patients the opportunity to talk about what they had done and reflect on what had happened during the day. The patient we spoke to said they felt confident to raise any issues at this meeting.
- Each ward held community meetings each week. A more formal user council for the whole hospital was held once a month. Cygnet hospitals had recently appointed an expert by experience lead to facilitate user

involvement across the organisation. The expert by experience lead explained that their role was to speak with patients and feedback their views to corporate leaders and hospital managers.

- The hospital conducted a patient satisfaction survey. Through this survey, the hospital asked patients for their views on the environment, care and treatment, therapies and information and rights. Between October and December 2016, the hospital received 47 responses. Overall, 70% of respondents gave positive answers to questions about care and treatment. This score was 62% for the environment, 55% for therapies and 70% for information and rights. The service received six compliments during the year to 30 November 2016.
- Whilst we did not see evidence of formal advance decisions, there were care plans for how staff would response if incidents arose. For example, there was clear evidence of patient involvement in a restraint care plan.

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

(for example, to feedback?)

Good

Access and discharge

- Bed occupancy on the ward was 99%. The service admitted patients from across England. At the time of the inspection, most service users on the ward were from local NHS hospitals.
- The service carried out an initial assessment to confirm whether the referral was appropriate. The service responded to requests for a pre-admission assessment within five days. After this assessment, there was, on average, a delay of 54 days before treatment commenced. This was usually because patients required authorisation from the Ministry of Justice for a transfer to take place.
- The service planned all admissions and discharges. Admissions and discharges took place at an appropriate time of the day.
- The service aimed to achieve an average length of stay for patients of between 12 and 18 months. The average length of stay was two and a half years. Two patients had been at the ward for over three and a half years. Between 1 December 2015 and 30 November 2016, the discharge of five patients had been delayed due to non-clinical reasons. The ward manager explained that it could be difficult to find suitable placements and accommodation for people leaving the ward. The hospital worked proactively to try to facilitate discharges.
- The service and commissioners reviewed arrangements for discharge at care programme approach meetings. The service held these meetings every six months. The care plans we reviewed did not specifically mention arrangements for aftercare under section 117 of the Mental Health Act 1983. This meant that patients may not have been aware of their rights to aftercare under this section of the Act.

The facilities promote recovery, comfort, dignity and confidentiality

- The ward was clean and well maintained. Patients were proud of the environment. The service provided a full range of rooms for patients to use including a lounge, dining room and quiet room. The clinic room did not have facilities for doctors to conduct physical examinations of patients.
- Patients could meet with visitors in their bedrooms or in the quiet room.
- The ward provided patients with basic mobile phones they could use to make calls and send text messages. The ward did not permit patients to have telephones with cameras.
- The ward was situated on the first floor. Patients had unrestricted access to a large balcony, equipped with a large table and chairs.
- The service was installing equipment to enable patients to make hot drinks whenever they wished to. The water temperature of this equipment was limited to 65 degrees centigrade to minimise the risk of scalding.
- Patient could personalise their bedrooms and many patients chose to do so.
- Patients could store personal items in their rooms.
- The hospital provided an extensive programme of activities throughout the week, in addition to the therapeutic programme. Care plans showed that patients had their own individual timetables. Creative groups included an arts and crafts group, cooking group, craft workshops and a baking group. Physical activity groups included gym sessions, a walking group and a weekly yoga session. The service also facilitated

pampering and relaxation groups. The service had timetable activities from Monday to Saturday. There were no structured activities on Sunday. Patients were very positive about the groups and activities available.

Meeting the needs of all people who use the service

- The ward was situated on the first floor of the hospital. A lift from the ground floor allowed step free access for patients and visitors who had limited mobility.
- The service could translate information leaflets in to specific languages on request.
- Staff displayed information about treatments, patients' rights and advice on how to complain on notice boards on the ward. The hospital displayed information about its performance on a large notice board near the entrance.
- The service could provide interpreters for patients whose first language was not English.
- The service provided food to meet the ethnic, religious and dietary requirements of patients.
- The hospital arranged for a chaplain to visit. Staff supported patients to attend churches and religious groups in the community. Patients could use a multi-faith room on Bewick Ward.

Listening to and learning from concerns and complaints

- From April 2016 to March 2017, there had been 40 complaints about the hospital. There had been 14 complaints about nursing staff and eight complaints about the quality of care. Some of these complaints had not been upheld or contained allegations that could not be substantiated. The service monitored themes of complaints the most prominent theme was complaints about staff and their relationship with patients. When complaints were upheld, the service took action to address the concerns raised and supported with staff with training if required. The ward provided patients with information on how to make a complaint. All patients we spoke with were aware of this procedure and felt comfortable making a complaint.
- There was one complaint about the forensic service during 2016. Following an investigation, the service upheld the complaint. The service sent a report of the investigation into the complaint to the complainant.
- Patients said they knew how to make a complaint. One patient said they had made a complaint and felt that the service had investigated the matter well. They said they were happy with the outcome of the complaint.
- The service told us they had introduced changes because of these complaints. For example, the service introduced better shift planning to ensure there were sufficient staff available to facilitate leave when this was scheduled.

Are forensic inpatient/secure wards well-led?

Good

Vision and values

- Staff were familiar with the organisations values of helpful, responsible, respectful, honest and empathetic. The service reflected its values in patient care. For example, the ward published a leaflet with a list of its core values, including the value of "no decision about you without you." Staff demonstrated this by ensuring patients were present throughout discussions at ward round and by staff offering choices in decisions.
- The service aims to continue its' development programme of reducing restrictions on patients, creating a safe environment with a focus on relational security and placing patients at the centre of every decision. These objectives were wholly consistent with the values of the ward.
- Staff knew who the senior managers were. Staff said that senior managers at the hospital frequently visited the ward.

Good governance

- The hospital manager, the clinical services manager, the general manager and the medical director were responsible for leadership and governance at the hospital. The heads of occupational therapy, social work and psychology attend monthly clinical governance meetings, along with the senior managers and ward managers. Clinical governance meetings included a review of complaints, serious incident reports, restraints, risk registers and service user engagement. In addition, there were monthly meetings of the audit committee and the heads of departments.

Good

Forensic inpatient/secure wards

- Nurses' compliance with mandatory training across the hospital was above 95%. Compliance for all clinical staff was above 90%. All staff received an annual appraisal and monthly supervision. The service consistently provided level of staffing determined to be adequate to meet patient needs. We observed staff maximising the time they spent on direct care. Nurses actively participated in clinical audits and reported incidents. Minutes of team meetings showed that learning from incidents, complaints and feedback from patients was an integral part of regular team discussions.
- NHS England funded patients' placements on Bewick Ward. The service was required to provide a quarterly report covering the key performance indicators. These included the number of admissions, discharges, bed occupancy, and the number of patients engaging in 25 hours of meaningful activity each week.
- During the last inspection in July 2015, we found that there were insufficiently robust systems to share learning from incidents and complaints across hospital wards. At this inspection, we found that the hospital promoted sharing information and learning from other wards. The hospital sent a daily report to managers. This contained information about incidents, safeguarding's and admissions for all the wards. Staff discussed all complaints and incidents at team meetings and in reflective practice sessions.
- The ward manager said they felt they had sufficient authority to manage the ward effectively. An administrator supported the ward manager.
- The service had a protocol for nurses and health care assistants to escalate concerns about the safety and effectiveness of care to a senior level.

Leadership, morale and staff engagement

- The staff survey for the whole hospital in 2016 received responses from 132 employees. The overall level of positive responses within the survey was 81%. Within the overall scores, 90% of respondents said that patients were the hospital's top priory and 80% said they enjoyed working for Cygnet. Negative scores reflected the high number of incidents. For example, 42% of respondents said they had personally experienced bullying, harassment or abuse from patients. The service had introduced an action plan to address these concerns. This included introducing the 'safe wards' programme, reducing conflict through minimising blanket restrictions and settings target to reduce incidents of violence and aggression by 50%.
- Staff sickness rates and turnover rates were low. The sickness rate for this service was 2.3% during the period October 2015 to October 2016. Staff turnover during this period was 9.5%.
- Staff told us they were aware of the whistleblowing process and they knew how to use this. Staff said they could raise concerns without fear of victimisation. None of the staff we interviewed raised concerns about bullying or harassment.
- Staff felt there was a good level of morale and support for colleagues within the team. Some of the nurses we spoke with described the staff team as being like a family. Staff spoke positively about their supervision, reflective practice and training opportunities.
- Nurses said that were opportunities for leadership development. For example, senior nurses provided cover for the ward manager when the ward manager was on leave. The service also appointed senior nurses to the role of nurse in charge of the hospital at weekends.
- Minutes of team meetings showed that staff had the opportunity to give feedback and contribute to service development.

Commitment to quality improvement and innovation

- The hospital operated a continuous improvement cycle covering policies and procedures, training, reviews and audits, feedback from patients and staff, and identifying themes and trends.
- Bewick Ward was a member of the Quality Network for Forensic Low Secure Services and was part of a national programme of peer review in 2015. Bewick has also achieved the 'Star Ward' status following a Star Wards review of therapeutic activities offered.

Good

Wards for people with learning disabilities or autism

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

Are wards for people with learning disabilities or autism safe?

Good

Safe and clean environment

- Hansa ward had no blind spots. Staff could readily observe patients. CCTV was used similarly in the communal areas of each ward to improve safety. Staff could access recordings when needed. For example, staff used recordings during investigations of incidents and complaints. Patients were aware that CCTV was in use. Patients had signed a form to confirm they were aware that CCTV recordings were being made.
- The ward had a fully equipped clinic room. This room was clean and well organised. Staff had access to emergency equipment and emergency drugs. Staff checked emergency drugs and equipment each week. Staff completed a weekly stock check of medication, including expiry dates and did a weekly stock order. Staff disposed of unwanted or expired medicines in a designated pharmacy waste bin. Staff kept records of these disposals.
- The hospital had completed a comprehensive ligature risk assessment. The hospital updated this audit every six months or following incidents involving ligatures. Since the last inspection in July 2015, the hospital had addressed all high-risk ligature points on the ward. For example, the service had replaced standard taps in patients' bedrooms with sensor taps. Bathroom doors had been fitted with anti-ligature hinges. The service had identified the remaining ligature risks and recorded these in the ligature risk assessment. The risk assessment included details of measures taken to mitigate the risk. All staff were required to read and sign the ligature risk assessment. Ligature cutters were easily accessible in the nursing office
- Hansa ward did not have a seclusion room. The ward did have a de-escalation room. The de-escalation room was not used for seclusion. Patients could leave the de-escalation room when they chose to.
- All areas of the ward were clean, had modern furnishings and were well-maintained. A housekeeper cleaned the ward each day. This included the cleaning of patients' bedrooms between Monday and Saturday.
- Arrangements for infection control were the same across all four wards. The hospital conducted an infection control audit each month. An infection control programme for 2017 included plans to ensure that every ward appointed a nurse as infection control champion, to develop guidelines for early notification of potential outbreaks of infections and to continue to develop the infection control audit programme. Guidance and information about handwashing was available for staff and visitors to follow. Staff used appropriate personal protective equipment such as gloves when needed.
- Information about environmental risks was the same for all services at the hospital. There service carried out a number of environmental checks. For example, there were monthly checks of drain covers and water guttering. The hospital carried out weekly checks of oxygen, water softeners and smoke and heat detectors. Records for the control of substances hazardous to health (COSHH) showed that staff had carried out risk assessments for each substance stored on the premises.

Records showed that the service checked the fire alarm system twice each year. The service checked emergency lighting, fire extinguishers and fire blankets once a year. All these records were up to date.

- Information about alarms and nurse call systems also applies to all services at the hospital. The service issued personal alarms to all staff. Staff checked their alarms when they received them at the start of each shift. The hospital carried out additional checks each month to ensure that the system indicating where a member of staff activated an alarm showed the correct location. There were no alarms in patients' bedrooms.

Safe staffing

- Staff felt safe working on the ward and said staffing levels were adequate. The day shift had a minimum of two qualified nurses and three support workers. The night shift had at least two qualified nurses and two support workers. The ward manager was able to adjust staffing levels daily to take account of patients' needs.
- The ward had 28 permanent staff. Two members of staff had left in the previous 12 months. There were no staff vacancies.
- The ward used a matrix for planning shifts to ensure the correct number of staff were available on the rota according to patient numbers.
- Staff were always present on the ward. Staff rarely cancelled patient's leave. If staff did cancel leave, they took extra care to provide activities on the ward to compensate for this. One to one meetings between patients and their named nurses happened regularly.
- A doctor was present on the ward from Monday to Friday between 9am to 5pm each day. An on-call doctor was available at weekends and out of hours.
- Information about mandatory training also applies to all the services at the hospital. The service provided 23 mandatory training courses for staff in clinical or therapeutic roles. These courses included prevention and management of violence and aggression, health and safety, safeguarding and fire safety. Nurses were required to complete a further five courses on the management of medicines. Nurses' compliance with mandatory training across the hospital was above 95%. Compliance for all clinical staff was above 90%. However, compliance with training on awareness of cardiopulmonary resuscitation and automated external defibrillators was only 73%.

Assessing and managing risk to patients and staff

- Staff completed a risk assessment of every patient on admission. Staff updated these assessments regularly. Staff assessed risks using the short-term assessment of risk and treatability (START) tool, and the HCR-20 female additional manual (FAM) risk assessment tool. The HCR-20 FAM was specifically designed to assess the risks of female patients who had a history of violence. A clinical psychologist assessed all patients. Psychology assessments provided information to staff on patient triggers for risks of violence and guidance on how to manage behaviour.
- The hospital had introduced a programme of promoting least restrictive practice across all four core services. This followed analysis carried out by the clinical services manager that showed most incidents began by staff say 'no' to patients. This led to initiatives such as ensuring facilities were available to patients whenever they needed them and installing equipment for patients to make hot drinks whenever they wanted to. The ward had designated a nurse and a patient as the least restrictive practice leads. Following the introduction of these initiatives, the number of incidents of restraint on most wards had declined.
- The ward displayed information relating to patient rights. There was one informal patient on the ward. This patient was aware of their right to leave the ward. This patient had easy read information in their care records about this.
- The provider had a policy and procedure for observation. Staff were aware of this policy. Staff Nursing staff observed some patients continuously, when required. Staff searched the bags of all patients returning from unescorted leave.
- Staff had received training in managing violence and aggression. Staff described in detail the techniques they used to de-escalate situations. Staffs discussed violent and aggressive incidents in handover meetings and ward rounds. Staff recorded incidents in individual patient care plans. Each patient had a positive behaviour support (PBS) care plan. PBS is a proactive approach staff use to support challenging behaviour for individuals with a learning disability.
- Staff only restrained patients as a last option in care interventions and proactively used de-escalation strategies to manage conflict. Between May 2016 and October 2016, there had been 25 incidents of restraint.

Of these, there was one incident of prone (face-down) restraint. In July 2015, we found that staff did not accurately record incidents of restraint. During this inspection, we found this had improved and restraints were recorded. We sampled recent incidents of restraint. Records showed that staff had correctly filled in incident reports. These reports specified staff involved, which parts of the patient's body had been in contact and how long the hold had been maintained for. Staff attached details of them debriefing patients after restraints to incident forms.

- Between May 2016 and October 2016, there was one use of rapid tranquilisation. Staff recorded physical health monitoring and a formal patient debrief. Two patients had oral rapid tranquilisation as part of their prescription. There was a rapid tranquilisation policy in place and staff followed NICE guidance for use of rapid tranquilisation.
- The service did not place patients in seclusion. Patients we spoke with said they had never been secluded. There was a de-escalation suite on the ward used to support patients if they presented with behaviours which were challenging to the service.
- Staff displayed a good understanding of safeguarding and knew how to make a safeguarding alert. Staff completed mandatory training in safeguarding children and adults and explained different types of safeguarding concerns. The social worker was the safeguarding link for the ward and attended monthly safeguarding meetings attended by hospital managers, the local authority safeguarding team and the police. The social worker received regular supervision from the senior safeguarding lead for the hospital.
- Staff provided patients with information about their medicines. A pharmacist and ward staff discussed medication with patients.
- Medicines were stored securely on the ward. Temperature records were kept for the medicines fridge and clinical room in which medicines were stored, providing evidence that medicines were stored appropriately to remain fit for use. The ward doctor checked patient's medication on admission and the pharmacist ensured reconciliation of medication.
- In July 2015, we found the ward had not ensured that all medicines were administered appropriately within the prescribed guidelines. During this inspection, we found this had improved and there was no excess prescribing of PRN medication.
- The provider had a policy and procedure in place for children visiting the hospital. This was managed on an individual basis and only took place after a multidisciplinary discussion had determined that the visits were in the child's best interest.

Track record on safety

- Between November 2015 and October 2016, there were 22 serious incidents recorded on Hansa Ward. Of these, 10 incidents involved allegations of abuse by staff and nine involved allegations of abuse by a third party. A number of serious incident reports stated that the patient withdrew their complaint, often with the support of an advocate. Some of the allegations of abuse by a third party involved historic abuse. We saw evidence of the involvement of the police, local authorities and the CQC. CCTV footage from the ward was used to investigate allegations.
- There was good evidence that staff applied the duty of candour during investigation of these incidents. Staff documented the outcome of each investigation and lessons learned.

Reporting incidents and learning from when things go wrong

- Incidents were being reported routinely on the ward. Staff knew how to report an incident and displayed a good understanding around the process. The ward manager understood the reporting system and knew which incidents they should report. In the previous six months, there had been 14 incidents of assaults on patients and 25 incidents of assaults on staff. However, staff and patients we spoke with said they felt safe on the ward. Staff discussed incidents in ward rounds and handover meetings. Although there were frequent incidents of assault this was attributed to high levels of challenging behaviour on the ward. Staff attempted to manage risks of assault through increasing observations of patients and restricting the movement of patients to reduce their contact with other patients. There was good communication of incidents across the team, including good communication with domestic staff.
- The provider supported and debriefed patients and staff if they were involved in incidents. Senior nurses discussed all incidents with perpetrator and victim. The

service offered mediation. We observed a ward round where the MDT sensitively discussed a recent incident with a patient. Staff provided explanations of their concerns and encouraged reflection from the patient.

- There was good evidence of learning from incidents on Hansa ward and other wards. There was a standing agenda to discuss incidents in monthly team meetings. Staff told us how they picked an incident related to Hansa ward and other wards to discuss how they could learn from them. In the nursing office there was a poster detailing lessons learned from recent incidents on across the hospital. The ward manager had good oversight of the incidents on the ward and reviewed them individually on a weekly basis to look for themes. The ward manager entered all incidents onto the central record that they sent to the central governance team.
- The approach taken to learning from incidents was similar across all wards. The clinical services manager carried out analysis of all incidents. This included looking at the circumstances leading up the incident, the staff involved, the time of day and the type of intervention used. Some individual members of staff were identified as being involved in a high number of incidents. Ward managers supported these staff to reflect on their practice and consider other ways of responding to situations. Senior staff reviewed all serious incidents in the monthly clinical governance meetings. The minutes of these meetings included details of the lessons learned from each incident. Standing items at team meetings in the ward included lessons learned from serious incidents, feedback from clinical governance meetings and risk assessments. Staff we spoke with confirmed that incidents were discussed at team meetings.

Are wards for people with learning disabilities or autism effective?

(for example, treatment is effective)

Good

Assessment of needs and planning of care

- We reviewed for four care records. Each patient had received comprehensive assessments. Care records showed that a doctor and nurse initially assessed patients on the day of admission. This included physical health assessments.
- Care records demonstrated that physical examinations had been completed and updated annually in the absence of physical health complaints. Each patient had a health action plan in place. The service developed care plans to ensure that concerns about physical health were addressed and monitored. For example, a patient who had non-epileptic seizures had a comprehensive care plan saying how to support them in an event of a seizure.
- Care records were up to date, personalised, holistic and recovery-oriented. Care plans were in a format that was accessible for the patient group. For example, they were in an easy read format and included simple, plain language and pictures. Each patient had a communication passport which detailed how best to communicate with them.
- Staff were trained in positive behaviour support (PBS) to ensure they could support patients with behaviours that challenge. Each patient had a PBS care plan. Staff reviewed this care plan with patients every two weeks in patients' ward rounds.
- Staff had access to all records. Records were stored in paper format. Care records were stored securely in the nursing office.
- Each patient had a regular six-month review of needs with community service and other agencies in line with the transforming care reviews programme. This ensured that the service was regularly reviewing needs with external agencies to plan care provision upon discharge.

Best practice in treatment and care

- There was evidence that staff followed NICE guidance when prescribing medication.
- Patients accessed psychological therapies as part of their treatment and there was a full time clinical psychologist and part time assistant psychologist as part of the ward team. Psychological therapies were recommended by NICE guidance. This included cognitive behavioural therapy, adapted dialectical behavioural therapy for people with a learning disability, trauma therapy and mindfulness groups.

- The ward doctor completed physical health care assessments for patients using the Lester screening tool to screen for physical wellbeing. Staff followed NICE guidance for assessment and intervention for obesity, hypertension and diabetes. Doctors reviewed patients after episodes of self-harm.
- A GP visited the ward weekly to carry out reviews of patient's physical health. A supply of physical health medication was kept on the ward.
- Staff used the SPELL framework to structure treatment approach which consisted of structure, positive (approaches and expectations), empathy, low arousal and link. Activities and occupation were a key feature of the programme, along with a positive acceptance approach and low stimulus environment that tried to avoid triggers.
- The service supported patients with identified nutritional needs. For example, where weight gain was an identified need, patients were referred to the hospital dietitian to support weight management.
- Staff used the Health of the Nation Outcome Scales (HoNOS) to measure outcomes. These scales covered 12 health and social domains and enabled the clinicians to build up a picture over time of their patients' responses to interventions.
- The ward staff focussed on recovery and wellbeing as part of care planning. Staff used the recovery star tool. This tool enabled patients to measure their own recovery progress with the support of staff.
- Staff participated in clinical audits, which included clinical notes, restraints and medication.

Skilled staff to deliver care

- The multidisciplinary team included a consultant psychiatrist, psychologists, an occupational therapist, a speech and language therapist, an art therapist and a social worker. A pharmacist visited the ward each week. The pharmacist had a good working relationship with staff on the ward. The pharmacist fed information back to ward staff through a report completed after each visit.
- The ward's compliance with staff receiving supervision each month was 95%. This was above the hospital's target at 80%. Staff said they received supervision each month in line with the hospital's supervision policy. Staff could attend a six-weekly reflective practice session led by the hospital's general manager. These sessions provided an opportunity for staff to reflect and learn from incidents. Staff spoke highly of the reflective practice.
- Non-medical staff had received an annual appraisal. All medical staff were regularly supervised and received annual appraisals.
- Staff said they attended monthly team meetings. We saw minutes of five team meetings from the past six months. The minutes were comprehensive. The team discussed safety checks, staffing and the mental capacity act.
- Staff said they received the necessary training for their role. All staff had access to PBS training. This training ensured staff appropriately supported patients with learning disabilities who presented with challenging behaviours. Staff received DBT training. This enabled nursing staff to work with patients in a way that was consistent with the therapeutic programme and working with people experiencing difficulties managing emotions. One member of staff was trained as a Gestalt group facilitator. Staff had opportunities to attend continuous professional development events.

Multi-disciplinary and inter-agency team work

- There were regular and effective MDT meetings. There were two daily handover shifts at the start of each nursing shift. The MDT worked well together on Hansa ward, and members of the MDT said they felt valued. For example, support workers said they were invited to attend patients' ward rounds.
- Practitioners and clinicians from different disciplines were involved in the assessment, planning and delivery of patient's care and treatment. Care records demonstrated that staff had identified and made contact with patient's care co-ordinators. Staff kept them up to date and invited them to MDT meetings and care programme approach meetings.
- The independent advocate had a good working relationship with staff on the ward. The advocate regularly visited the ward and attended the hospital's safeguarding meetings. They said they felt welcomed onto the ward by both staff and patients.
- Care records showed that the ward doctor had effective working relationships with patients' GPs and regularly contacted them to provide updates on the patient's physical health.

Good

Wards for people with learning disabilities or autism

Adherence to the MHA and the MHA Code of Practice

- Across the hospital, 84% of staff had completed mandatory training on the Mental Health Act (MHA) and the MHA Code of Practice.
- MHA documentation was stored in paper files. There were records of leave arrangements, relevant capacity assessments and detention paperwork. The ward had attached consent and authorisation certificates to patients' medicine charts.
- Most of the patients we spoke with told us that staff had made them aware of their rights. Staff recorded the occasions when they explained patients' rights in care plans.
- The ward displayed information about independent mental health advocates (IMHA) who attended the ward on a weekly basis.
- The hospital conducted regular audits of the MHA to ensure staff applied it appropriately. Relevant information following these audits was fed back on a ward level during meetings and during supervision where appropriate.

Good practice in applying the MCA

- The majority of staff (81 %) had completed training in the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS). In July 2015, staff were unable to describe the five statutory principles of the MCA and could not tell us how they would implement the MCA while providing care and treatment for patients. At this inspection, staff we spoke with had a good understanding of the MCA and were able to describe the five statutory principles and how they would use them in practice.
- One patient had an application for a DoLS authorised. We saw evidence in this patient's care records that a comprehensive DoLS application had been completed, was in date and had a best interests assessment attached and had been accepted by the local authority.
- Patients' capacity to consent was assessed regularly and recorded appropriately. Patients had capacity to consent to treatment forms in their care records. Efforts had been made to improve communication when assessing capacity, for example the use of shorter sentences. Staff discussed consent and capacity to consent to treatment with patients in their fortnightly ward round. The psychologist provided an example of completing a capacity assessment around a patient's understanding of sexual relationships. The patient was deemed to have capacity but was provided with further appropriate education, assertiveness sessions with the psychologist, and sessions with the speech and language therapist.

Are wards for people with learning disabilities or autism caring?

Good

Kindness, dignity, respect and support

- We observed staff interacting with patients in a caring and compassionate way. Staff responded to people in distress in a calm and respectful manner. They de-escalated situations by listening to and speaking quietly to people who were frustrated or distressed. Staff appeared interested and engaged in providing good quality care to patients.
- Patients spoke positively about staff and said they were kind, respectful and supportive. Patients said staff knocked on their bedrooms before entering. Patients knew who their named nurse was and enjoyed positive relationships with them.
- When staff spoke to us about patients, they discussed them in a respectful manner and showed a good understanding of their individual needs.

The involvement of people in the care they receive

- The ward had developed a welcome pack that orientated patient to the ward on admission. Staff provided patients with a copy of this. There was a clear structure in place to orient patients to the ward. For example, within 72 hours of admission, the assistant psychologist would meet with the patient and the occupational therapist completed an interests checklist with patients. Therapists used this assessment to plan appropriate activities on the ward.
- Patients felt involved in their care and treatment. For example, a patient showed us her feedback from their latest ward round. The service invited all patients to attend their fortnightly ward round. We saw evidence of staff involving patients in the development of their care plans and risk assessments. Where patients refused

involvement in care planning and risk assessment, staff had documented this clearly. If required, the MDT reviewed patients on a weekly basis if there were concerns around their presentation or behaviour.

- The ward rounds were positive and patient focussed. Patients were made aware of the ward round format and were given feedback following the meeting to summarise key points and actions which were at a level tailored to their individual needs. The MDT used language that was warm in tone and appropriate for the patient. There was a strong focus on recovery and moving patients onto the least restrictive setting. The format of the ward round was well structured and considered all needs, such as physical and social needs.
- The service displayed details of advocacy services on the ward. Patients spoke positively about the advocate. The advocate visited the ward once a week and said the main themes of referrals were to assist with making complaints, explaining leave and rights to patients.
- Patients said staff supported them to maintain contact with families and carers. With permission from patients, families were appropriately involved in their care and treatment. Patients said that despite significant geographical distances and staff regularly supported them to visit their home.
- Each ward held community meetings each week. A more formal user council for the whole hospital was held once a month. Cygnet hospitals had recently appointed an expert by experience lead to facilitate user involvement across the organisation. The expert by experience lead explained that their role was to speak with patients and feedback their views to corporate leaders and hospital managers.
- The hospital conducts a patient satisfaction survey. Through this survey, the hospital asks patients for their views on the environment, care and treatment, therapies and information and rights. Between October and December 2016, the hospital received 47 responses. Overall, 70% of respondents gave positive answers to questions about care and treatment. This score was 62% for the environment, 55% for therapies and 70% for information and rights. The service received six compliments during the year to 30 November 2016.
- The ward displayed a “you said, we did” noticeboard. This outlined issues over a number of areas such as activities and spiritual raised by patients and the action the hospital had taken in response. However, this was located outside of the ward entrance so was not accessible to all patients. .

Are wards for people with learning disabilities or autism responsive to people’s needs?

(for example, to feedback?)

Good

Access and discharge

- The ward accepted referrals from across England. At the time of inspection, the average length of stay for patients was 12 months. The average bed occupancy from June 2016 to November 2016 was 92%.
- Patients were not moved between wards during an admission for non-clinical reasons. When staff discharged or transferred patients, it happened at an appropriate time of day.
- Between December 2015 and November 2016, there were four delayed discharges. At the time of inspection, there were two delayed discharges. These delays were due to difficulties in finding patients suitable placements. These patients had complex needs. Staff demonstrated that they had taken action to find suitable placements in the community.
- Staff engaged with commissioners, other service providers, local authorities, patients, and their families in discharge planning. The ward had a clear care pathway for their patients. Staff completed discharge care plans with patients, which were in an easy read format. This included where they wished to move and what sort of accommodation they wished to have. Staff supported patients to take leave and visit the placement.

The facilities promote recovery, comfort, dignity and confidentiality

- A full range of rooms and equipment to support treatment and care were available on the ward. These included a communal lounge, quiet room, an occupational therapy room and an activities of daily

living kitchen. The ward had a sensory room which contained soft furnishings, mood lighting and played soothing music. Patients said they liked spending time in the sensory room.
- Patients were able to access mobile phones supplied by the ward to make personal phone calls in private.
- Patients had access to outdoor space on the ward whenever they wished to. The garden area was a pleasant, well-maintained environment with contained flowerbeds.
- There was a good quality of food on the ward. Staff supported patients to fill in the daily menu planner to choose their lunch and dinner choices for the next day. Lunch and dinner options varied from day to day and there was a range of options to choose from, including a healthy option. Patients we spoke to spoke positively about the standard and choice of food.
- Patients were able to make hot drinks whenever they wished. The ward had recently installed a hot water dispenser so patients could make hot drinks. The hot water dispenser did not go above 65 degrees to ensure safe use of the hot water. Patients had access to snacks whenever they wished. Patients said they were able to keep snacks in their bedrooms.
- Patients were encouraged to personalise their bedrooms. We saw evidence of this. Patients had lockable space to store their possessions safely and securely.
- There was good provision of activities on the ward that were available every day, including weekends. The ward's activities timetable was clearly displayed and patients had their own timetables according to activity preference. Activities included bowling, a current affairs group and art therapy at the hospital's recovery college. Patients said activities happened every day.
- Staff supported patients with physical exercise. This included escorting patients to use the onsite gym, swimming and a walking group. Also, a yoga instructor visited the hospital every Saturday.

Meeting the needs of all people who use the service

- The ward was located on the ground floor and was accessible to people with disabilities. There were pictures on doors to communicate information. For example, there was a picture of a shower to indicate it was the shower room.
- The ward did not display information leaflets in other languages. Some information were provided in an easy-read format. At the time of inspection, all patients' first language was English. The manager could request leaflets in other languages from the provider if needed.
- The service displayed information on patients' rights, local services and making complaints.
- Staff could book interpreting services if required.
- Patients had access to appropriate spiritual support. Patients we spoke to said they were aware of this spiritual support and that a priest had recently visited the ward.

Listening to and learning from concerns and complaints

- From April 2016 to March 2017 there had been 40 complaints about the hospital. There had been 14 complaints about nursing staff and eight complaints about the quality of care. Some of these complaints had not been upheld or contained allegations that could not be substantiated. The service monitored themes of complaints. The most prominent theme was complaints about staff and their relationship with patients. When complaints were upheld, the service took action to address the concerns raised and supported with staff with training if required. The ward provided patients with information on how to make a complaint. All patients we spoke with were aware of this procedure and felt comfortable making a complaint.
- Patients we spoke to knew how to make a complaint and felt comfortable to raise concerns with all members of staff. There were four complaints made on Hansa ward in the last 12 months. We reviewed three of these complaints. Complaints were dealt with in a timely manner in accordance to the provider's policy and thorough investigations had taken place. However, none of the complaints included information about how to contact the parliamentary health service ombudsman, which is an independent service to handle unresolved complaints.
- Staff were aware of the complaints procedure, and were able to describe the process to follow if patients wished to make a complaint. Staff said they discussed outcomes of complaints in team meetings.

Are wards for people with learning disabilities or autism well-led?

Good

Wards for people with learning disabilities or autism

Good

Vision and values

- The ward staff were aware of the organisation's values: helpful, responsible, respectful, honest and empathetic and felt they reflected the ethos of the ward.
- Hansa ward implemented its own philosophy that involved providing a modern, person centred and holistic service, where patients' dignity, choice and respect are underpinned by a safe and supportive environment. Staff had also embedded the least restrictive practice project which was part of the hospital's improvement project.
- Staff knew most senior managers in the hospital and said these managers had visited the ward. Staff spoke positively about the leadership structure within the organisation and that it was not hierarchal.

Good governance

- The hospital manager, the clinical services manager, the general manager and the medical director were responsible for leadership and governance at the hospital. The heads of occupational therapy, social work and psychology attend monthly clinical governance meetings, along with the senior managers and ward managers. Clinical governance meetings included a review of complaints, serious incident reports, restraints, risk registers and service user engagement. In addition, there were monthly meetings of the audit committee and the heads of departments.
- The service regularly collected data on performance. The ward manager had key performance indicators to report to senior management on a monthly basis. This included information on training and staff sickness. This ensured a good oversight at a local and hospital level of the operations on Hansa ward. The ward manager felt well supported by senior management.
- In July 2015, we found that there were insufficiently robust systems to share learning from incidents and complaints across hospital wards. At this inspection, we found that the hospital promoted sharing information and learning from other wards. The hospital sent a daily report to managers. This contained information about incidents, safeguarding's and admissions for all the wards. Staff discussed all complaints and incidents at team meetings and in reflective practice sessions.
- Ward managers had good access to meetings with outside of the ward. The ward manager attended the weekly hospital manager's meeting where they discussed referrals, admissions and incidents. The ward managers also met at the start of each shift to handover. This enabled shared learning between the wards. The ward manager also attended a monthly meeting with other managers to discuss business development.
- The ward manager attended the monthly audit committee which was chaired by the hospital manager. Here they shared good practice and looked at NICE guidance. This showed the ward manager participated in sharing practice and learning from other wards.
- The ward manager told us that they had enough time and autonomy to run the ward. They also said that, where they had concerns, they could raise them. The ward had a local risk register which fed into the hospital risk register.

Leadership, morale and staff engagement

- The staff survey for the whole hospital in 2016 received responses from 132 employees. The overall level of positive responses within the survey was 81%. Within the overall scores, 90% of respondents said that patients were the hospital's top priory and 80% said they enjoyed working for Cygnet. Negative scores reflected the high number of incidents. For example, 42% of respondents said they had personally experienced bullying, harassment or abuse from patients. The service had introduced an action plan to address concerns. This included introducing the 'safe wards' programme, reducing conflict through minimising blanket restrictions and settings target to reduce incidents of violence and aggression by 50%.
- There was evidence of clear leadership at a local level. The ward manager was visible on the wards during the day-to-day provision of care and treatment. They were accessible to staff and they were proactive in providing support. The culture on the ward was open and encouraged staff to bring forward ideas for improving care. Staff spoke positively about the ward manager and felt well supported by them.
- The ward staff were enthusiastic and engaged with developments on the ward, particularly with the least

restrictive practice improvement project. They told us they felt able to report incidents, raise concerns and make suggestions for improvements. They were confident they would be listened to by their line manager.

- All staff we spoke to said morale was high on the ward and that it was a good place to work. Staff said they sometimes felt stressed due to the challenging patient group, however they felt well supported by their team and the rest of the organisation.
- Sickness rates were around 3% during the year to October 2016.
- Staff were aware of the whistleblowing process if they needed to use it.
- The provider gave staff opportunities to undertake extra training for leadership development.
- All staff said there was excellent team working on Hansa ward. Staff said their colleagues worked hard and provided support for one another. All disciplines of the MDT felt valued by one another and there were good working relationships between therapy and nursing staff.
- Staff were offered the opportunity to give feedback on services and saw changes due to this. For example, one staff member told us they fed back to the hospital that the need for more transport to take patients on leave. The hospital then provided two extra cars for staff to use.

Commitment to quality improvement and innovation

- The hospital operated a continuous improvement cycle covering policies and procedures, training, reviews and audits, feedback from patients and staff, and identifying themes and trends.
- The ward was committed to quality improvement. In November 2016, the Quality Network for Inpatient Learning Disability Services awarded Hansa ward accreditation for inpatient learning disability mental health services.

Tier 3 personality disorder services

Safe	
Effective	
Caring	
Responsive	
Well-led	

Are tier 3 personality disorder services safe?

Safe and clean environment

- There were clear sight lines along the corridors. The service had installed convex mirrors to improve visibility. Staff were present in the nursing office and communal areas. CCTV was used similarly in the communal areas of each ward to improve safety. Staff could access recordings when needed. For example, staff used recordings during investigations of incidents and complaints. Patients were aware that CCTV was in use. Patients had signed a form to confirm they were aware that CCTV recordings were being made.
- At our last inspection in July and August 2015, we found the service had not addressed the risks presented by ligature anchor points. At this inspection, we found the service had introduced anti-ligature bathroom fittings, door handles and hinges throughout the ward. Staff recorded a list of remaining ligature anchor points in an environmental audit. The audit included a rating of the level of risk, a photograph of the ligature point, details of the location and information on how the staff addressed these risks.
- Clinic rooms were clean and tidy. Staff checked and recorded fridge temperatures each day. Clinic rooms were small and there was no room for examination couches. This meant that physical examinations took place in patients' bedrooms.
- In July 2015, we found there was insufficient emergency equipment. At this inspection, both clinic rooms had a designated emergency bag. Emergency equipment included oxygen, a defibrillator, a pulse oximeter and ligature cutters. Staff checked the contents of these bags each day.
- The ward was clean. Furniture was in good condition.
- Arrangements for infection control were the same across all four wards. The hospital conducted an infection control audit each month. An infection control programme for 2017 included plans to ensure that every ward appointed a nurse as infection control champion, to develop guidelines for early notification of potential outbreaks of infections and to continue to develop the infection control audit programme. Guidance and information about handwashing was available for staff and visitors to follow. Staff used appropriate personal protective equipment such as gloves when needed.
- The facilities department was responsible for the maintenance of equipment. Records showed that staff calibrated equipment and contractors carried out portable appliance tests.
- Housekeeping staff completed a duty sheet to show which areas of the ward they had cleaned. Housekeepers also completed a weekly record to show when bedding and towels were changed. Records showed housekeepers carried out a deep clean of bedrooms and areas of the ward on a rotational basis.
- Information about environmental risks was the same for all services at the hospital. There service carried out a number of environmental checks. For example, there were monthly checks of drain covers and water guttering. The hospital carried out weekly checks of oxygen, water softeners and smoke and heat detectors. Records for the control of substances hazardous to health (COSHH) showed that staff had carried out risk assessments for each substance stored on the premises. Records showed that the service checked the fire alarm system twice each year. The service checked emergency lighting, fire extinguishers and fire blankets once a year. All these records were up to date.
- Information about alarms and nurse call systems also applies to all services at the hospital. The service issued personal alarms to all staff. Staff checked their alarms when they received them at the start of each shift. The

hospital carried out additional checks each month to ensure that the system indicating where a member of staff activated an alarm showed the correct location. There were no alarms in patients' bedrooms.

Safe staffing

- The service allocated 14.2 full time equivalent nurses and 18.9 full time equivalent nursing assistants to the ward. There were two vacancies for nurses. Between October 2015 and October 2016, the staff turnover rate was 12% and the sickness rate was 2.2%
- The service operated two shifts each day. During the day, the service allocated eight staff to the ward including at least three qualified nurses. At night, the service allocated six staff, including at least two qualified nurses.
- Between November 2015 and November 2016, the service had used bank staff to cover 227 shifts. The service had used agency staff to cover seven shifts. Bank staff were familiar with working on the ward. In July 2015, patients said that bank staff were more frequently deployed on New Dawn Two and this affected the quality of care. There were no concerns raised about the deployment of bank staff during this inspection.
- The nurse in charge was able to book additional staff from the bank nurses and health care assistants if the clinical needs of patients required more staff. For example, the service allocated additional staff if patients needed to be accompanied to external appointments, if there was an increase in the number of patients requiring enhanced observations or if there had been a number of incidents.
- A member of staff was present in communal areas at all times.
- Staff said that the service allocated sufficient staff to the ward to facilitate escorted leave, individual discussions with patients and activities. None of the patients we spoke with raised concerns about the availability of staff.
- Staff said that the service allocated sufficient staff to the ward to carry out physical interventions.
- A doctor on the ward provided medical cover between 9am and 5pm from Monday to Friday. Outside these hours, a duty doctor was available on-call. This doctor was not based on site, but was required to attend within an hour of being called.
- Information about mandatory training also applies to all the services at the hospital. The service provided 23 mandatory training courses for staff in clinical or therapeutic roles. These courses included prevention and management of violence and aggression, health and safety, safeguarding and fire safety. Nurses were required to complete a further five courses on the management of medicines. Nurses' compliance with mandatory training across the hospital was above 95%. Compliance for all clinical staff was above 90%. However, compliance with training on awareness of cardiopulmonary resuscitation and automated external defibrillators was only 73%.

Assessing and managing risk to patients and staff

- Between 1 May 2016 and 31 October 2016, there were four incidents of staff using restraint on patients. These incidents involved three patients. None of these restraints were in the prone position. None of these incidents resulted in rapid tranquilisation whilst the patient was being restrained.
- Across the whole hospital, 99% of staff had completed the mandatory training on preventing and managing violence and aggression.
- In July 2015, we found that the service was not ensuring pre-admission information was available to staff. During this inspection, we saw that when NHS trusts and clinical commissioning groups referred a patient to the service, the service asked them to provide a full risk assessment. Staff included this information in the patient record. The MDT would only admit patients to the service if they assessed the level of risk as being manageable. Staff undertook a risk assessment of patients when they arrived at the ward using the short-term assessment of risk and treatability (START) model. Areas of risk identified within this assessment include risk to others, self-harm, self-neglect unauthorised leave and victimisation. Staff updated assessments throughout the patients' time on the ward. Patients' records showed that staff updated risk assessments after incidents took place. Care plans for the management of risk included details of specific triggers to incidents, indicators of heightened risk and planned responses to incidents. Staff worked with patients therapeutically to help them understand and manage their risks.
- The hospital had introduced a programme of promoting least restrictive practice across all four core services. This followed analysis carried out by the clinical services manager that showed most incidents began by staff say

'no' to patients. This led to initiatives such as ensuring facilities were available to patients whenever they needed them and installing equipment for patients to make hot drinks whenever they wanted to. The ward had designated a nurse and a patient as the least restrictive practice leads. Following the introduction of these initiatives, the number of incidents of restraint on most wards had declined.

- The service displayed a notice on the door to the ward advising informal patients of their right to leave.
- The service placed patients who presented a heightened level of risk on enhanced observations. Enhanced observation levels could be every 15 minutes, constant one-to-one observation within eyesight, constant one-to-one observation within arms-length or two-to-one observation. If someone arrived at the ward having been on one-to-one observations at the previous hospital, this was continued. Staff reviewed observation levels at handovers and MDT meetings. Staff could only reduce the level of observation after a review by a doctor. The service did not permit patients to have items that could cause harm such as sharp objects, drugs, alcohol or cigarette lighters. Staff searched each patient's property when they were admitted and when they returned from leave. Patient could store some restricted items in their own box. Nurses stored these boxes in their office.
- All staff were trained in de-escalation skills. Staff told us that they knew patients well and that staff worked together to identify early indicators of patients becoming distressed or agitated. Staff explained that when patients were very unsettled they would talk to them about what was causing them to be worried. Staff received training in dialectical behavioural therapy to enable them to provide interventions that were consistent with the work patients were doing with the psychologist. For example, staff would help patients to identify triggers and used their coping skills to avoid undesired reactions. Patients could also use the sensory room or the quiet room to be in a lower stimulus environment. The ward provided a self-soothing box of items that patients could use to distract themselves from intense feelings of distress.
- Information about mandatory training in the report on acute wards for adults of working age and psychiatric intensive care units also applies to this service. See page 21.
- The hospital had a service level agreement with a pharmacy to supply medication to the wards. There was a named pharmacist attached to the hospital who conducted a weekly audit of medication standards and compliance with the Mental Health Act. The pharmacy also provided a weekly report to alert staff to any errors identified and provided advice on action required to address any errors. Managers presented a report on medicines management to the monthly clinic governance meeting.
- When children visited patients, they met in a specifically designated room in the hospital.

Track record on safety

- There were eight serious incidents on this ward during the year from 7 November 2015 to 29 October 2016. Three of these incidents involved an unauthorised absence. Two involved an allegation of abuse of a patient.
- Following an incident involving a patient climbing onto the roof, the service immediately removed a canopy over the balcony and the door fittings that the patient had used to climb. Changes had also been made immediately to the locks and closing mechanism on the clinic room to prevent unauthorised access.

Reporting incidents and learning from when things go wrong

- Staff told us they knew how to complete incident forms. One nurse said the nurse in charge of the shift usually completed the form and passed it to the senior manager for discussion at the clinical governance meeting. Staff discussed all incidents at the following handover meeting.
- In the three months from December 2016 to February 2017, staff had recorded 52 incidents on New Dawn. Nineteen of these incidents involved self-harm. Staff recorded eight incidents of violence towards staff and there were six incidents of patients attempting to abscond. Staff worked with patients with challenging behaviours and complex mental health problems, which often led to incidents occurring. Incidents were recorded promptly and accurately. Staff recorded eight accidents, including slips, trips and falls, and two incidents involving medication. Staff recorded all incidents using the Cygnet Incident and Accident Reporting log.

Tier 3 personality disorder services

- The approach taken to learning from incidents was similar across all wards. The clinical services manager carried out analysis of all incidents and supported staff to learn from incidents. This included looking at the circumstances leading up the incident, the staff involved, the time of day and the type of intervention used. Some individual members of staff were identified as being involved in a high number of incidents. Ward managers supported these staff to reflect on their practice and consider other ways of responding to situations. Senior staff reviewed all serious incidents in the monthly clinical governance meetings. The minutes of these meetings included details of the lessons learned from each incident. Standing items at team meetings in the ward included lessons learned from serious incidents, feedback from clinical governance meetings and risk assessments. Staff we spoke with confirmed that incidents were discussed at team meetings.
- The hospital held debriefing sessions after incidents and facilitated reflective practice sessions for staff each month. Reflective practice sessions were based on the 'Map and Talk' model which is a structured conversation to enable staff to organise discussions in a way that reflected their feelings, patterns of thought, roles and relationships.

Duty of candour

- Duty of candour is a legal requirement, which means providers must be open and transparent with clients about their care and treatment. This includes a duty to be honest with clients when something goes wrong. Staff informed each patients nominated close relative if the patient was involved in a serious incident.

Are tier 3 personality disorder services effective?
(for example, treatment is effective)

Assessment of needs and planning of care

- The service planned admissions to the ward to take place on the same day as ward rounds to ensure that the full multidisciplinary team (MDT) was available to carry out assessments. The service completed medical assessments, nursing assessments, occupational therapy assessments and psychology assessments. The MDT used these assessments to formulate an initial treatment plan.
- A comprehensive physical assessment was undertaken by the doctor and nurse within 24 hours of admission. This included a medical history and physical examination, blood tests, measuring vital signs, and assessing general health and lifestyle.
- Care records were up to date, holistic and personalised. Care plans included details of the patient's understanding of their condition. Recovery care plans included goals and milestones that patients and staff had agreed.
- Staff completed care records on paper and stored these documents in folders which were security kept in the nurses' office.

Best practice in treatment and care

- The psychiatrist prescribed medication in accordance with guidance published by the National Institute of Health and Care Excellence (NICE). Two patients were receiving high doses of antipsychotic medication. Staff had clearly documented this and recorded frequent monitoring of the patients physical health checks.
- Care plans showed that the service provided psychological therapies in accordance with NICE guidance. The primary programme of treatment involved a session of dialectical behavioural therapy (DBT) lasting for two hours each week and an individual weekly session with the psychologist for one hour each week. Nursing staff were trained in DBT. Nurses offered patients one-to-one therapeutic engagement each day. Nurses gave patients the opportunity to explore their thoughts around medication, wellness and recovery, and to discuss any matters that might impede their recovery. This meant that staff could support patients to manage their behaviour and emotions throughout the week in a way that was consistent with the therapeutic programme. In addition, the service provided groups on psychology, well-being, and mindfulness.
- A GP attended the ward twice each month. When the GP was not available ward doctors provided assistance with physical healthcare. Staff referred patients to specialist services at the local general hospital and supported patients to attend appointments. The ward doctor reviewed patients after episodes of self-harm.

- The hospital employed a dietician to support patients with specific dietary needs.
- The service used the Health of the Nation Outcome Scales (HoNOS) to measure patients' progress. Staff carried out a HoNOS assessment when they admitted each patient and repeated this every quarter thereafter. The psychology service used specific rating scales to measure patients' ability to manage emotions.
- Clinical staff participated in audits of clinical notes, infection control and clinical effectiveness.

Skilled staff to deliver care

- The staff team on New Dawn Ward included nurses, nursing assistants, two ward doctors, an activities co-ordinator, an occupational therapist, a lead psychologist, an assistant psychologist and a social worker. The service allocated an art therapist to the ward for one day each week. A dietician worked across all four wards at the hospital.
- New staff received an induction over a period of six weeks. Staff were supernumerary for their first week to allow time for them to work closely alongside experienced members of staff. New staff were supported by a supervisor and a 'buddy' who was employed in the same role. Staff induction also included training on the organisation's policies.
- The hospital required staff to receive one supervision session each month. Information from the hospital showed the rate of compliance with this requirement was 98%. Staff spoke positively about the supervision and support they received. In addition, to individual supervision with their manager, staff attended a monthly reflective practice session. All staff received an annual appraisal. The service held team meetings each month. During these meetings staff discussed lessons learned for serious untoward incidents and complaints, feedback from clinical governance meetings, ward security, risk assessments and improving patients' experiences.
- Information provided by the hospital showed that 96% of staff on the ward had received an appraisal in the last 12 months.
- In July 2015, we found staff were not receiving specialist training about working with people with personality disorders. At this inspection, all staff had received DBT awareness training. Twenty staff were trained as DBT skills coaches. The ward manager and psychologist were DBT supervisors and a further two staff were DBT trainers. This meant that nurses and nursing assistants could provide daily care and treatment that was consistent with the therapeutic programme.
- Managers addressed poor staff performance through supervision.

Multi-disciplinary and inter-agency team work

- The service held two multidisciplinary team meetings each week. The team discussed nine patients at each meeting. During the ward round we observed, there were very detailed discussions with patients about many aspects of their care and treatment including medication, personal care, diet, occupational therapy, psychology and leave. All the staff at the meeting contributed to the discussion and encouraged the patient to be involved in decisions.
- A handover meeting took place at the start and end of each nursing shift. The multidisciplinary handover took place once a day. At the end of each shift, the nurse in charge of the hospital circulated a handover report to all managers and senior nurses giving details of all admissions, discharges and incidents that had taken place during the shift.
- The service had good relationships with other organisations. The service invited commissioning authorities to care programme approach meetings every three months at which the hospital and commissioners discussed the patient's progress. The hospital held monthly safeguarding meetings with the local authority safeguarding team and the police.

Adherence to the MHA and the MHA Code of Practice

- Across the hospital, 84% of staff had completed mandatory training on the Mental Health Act (MHA) and the MHA Code of Practice.
- MHA documentation was stored in paper files. There were records of leave arrangements, relevant capacity assessments and detention paperwork. The ward had attached consent and authorisation certificates to patients' medicine charts.
- Most of the patients we spoke with told us that staff had made them aware of their rights. Staff recorded the occasions when they explained patients' rights in care plans.
- The ward displayed information about independent mental health advocates (IMHA) who attended the ward on a weekly basis.

- The hospital conducted regular audits of the MHA to ensure staff applied it appropriately. Relevant information following these audits was fed back on a ward level during meetings and during supervision where appropriate.

Good practice in applying the MCA

- Across the hospital, 81% of staff had completed mandatory training on the Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS). In July 2015, staff were unable to describe the five statutory principles of the MCA and could not tell us how they would implement the MCA while providing care and treatment for patients. At this inspection, staff had a good understanding of the MCA and its principles.
- A doctor and nurse assessed each patient's capacity to consent to admission and treatment when patients were admitted. Staff updated these assessments when it was appropriate. Staff recorded assessments of patients' capacity to consent to treatment and stored these in the patient's records.
- Nurses provided examples of occasions when a patient's mental capacity has been in doubt. Nurses explained that when capacity fluctuates, they ensured that regular assessments were carried out.

Are tier 3 personality disorder services caring?

Kindness, dignity, respect and support

- Staff displayed a positive and caring attitude towards patients throughout our inspection. When patients were upset or unhappy staff responded with calm and gentle encouragement to help the patient address their concerns.
- Patients' views of staff were positive, although some patients were concerned about specific incidents. We received ten comment cards from six patients. Six comment cards were positive and four were negative. One patient said there had been distinct improvements over the past year, with staff becoming more knowledgeable and more caring. Four responses said that staff were caring and listened to them. Patients found the dialectical behavioural therapy (DBT) programme helpful. There was very positive feedback about the occupational therapy team who one patient described as excellent, providing fun and interesting activities. The negative comments focussed on specific incidents such as when staff asked a patient to wait for their medication. During interviews, patients told us about incidents. For example, a patient said staff left them in pain caused by a medical condition. Another patient told us about an occasion when staff did not respond to a patient who was distressed. Two patients told us about an occasion when patients felt that staff did not respond quickly enough to a patient becoming unwell in the dining room. Patients were positive about the groups and activities.
- In July 2015, patients said that staff discussed confidential information about patients in communal areas of the ward. Patients also said that staff spoke to them through the office door. During this inspection, we found no evidence of these practices. None of the patients raised concerns of this nature.
- The inpatient programme of treatment provided on the ward lasted for between a year and 18 months. During this time staff got to know patients very well. Patients said that staff had a good understanding of their individual needs.

The involvement of people in the care they receive

- Information about the patient satisfaction survey in the report on acute wards for adults of working age and psychiatric intensive care units also applies to this service. See page 28.
- Patients attended a ward round with their consultant psychiatrist and multidisciplinary team each week. Patients were encouraged to engage in decisions about their care and about how staff could support them to manage their presenting risks. Patients met with their primary nurse each month to update their care plan. Records showed evidence of patients being involved in care planning. The service used the 'My Shared Pathway' workbooks to help patients identify the outcomes they wanted to achieve as part of their recovery.
- An advocate attended the ward at least once a week. One patient told us that the advocate had helped her to discuss her concerns with the ward manager.
- Families and carers were actively involved if patients wanted them to be. During this inspection, a patient attended her ward round with her partner. One patient's mother visited and discussed plans for care and leave

with the nurses. Other patients told us how the service was supportive in authorising leave for them to visit their families and maintain their relationships outside hospital.

- Each ward held community meetings each week. A more formal user council for the whole hospital was held once a month. Cygnet hospitals had recently appointed an expert by experience lead to facilitate user involvement across the organisation. The expert by experience lead explained that their role was to speak with patients and feedback their views to corporate leaders and hospital managers.
- The hospital conducts a patient satisfaction survey once each year. Through this survey, the hospital asks patients for their views on the environment, care and treatment, therapies and information and rights. Between October and December 2016, the hospital received 47 responses. Overall, 70% of respondents gave positive answers to questions about care and treatment. This score was 62% for the environment, 55% for therapies and 70% for information and rights. The service received six compliments during the year to 30 November 2016.

Are tier 3 personality disorder services responsive to people's needs?
(for example, to feedback?)

Access and discharge

- The service admitted all patients from other inpatient services. Between 1 June 2016 and 30 November 2016, average bed occupancy was 98%.
- NHS trusts and Clinical Commissioning Groups across England referred patients to this specialist service. The service received a high number of referrals and held a list of patients waiting to be assessed and admitted. The waiting list was in part due to the discharge of patients being delayed. On average, it took two weeks for the service to assess a patient referred to the service. Following assessment, it took, on average, a further six weeks for treatment to begin.
- The service planned admissions with the referring NHS trust or commissioning group. This meant that the service always admitted patients at an appropriate time of day.
- The service had designed the treatment programme to involve an inpatient stay of between 12 and 18 months. Between 1 December 2015 and 30 November 2016 the average length of stay was 16 months. However, during this period the service recorded nine patients as having their discharge delayed for non-clinical reasons. Staff said this was usually because of difficulties in finding supported placements for patients to move to after their discharge.
- We found that care plans provided details of patients' aims and goals, with a strong focus on their recovery. However, staff had not recorded specific details about plans for patients' discharge or aftercare provided under section 117 of the Mental Health Act.

The facilities promote recovery, comfort, dignity and confidentiality

- A patient and a member of staff showed us around the ward. There were a range of rooms and equipment to support the treatment of patients. The service had divided the ward into two areas. New Dawn One was for patients the service had recently admitted. New Dawn Two was designed to be a quieter part of the ward for patient who were settled and looking towards discharge. There was a lounge and dining room that patients could use whenever they wished to. Patients could use a gym that was situated off the ward. The recovery college was situated on the ground floor of the hospital. Each area of the ward had its own clinic room but neither of these was big enough to accommodate a couch for physical examinations.
- There was a quiet room and sensory room that patients could use if they wanted to be in a low stimulus environment. Patients could meet visitors in their bedrooms or quiet rooms.
- The ward provided patients with basic mobile phones they could use to make calls and send text messages. The ward did not permit patients to have telephones with cameras.
- Patients could access a large balcony under the supervision of staff.
- In January 2017, the local authority awarded the hospital a food hygiene rating of five out of five. Some patients said the quality of food was poor and they found the menu rotation every three weeks meant that meals were predictable.

- As part of the least restrictive initiative, the service had introduced facilities for patients to make hot drinks whenever they wished.
- Patients were able to personalise their bedrooms and many patient chose to do so.
- Patients were able to keep their belongings securely in their bedrooms.
- The hospital provided an extensive programme of activities throughout the week, in addition to the therapeutic programme. Care plans showed that patients had their own individual timetables. Creative groups included an arts and crafts group, cooking group, craft workshops and a baking group. Physical activity groups included gym session, a walking group and weekly yoga session. The service also facilitated pampering and relaxation groups. The service had a timetable of activities from Monday to Saturday. There were no structured activities on Sunday. Patients were very positive about the groups and activities available.

Meeting the needs of all people who use the service

- The ward was situated on the first floor of the hospital. A lift from the ground floor allowed step free access.
- Information leaflets could be translated in to specific languages on request.
- Staff displayed information about treatments, patients' rights and advice on how to complain on notice boards on the ward. The hospital displayed information about its performance on a large notice board near the entrance.
- The service could provide interpreters for patients whose first language was not English.
- The service provided food to meet the ethnic, religious and dietary requirements of patients.
- The hospital arranged for a chaplain to visit. Staff supported patients to attend churches and religious groups in the community. Patients could use a multi-faith room on Hansa Ward.

Listening to and learning from concerns and complaints

- From April 2016 to March 2017 there had been 40 complaints about the hospital. There had been 14 complaints about nursing staff and eight complaints about the quality of care. Some of these complaints had not been upheld or contained allegations that could not be substantiated. The service monitored themes of complaints the most prominent theme was complaints about staff and their relationship with patients. When complaints were upheld, the service took action to address the concerns raised and supported with staff with training if required. The ward provided patients with information on how to make a complaint. All patients we spoke with were aware of this procedure and felt comfortable making a complaint.
- There were three complaints about the service for people with personality disorders during 2016. These complaints were about home leave not being facilitated, a patient feeling bullied and unsafe on the ward, and a breach of the hospital's information governance duties. The service upheld two of these complaints. None of the complainants referred their concerns to the ombudsman.
- Patients said they knew how to make complaints and would feel confident in doing so.
- The service sent a report of the investigation into the complaint to the complainant. The service told us they had introduced changes because of these complaints. For example, the service introduced better organisations to facilitate leave.

Are tier 3 personality disorder services well-led?

Vision and values

- Staff were familiar with the organisations values of being helpful, responsible, respectful, honest and empathetic.
- The service aimed to continue its' develop programme of reducing restrictions on patients and creating a safe environment. These objectives were wholly consistent with the values of the ward.
- Staff knew who the senior managers were. Staff said that senior managers at the hospital frequently visited the ward.

Good governance

- The hospital manager, the clinical services manager, the general manager and the medical director were responsible for leadership and governance at the hospital. The heads of occupational therapy, social work and psychology attend monthly clinical governance meetings, along with the senior managers and ward managers. Clinical governance meetings included a

review of complaints, serious incident reports, restraints, risk registers and service user engagement. In addition, there were monthly meetings of the audit committee and the heads of departments.

- Nurses' compliance with mandatory training across the hospital was above 95%. Compliance for all clinical staff was above 90%. All staff received an annual appraisal and monthly supervision. The service consistently provided the correct level of staffing. We observed staff maximising the time they spent on direct care. Nurses actively participated in clinical audits and reported incidents. Minutes of team meetings showed that learning from incidents, complaints and feedback from patients was an integral part of regular team discussions. Staff followed procedures for safeguarding, the Mental Health Act and the Mental Capacity Act.
- NHS England funded patients' placements on New Dawn Ward. The service was required to provide a quarterly report covering the key performance indicators. These included the number of admissions, discharges, bed occupancy, the number of patients who had a care programme approach meeting during the quarter and the number of patients engaging in 25 hours of meaningful activity each week.
- During the last inspection in July 2015, we found that there were insufficiently robust systems to share learning from incidents and complaints across hospital wards. At this inspection, we found this had improved and the hospital promoted sharing information and learning from other wards. The hospital sent a daily report to managers. This contained information about incidents, safeguarding's and admissions for all the wards. Staff discussed all complaints and incidents at team meetings and in reflective practice sessions.
- The ward manager had sufficient authority to manage the ward effectively. An administrator supported the ward manager.
- The service had a protocol for nurses and health care assistants to escalate concerns about safety and effectiveness of care to a senior level.

Leadership, morale and staff engagement

- The staff survey for the whole hospital in 2016 received responses from 132 employees. The overall level of positive responses within the survey was 81%. Within the overall scores, 90% of respondents said that patients were the hospital's top priory and 80% said they enjoyed working for Cygnet. Negative scores reflected the high number of incidents. For example, 42% of respondents said they had personally experienced bullying, harassment or abuse from patients. The service had introduced an action plan to address these concerns. This included introducing the 'safe wards' programme, reducing conflict through minimising blanket restrictions and settings target to reduce incidents of violence and aggression by 50%.
- The sickness rate for this service was 2.2% in the 12 months to the 31 October 2016. Staff turnover during this period was 12%.
- Staff told us they were aware of the whistleblowing process and they knew how to use this. Staff said they could raise concerns without fear of victimisation. Staff said the ward manager was very approachable and always listened to nurses' concerns. None of the staff we interviewed raised concerns about bullying or harassment.
- All staff acknowledged that the ward could be a difficult environment to work in. At times, patients could be very distressed and require a lot of reassurance. However, there was a good level of morale and support for colleagues within the team. Staff spoke positively about their supervision, reflective practice and training opportunities.
- There were opportunities for leadership development. For example, senior nurses provided cover for the ward manager when the ward manager was on leave. The service also appointed senior nurses to the role of nurse in charge of the hospital at weekends.
- Minutes of team meetings showed that staff had the opportunity to give feedback and contribute to service development. One nurse said that managers always listened to ideas for changes, but staff had to support these ideas with evidence.

Commitment to quality improvement and innovation

- The hospital operated a continuous improvement cycle covering policies and procedures, training, reviews and audits, feedback from patients and staff, and identifying themes and trends.

Outstanding practice and areas for improvement

Outstanding practice

We found the following examples of outstanding practice:

- The service had introduced a comprehensive programme to reduce restrictive practices. This included appointed a nurse and a patient as restrictive practice leads for each ward.
- The service employed an expert by experience lead who had supported patients to voice their views on services and was working towards ensuring that service user involvement was embedded across the hospital.

Areas for improvement

Action the provider SHOULD take to improve

- The provider should ensure patients are given information to contact the parliamentary health service ombudsman should they feel a complaint has not been resolved.
- The provider should ensure that care plans include arrangements for aftercare under section 117 of the Mental Health Act 1983.
- The provider should ensure that they demonstrate that incidents have been dealt with in order to reassure patients who may be upset or concerned.
- The provider should ensure that all staff have completed mandatory training in awareness of cardiopulmonary resuscitation and automated external defibrillators.

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.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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