# Cygnet Hospital Coventry

## 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 | Requires improvement |
| Are services safe? | Requires improvement |
| Are services effective? | Good |
| Are services caring? | Good |
| Are services responsive? | Requires improvement |
| Are services well-led? | Requires improvement |

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

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

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

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

# Summary of findings

## Overall summary

**We rated Cygnet Hospital Coventry as requires improvement because**:

- There had been some issues with governance at the hospital, which will require actions to be taken at a senior level. The hospital had been open for six months. The senior management team had action plans in place but these had not been properly embedded at the time of the inspection. The issues included recruitment and retention of staff, lack of clinical audits, training, lack of signed and dated cleaning records in clinic rooms, following up on the audits completed by the external pharmacist, and a lack of communication with carers.
- The hospital had an issue with patients leaving the hospital without permission during an incident when the fire alarm had been activated. This was unsafe for patients. The hospital had reviewed its fire evacuation plan and put in a new door but needed to continue to review its fire evacuation plan and ensure it met the needs of all individuals.
- The visitor's room on Dunsmore psychiatric intensive care unit was at the entrance to the ward and carers found that once in the room it was difficult to attract the attention of staff if they needed support or to be able to leave the ward to use the facilities.
- The wards reported 457 episodes of restraint for the five months from April 2017 to August 2017. We found these numbers to be high for a five month period. Ward managers had been working with staff to reduce the number of times restraint was used through training and de-escalation techniques which had started to show some improvement in the numbers.
- The wards had not always recorded the physical health checks following rapid tranquilisation and one clinic room had some items which were no longer in their packaging making it difficult to determine what they were for or if they were still in date.

However

- The wards provided a clean and well-maintained environment for patients. Clinic rooms were well equipped and each ward had a separate room for dispensing medication. Access to doctors was good with each ward having a consultant and a specialist doctor. Serious incidents had been investigated and staff received feedback from managers as to the actions that were needed to reduce the risks in the future.
- Patient records and Mental Health Act paperwork was in good order. Care plans included patients' views and were holistic and person centred. Physical health care was a key focus for staff and included the use of a specialist eating disorder nurse and a dietician.
- Staff behaved in a way that was caring and respectful to patients. They demonstrated a good knowledge of the patient group on each ward. Patients had access to advocacy and staff supported them to use this service.
- The hospital was purpose built and had a full range of rooms and facilities for patients to use including a gym, a beauty salon and a library. Patients had access to outside space and communal areas for relaxing. Wards had good access for people with disabilities and displayed a wide range of leaflets and information for patients to use.

# Summary of findings

## Our judgements about each of the main services

| Service | Rating | Summary of each main service |
|---|---|---|
| Acute wards for adults of working age and psychiatric intensive care units | Requires improvement  | see detailed findings |

# Summary of findings

## Contents

Requires improvement

# Cygnet Hospital Coventry

**Services we looked at**
Acute wards for adults of working age and psychiatric intensive care units

# Summary of this inspection

## Background to Cygnet Hospital Coventry

Cygnet Hospital Coventry is part of the Cygnet Health Care group, which provides mental health care nationally.

The hospital in Coventry is newly built and opened in April 2017. It has three wards and seven self-contained step down flatlets called Ariel Court, which are not yet open. All wards are for women.

The wards are:

- Dunsmore psychiatric intensive care unit, which has 16 beds. Only 10 beds were in use during the inspection
- Middlemarch Ward had 17 beds and is a locked rehabilitation ward. It had nine beds occupied during this inspection.
- Ariel Ward is a specialist personality disorder ward, which offers enhanced care for patients who have co-morbid disordered eating. The focus of this ward is to offer dialectical behavioural therapy as the main type of treatment. It is a 16 bedded ward and they had 14 patients admitted at the time of the inspection.

The hospital has a registered manager and this is the first inspection.

## Our inspection team

Team leader: Linda Clarke CQC inspector

The team that inspected the service comprised four CQC inspectors, a CQC inspection manager, a pharmacy inspector and an expert by experience. Experts by experience are people who have personal experience of using or caring for people who use health and social care services.

## Why we carried out this inspection

We inspected this service as part of our ongoing comprehensive mental health inspection programme.

## 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, asked a range of other organisations for information and sought feedback from patients at three focus groups.

During the inspection visit, the inspection team:

- visited all three wards at the hospital, looked at the quality of the ward environment and observed how staff were caring for patients
- spoke with 14 patients who were using the service and five carers
- spoke with the registered manager and managers for each of the wards
- spoke with 25 other staff members; including doctors, nurses, occupational therapist, psychologist and social worker, administrators and domestic staff
- received feedback about the service from two external care co-ordinators and commissioners
- spoke with an independent advocate

# Summary of this inspection

- attended and observed one hand-over meeting, a ward round, a daily risk management meeting and a ward managers' meeting
- collected feedback from nine patients using comment cards and one staff member
- looked at 19 care and treatment records of patients
- carried out a specific check of the medication management on all wards including 19 prescription charts
- reviewed six sets of Mental Health Act paperwork
- looked at a range of policies, procedures and other documents relating to the running of the service.

## What people who use the service say

We spoke to 14 patients and received feedback from five carers. We also received nine comments cards from patients. Of the comments cards, three were positive about the hospital and the progress it had made, four were negative and mainly related to peoples personal situations and three were mixed. Two sets of carers raised issues about the lack of communication from the hospital and were unhappy about how complaints had been handled. One carer stated that the therapeutic programme discussed prior to admission had been slow to be started.

Patients had mixed views about the hospital. These related mainly to staffing issues and the high turnover of staff resulting in significant use of agency staff. Seven patients we spoke to said that staff were polite, caring and supportive. Patients said that the lack of access to meaningful activities meant that they had become bored and staff said it was difficult to motivate patients following the issues with staffing. Five patients reported that leave had been cancelled on several occasions and that they had felt unsafe on the wards.

# 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?

Requires improvement 

We rated safe as requires improvement because:

- The hospital had an issue with patients leaving the hospital without permission during an incident when the fire alarm had been activated. This was unsafe for patients. The hospital had reviewed its evacuation plan and put in a new door but needed to continue to review its fire evacuation plan and ensure it met the needs of all individuals.
- The wards reported 457 episodes of restraint for the five months from April 2017 to August 2017. We found these numbers to be high for a five month period. Ward managers stated that they working on reducing the levels of restraint through training for staff and use of de-escalation techniques with patients.
- We found a high use of agency staff and there were vacancies at the time of our inspection. Though the organisation made every effort to ensure that agency staff had good knowledge of the patient group, patients reported that they did not always feel that this was the case. The hospital had experienced a high turnover of staff since opening and this had resulted in some shortfall in training and supervision levels. Recruitment had been undertaken and there were a number of new staff undergoing pre-employment checks prior to taking up full time roles.
- Staff had not completed regular observations or clinical checks for one patient following rapid tranquilisation to ensure the safety and wellbeing of the patient. Staff reported that the patient had refused the checks but this had not been recorded.
- The wards used an external pharmacist for medication management. The pharmacist visited weekly and produced an audit report for the hospital. However, they reported that staff did not always communicate when actions had been completed. Medication on Middlemarch Ward was not always stored correctly.
- Cleaning records had not always been signed or dated so staff could not be sure that areas such as the clinic rooms had been cleaned.

However:

- Ward areas were well maintained and for the most part were clean and well presented. Ligature risk assessments had been

# Summary of this inspection

undertaken for all areas and any ligature risks had been mitigated with observations or working processes. Ward areas were spacious and well lit and bedrooms were well laid out to maximise comfort.
- Staff undertook risk assessments for all patients upon admission. Advanced statements were in place and, where possible, these had been created in collaboration with the patient.
- There was good evidence that the hospital had reviewed serious incidents and developed procedures and new systems of working to ensure that these types of incidents did not re-occur.

## Are services effective?

Good

We rated effective as good because:

- The hospital used a paper recording system to manage patients' care records. These were well presented and maintained and were accessible to staff. They were stored securely in nursing offices in locked cupboards to maintain confidentiality. All information required to deliver care was present in the patients' care records we checked.
- Staff followed National Institute for Health and Care Excellence guidance in a number of areas. These included management of prescribed medication and meeting physical healthcare needs. There were a number of people employed to manage conditions relating to physical healthcare. These included a dietitian and a specialist eating disorder nurse.
- There was a full range of staff included in the multi-disciplinary team. This included psychologists, a psychiatrist, occupational therapists and social workers.

However:

- Though the hospital delivered Dialectical Behaviour Therapy as part of its therapies programme it was sometimes the case that there were no staff on site to facilitate this. Staff who had been trained in various areas of therapy support had subsequently left the organisation. This meant that the hospital was short of staff with knowledge at the time of our inspection.
- Training levels in relation to the Mental Health Act were low at 25% for Ariel Ward, 53% for Dunsmore PICU and 92% for Middlemarch Ward and some staff had not received training since taking up a full time post. We did not find any errors in the completion or recording of Mental Health Act paperwork. Staff we spoke to all had good knowledge of the Act and were able to give examples of how it had been applied correctly.

# Summary of this inspection

## Are services caring?

Good

We rated caring as good because:

- We observed staff interactions with patients throughout the period of our inspection. They treated patients with dignity and respect and tailored their interactions to individual patient's needs and levels of understanding.
- The hospital had responded to patient to patient bullying by contracting an external supplier to deliver sessions specific to reducing incidents of bullying. The police had also visited the unit to talk with the patient group. Though this had been successful in reducing the incidents of bullying some patients reported to us that they still felt unsafe.
- Staff had good knowledge of the patient group and in the cases of new members of staff, there were measures in place to ensure that they were given information about the existing patient group.

However

- Some patients reported that they did not feel engaged by agency staff. Some felt that they did not know them and could not work with them effectively.
- Two of the carers we spoke to felt that communication was poor from the organisation.

## Are services responsive?

Requires improvement

We rated responsive as requires improvement because:

- Families raised a concern that when in the visitors area of Dunsmore PICU they were cut off from the ward and were unable to ask for help or leave the area to use the toilet. The only way to attract the attention of staff was by phoning reception. They felt this was not safe for them or their relative as they could be left there for some considerable time without being monitored.
- Some patients reported to us that the food was not of a good quality. As a result, patients had taken to ordering in their own shopping sometimes in large quantities, which had taken up quite a lot of storage space. Staff were working with patients to monitor this and to limit the amount of spare food stored on the wards.

However:

- The wards had a wide range of rooms and equipment available to support patients. They had a separate therapy suite, which included a kitchen, and arts area, a large hall, a gym a beauty salon, a library and a multi faith room.

# Summary of this inspection

- The unit had good access and facilities for people who may have had a disability. There were leaflets posted around wards giving patients information on the service. This included information about complaints, accessing advocacy services and specialist external services. The hospital also had access to interpreters including British Sign Language.
- Patients had access to outside space. This was easy to observe and had privacy from the housing estate next to the hospital.

## Are services well-led?

**Requires improvement**

We rated well-led as requires improvement because:

- We found there had been some issues with governance within the hospital. Recruitment and retention of staff had been difficult with a high turnover of staff leaving or being dismissed. The hospital had used a lot of agency staff but this had improved with the use of block booking agency staff who knew the hospital. Supernumerary staff such as occupational therapy assistants had to support the work on the wards when staffing numbers were low which affected patients receiving activities. Complaints had not always been investigated in a timely manner and communication with relatives had been poor. The hospital did not have an equality and diversity lead and this would support them to ensure that the needs of patients as individuals had been met.
- Staff supported each other but some had been working in difficult circumstances and managers acknowledged that they needed to work on building their teams.

However

- Staff knew and agreed with the organisations visions and values. Their objectives and appraisals were tailored to these. Staff were also aware of who the organisations most senior managers were. They stated that they had visited the unit and were approachable.
- The ward managers although new felt they had the authority and support from the senior management team to do their jobs. They had access to administration support and Dunsmore PICU had a ward clerk who supported the team.
- All staff we spoke to except one stated that since the new ward managers had started morale had improved although it was still early days. People who had considered leaving felt they would stay as they had started to enjoy and feel supported in their roles.

# Detailed findings from this inspection

## Mental Health Act responsibilities

We do not rate responsibilities under the Mental Health Act 1983. We use our findings as a determiner in reaching an overall judgement about the Provider.

Training in the Mental Health Act was low at 25% for Ariel Ward, 53% for Dunsmore PICU and 92% for Middlemarch Ward.. This was because there had been a high staff turnover and new starters had not yet received the face-to-face training, which was planned to take place. Despite this staff showed a good knowledge of the Act and how it was applied to the patients in their care. The hospital had a Mental Health Act administrator who had oversight of the paperwork and ensured this was in good order and up to date. Unqualified staff stated they could speak to doctors or qualified staff for guidance if they needed this.

Consent to treatment and section 17 leave paperwork was in good order and stored appropriately.

## Mental Capacity Act and Deprivation of Liberty Safeguards

Staff had received training in the Mental Capacity Act and showed an understanding of the five guiding principles of the Act and how it supported patients. Some staff felt they needed more experience to fully embed this into to daily practice. Staff understood that capacity could fluctuate and that assessments needed to be decision specific.

The hospital had not made any Deprivation of Liberty Safeguards referrals as all patients had been detained under the Mental Health Act.

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

Requires improvement

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

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

Requires improvement

### Safe and clean environment

- Although the layouts of the wards did not allow staff to observe all areas mirrors had been placed to mitigate against any risks. Ligatures had been risk assessed. The building was newly built and bedrooms and bathrooms had anti ligature fittings. The hospital had CCTV in communal areas of the ward to monitor potential ligature risks. Each ward had a ligature audit which was checked and up dated.
- The hospital is for women so all areas comply with guidance on same sex accommodation.
- The clinic rooms are fully equipped and separate from the dispensary where medication was given out to patients. This was the same for all wards. Emergency bags were checked regularly and staff had been trained to use them. The rooms looked clean but the housekeepers cleaning records were not always signed or dated to show who had completed the cleaning.
- All three wards had a seclusion room. The rooms on Ariel and Middlemarch wards had not been used for seclusion and on Ariel ward the room smelled of stale water because of the water trap in the sink. Once informed of this staff took action to clear the issue. The seclusion rooms were modern and fit for purpose and had additional features such as low-level mood lighting to help calm patients. Seclusion records for Dunsmore PICU had been completed appropriately and were up to date.
- Wards areas were clean and had furnishings, which had been well maintained. On Ariel Ward, one area had staining on the wall. This had been cleaned using infection control methods but the stain remained. When spoken to ward staff agreed that the wall needed repainting and this would be completed as soon as possible.
- Staff adhered to infection control principles. Hand washing posters were displayed and gel was available throughout the hospital.
- Domestic staff had responsibility for cleaning all areas. They kept their own records to ensure the ward areas had the level of cleaning required and when this needed to be completed.
- Managers undertook environmental risk assessments. These showed a red, amber, green rating and what actions needed to be completed. The risk assessments showed when new items had been added and the date other actions had been finished.
- The hospital had an alarm system that showed where an alarm had been triggered and the level of response needed. All staff carried alarms and patients bedrooms had a call button in the bedroom and ensuite.

### Safe staffing

- Staffing establishment figures had been worked out using an hours per patient day system. Managers used a matrix based on this to ensure staffing levels met the needs of patients and could adjust this on a daily basis. On Dunsmore PICU, the manager had identified that the matrix did not always do this as it did not allow for the high level of needs of the patients so an adapted

version was being used. Staffing turnover had been an issue since the hospital opened in April 2017 and use of agency staff had been high to maintain the levels needed for patient safety.

- At the time of the inspection, the hospital reported that they had been through a significant period of recruitment. They now had three new ward managers in post who had the level of experience needed to ensure patients' needs were being met. They had several new staff both qualified and healthcare support workers going through the post recruitment checks who would be starting in the near future. This left three vacancies for qualified staff. Two of these were on Dunsmore and one on Ariel. The hospital had six vacant posts for healthcare support workers. Two on each ward.
- Managers block booked agency staff who had received an induction and had supervision on a regular basis. However, patients reported that there had been a lack of consistency around staffing and this had caused them to feel unsafe on the wards. This was a particular issue for patients on Ariel Ward where they felt their needs had not always been met because staff did not know them. The rotas we looked at indicated that all shifts had been covered and managers stated that continuity of care had improved with the use of agency staff who were familiar with the ward.
- A qualified or experienced member of staff was present in communal areas to support patients. On Ariel Ward, patients on five-minute observations were encouraged to stay in communal areas so that their levels of observations could be reduced allowing staff to engage more with the patients.
- There had not always been enough permanent staff for 1:1 time with a named nurse to take place. Staff on both Dunsmore PICU and Ariel ward stated that patients did not have enough access to meaningful activities during the day, in the evenings or at weekends. The occupational therapists provided activities but patients did not always feel motivated or supported to access these. Feedback from patients confirmed that they did not feel there was enough to do and activities did not always meet their individual needs.
- The wards had enough staff that had been trained to carry out physical interventions on each ward.
- All wards had access to a consultant psychiatrist and another doctor. The doctors covered an on call rota out of hours. In a medical emergency staff would call the emergency services.
- Staff completed mandatory training during their induction period. This is in the form of e-learning. Managers allowed protected time for staff who needed to complete training. At the time of the inspection, Middlemarch Ward had mandatory training figures, which were all above 80%. Dunsmore PICU lowest figures were 53% for Mental Health Act code of practice and 57% for rapid tranquilisation. Ariel Wards lowest figure was 25% for Mental Health Act code of practice and 50% for Mental Capacity Act and Deprivation of Liberty Safeguards.

**Assessing and managing risk to patients and staff**

- The hospital reported 47 incidents of seclusion from April 2017 to August 2017. The highest amount was 43 for Dunsmore PICU. None of the wards had used long-term segregation. The wards reported 457 episodes of restraint for the same period. Of these 41 had been in the prone position. Dunsmore PICU had the highest numbers with 303 incidents of restraint with 32 in the prone position.
- We reviewed 19 sets of care records. On Middlemarch and Ariel wards, risk assessments started prior to admission. For Dunsmore PICU risk assessments started as soon as the patient had been admitted although staff reviewed the risk assessment provided by the previous placement as part of the referral process. The wards had a daily risk update meeting where changes to patient's level of risk were discussed. The risk assessments had been updated on a regular basis and when an incident occurred.
- Staff used short-term assessment of risk and treatability, which was a recognised risk assessment tool.
- Staff applied some restrictions especially on Ariel Ward where there was a high level of one to one observations for patients at risk of self-harm. Patient on this level of observations could not access their rooms between 8am and 8pm except for an hour at lunchtime. Instead, patients had been encouraged to use the communal areas so the level of observations could be reduced from five minutes to 15 minutes, which was less restrictive for patients and allowed staff to engage in a positive way with patients.
- At the time of the inspection, the wards did not have informal patients so no one could leave without permission of the ward staff.

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

Requires improvement

- Staff followed the hospital policy for completing observations. On Dunsmore PICU, the ward manager completed audits of observation records on a weekly basis comparing notes alongside CCTV to ensure accuracy of recording.
- The wards searched patients and their rooms on admission and then on an ad hoc basis depending on level of risk. This was in line with the policy set out by Cygnet Health Care.
- Staff stated that they only used restraint as a last resort and preferred to use de-escalation and distraction techniques. Wards had quiet areas for patients who needed time out from the ward. Staff on Dunsmore PICU said that restraint was more likely to be with new patients rather than those who had been on the ward for a few days. The hospital had set up a reducing restrictive practice group, which was chaired by the clinical manager and Cygnets regional lead for the north of England. The group had representatives from a range of roles across the hospital and patients. Although in its early stages the hospital were already looking at actions that they could take to reduce restrictive practice. Staff had been trained in the use of prevention and management of violence and aggression (PMVA) and RAID (Reinforce Appropriate Implode Disruptive) training although managers informed us that not all new staff had been able to access PMVA training at the point of their induction. Patients had been supported to complete advance statements to indicate their wishes during restraint. We saw that on Middlemarch Ward these had been completed in detail.
- The hospital recorded the use of rapid tranquilisation as both oral and intra muscular and it was not possible to separate these figures. They reported that this had been used 18 times between April 2017 and August 2017 with Dunsmore PICU having the highest figures with 13. Rapid tranquillisation had been administered to one patient on Dunsmore PICU however, the rapid tranquillisation policy had not been fully followed. There was a lack of regular observations or clinical checks recorded to ensure the safety and wellbeing of the patient. Staff reported that the patient had refused the checks but this had not been recorded,
- Seclusion was used appropriately and followed best practice. The seclusion records had been completed and kept in an appropriate manner.
- Staff had completed safeguarding training for adults and children. There had been an issue with staff making safeguarding referrals to the local authority safeguarding team without fully understanding the local authority threshold for this however managers felt it was better to make these referrals to be open and transparent. To resolve this the hospital social worker screened all referrals and supported staff to ensure these were made in the right way.
- The wards used an external pharmacist for medication management. The pharmacist visited weekly and produced an audit report for the hospital. However, they reported that staff did not always communicate when actions had been completed. On Middlemarch Ward, safe disposal of expired medicines was not always undertaken. The pharmacist had identified an expired medicine (September 2017) in the refrigerator however despite informing staff it was still stored in the medicine refrigerator a week later. There was an increased risk that this medicine could have been administered. On Middlemarch Ward, medicines were not always stored in their original container. Loose strips of a medicine were found inside the medicine trolley. Therefore, there was an increased risk of a medicine error. We also found on this ward that staff had not completed medication records to document the administration of a medicine. Of the six patient medicine records, we checked we found two with gaps in their administration records. This meant it was not possible to determine if the medicine had been administered and there was no reason documented to explain why the medicine had not been administered.
- Staff monitored physical health and on Ariel Ward. They employed a specialist eating disorder nurse to support patients with additional physical health needs.
- Each ward had a room at the entrance to the ward, which could be used for children to visit. This was in line with Cygnet Healthcare visitors policy.

**Track record on safety**

- The hospital stated they had nine serious incidents since they opened in April 2017 to August 2017. These related to cases of self-harm by patients who had brought items on to the wards. Action had been taken to improve this. Staff discussed it in team meetings and it was an agenda item at the health, safety and security monthly meetings.

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

Requires improvement

- The hospital had also had an issue with patients leaving the hospital without permission during an incident when the fire alarm had been activated. The hospital has had to look at its evacuation plan and improve this to ensure the safety of patients. It had also carried out additional fire drills and had the door changed to improve safety for patients during the fire evacuation.

**Reporting incidents and learning from when things go wrong**

- All staff including agency staff had access to the electronic recording system for reporting incidents. One member of agency staff stated they did not have access to this but was aware that other staff did.
- Staff understood that they had a duty to be open and honest with patients when incidents happened and this was reflected in the patients' records.
- Staff received feedback from incidents through handover and team meetings and during one to one sessions.
- There was evidence of change following incidents such as improved communication between staff at handovers.
- Staff received a full debrief following incidents and could ask for additional support if they needed it.

## 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 19 sets of patient records. The care plans were detailed, holistic, person centred and recovery focussed. For Middlemarch and Ariel wards, assessment started prior to admission and from the point of admission on Dunsmore PICU. The records showed there was physical healthcare monitoring and this was ongoing throughout a patients stay on the wards.
- The wards used paper records. All information needed to deliver care had been stored in locked cupboards inside the nurses' office, which was also locked.

**Best practice in treatment and care**

- Staff followed National Institute for Health and Care Excellence guidance when prescribing medication.
- The wards had access to a psychologist and psychology assistants and staff had been trained to provide dialectical behavioural therapy (DBT). However, the high turnover of staff meant that staff that had been trained had left and staff stated it was not always possible to offer these therapies in the way that would benefit patients. Ariel Ward particularly focussed on offering patients DBT as its main form of treatment. The hospital had identified that they need to recruit a full time DBT specialist to ensure patients received continuity of care.
- The wards offered good levels of physical healthcare although the hospital had experienced difficulties in developing a service level agreement with local GPs. On Ariel Ward where some patients had eating disorders, a nurse who specialised in this area had been employed to work with patients and support staff with training. The ward had access to a dietician who attended the hospital for four hours a week.
- The patient's nutrition and hydration needs had been assessed. Staff used tools such as the national early warning score, which looks at areas such as respiratory rate and blood pressure to assess patient's needs. On Ariel Ward, some patients received nutrition through a nasogastric tube, which was a special tube that carries food and medicine to the stomach through the nose. This treatment was care planned to support them with their eating disorder.
- Staff used Health of the Nation Outcomes Scales to monitor progress in patients. They also used the recovery star for some patients to support patients to think about their goals for recovery.
- The hospital carried out audits but as it was still relatively new and they had a high turnover of staff initially, staff had not really been involved in audits. We saw evidence that staff had completed the ligature risk audits and a review of seclusion and long-term segregation.

**Skilled staff to deliver care**

- The wards provided a full range of skilled staff to support patients including a psychologist, occupational therapists, a social worker, nurses, doctors and healthcare assistants.

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

Requires improvement

- Staff had the experience and qualifications to do their jobs although issue with recruitment meant it had taken time to find staff with the right level of experience for the wards, particularly ward managers who were all new in post at the time of the inspection.
- Staff received a detailed induction, which initially involved five days of e learning, and classroom based learning. This was being reviewed as ward managers felt some of this time should be spent being orientated to the wards.
- Staff received supervision on a regular basis and wards displayed the supervision tree in the ward office so staff knew who their supervisor would be. Regular supervision time had been added into the rotas as protected time so staff knew when this would take place. Dunsmore PICU had a 100% completion rate at the time of the inspection however, Middlemarch was 93% and Ariel Ward was 89%. As the hospital had only been open for six months staff had not been employed long enough for appraisals to take place
- Staff received the necessary training they needed for their role but staff on Ariel Ward felt they would benefit from specialist training in supporting people with a personality disorder. The ward manager reported that they were looking at this training for staff.
- Managers spoke about addressing poor performance and an example was given of staff being dismissed as they failed to reach the standards expected by the hospital. Managers also spoke about supporting and mentoring staff as a way of retaining new staff.

**Multidisciplinary and inter-agency team work**

- The hospital held a range of meetings to ensure the effective running of the hospital. These included ward handovers, team meetings, risk management meetings, ward managers meetings and integrated governance meetings. Some meetings had only started recently but we observed a handover, the daily risk management meeting, the ward managers meeting and ward reviews for patients and found all to be informative and inclusive.
- The hospital was working to improve relationships with care coordinators and commissioners following some concerns which had been raised initially about patient safety and staffing after the hospital opened. The commissioners we spoke to felt that significant improvements had been made and that their initial concerns no longer existed.
- The hospital had worked with the local safeguarding team to ensure referrals they had made were appropriate which had not always been the case.

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

- We reviewed six sets of Mental Health Act paperwork. The paperwork was received and reviewed by a qualified member of staff when a patient was admitted.
- The hospital had a Mental Health Act administrator who coordinated the paperwork and ensured the proper processes for tribunals took place.
- Section 17 leave was recorded. Staff understood the leave granted and the parameters of this however, there had been one occasion where staff had not fully risk assessed a patient before leave started which had led to an incident while they were out. Learning from this was documented and improvements made to risk assessments for section 17 leave being completed.
- Training figures for the Mental Health Act were low at 25% for Ariel Ward, 53% for Dunsmore PICU and 92% for Middlemarch Ward. The hospital manager clarified that this was partly due to high staff turnover and the fact the training was delivered face to face and there had been some gaps in the delivery of this training for new staff. This had been resolved and staff who had not completed it were booked on to training and it now formed part of the induction for new starters. Staff we spoke to showed an awareness of the Mental Health Act and knew who to speak to for advice and guidance.
- Consent to treatment and capacity requirements had been adhered to and paperwork was attached to the medication charts and monitored by staff giving out medication.
- Patients had their rights under the Mental Health Act explained to them on admission and on a regular basis after that.
- Staff could access support from the Mental Health Act administrator at the hospital or from the wider team at Cygnet.
- Detention paperwork had been completely was up to date and stored in an orderly fashion.
- The Mental Health Act administrator audited paperwork and shared learning with ward staff.

**Good practice in applying the Mental Capacity Act**

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

Requires improvement

- Staff had completed Mental Capacity Act training. This was 100% on Ariel Ward, 72% on Dunsmore PICU and 83% on Middlemarch Ward.
- There had been no Deprivation of Liberty Safeguards applications as most patients had been detained under the Mental Health Act although staff understood how and when these should be made.
- Staff demonstrated an understanding of the act and its five statutory principles and how it could be used to support patients although some staff stated they felt they needed more training to fully implement this within their work.
- Staff had recorded capacity to consent for patients where it had been felt they might lack capacity and this had been recorded in the records. Staff understood that a best interests decision would be decision specific and made by the multidisciplinary team with family and carers included when possible and include the previous wishes of the patient.
- Staff understood the Mental Capacity Act definition of restraint, which had been covered in their training.
- Staff could access advice through Cygnet hospital or the local authority.
- Cygnet hospital had arrangements in place to monitor adherence to the Mental Capacity Act.
- Staff and patients knew who the independent mental health advocate was and how to make a referral. We spoke to the service who visited the ward twice a week and at other times as requested by patients and they stated that advocacy was well received and patients had been encouraged to use the service.

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

Good

### Kindness, dignity, respect and support

- Although many patients were sitting in communal areas with staff observing them it did not appear as if staff were actively engaging or motivating patients. However, when they did they treated patients' with dignity and respect. This was not the case in activities area off the ward where staff and patients were preparing for a party and the atmosphere was light and interactive. During ward round on Ariel Ward, we saw that all clinical staff modified their use of jargon and medical language while the patient was in the room to ensure the patients understanding of their treatment.
- Of the 14 patients we spoke to, seven stated that staff were polite, friendly and respectful towards them however, the others did not answer this question. On Ariel Ward, patients showed the highest level of dissatisfaction. Five patients reported feeling unsafe and complained about the level of agency staff being used. There had been several incidents of bullying on this ward by patients towards other patients. The new ward manager had arranged for an external provider to deliver a programme of four sessions called 'My Rights and Responsibilities' to try and manage this issue. They had also involved the police to talk to patients. While it was reported that this had been partially successful the current mix of patients on this ward meant that patients complained this was still an issue. Additional support was being given to staff to support them to recognise and deal with these issues as they occurred.
- Most staff understood the needs of individual patients although some staff had only recently joined the hospital and were still getting to know individuals. On Dunsmore PICU they used a 'get to know me file' which contained relevant information on each patients so new staff or agency staff could familiarise themselves with patients before starting work.

### The involvement of people in the care they receive

- Staff supported patients to become familiar with the wards on admission and new patients would have increased observations while they were settling in.
- Of the fourteen patients we spoke to six said they had been offered copies of their care plans. The other eight patients did not know or declined to answer the question. We saw in the care records that patients had been included in the writing of their care plans and had been offered a copy of these.
- Patients had access to advocacy and information about the service was displayed on all wards.
- Of the five carers that we received feedback from, three made positive comments about the wards environment although one felt that the dialectical behaviour therapy programme that had been talked about prior to admission had not happened in the way that they had hoped. Two families felt communication with the hospital was poor and that they had not been kept fully

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

Requires improvement

informed of issues relating to their relative. The hospital had a friends and family experience improvement plan but it was too early at the time of the inspection to see if this had an impact on the experience of carers.

- Patients could complete comments cards and give feedback on the service but on Ariel Ward patients felt this would not be listened to or their views taken into account.
- It was too soon for patients to be fully involved in decisions about the service but Cygnet Health Care had a dedicated person who was an expert by experience who worked across all their hospitals looking specifically at the patient experience. The service had set up a Peoples Council which was run by patients with representatives from each ward and managers stated they had started work on a welcome pack for new admissions although we did not see evidence of this during the inspection.
- In the care records, we saw that patients had advance decisions and statements in place.

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

Requires improvement

### Access and discharge

- The hospital took referrals from across the country. Dunsmore PICU's referral line was monitored regularly and they provided a response to the referrer within one hour of the referral being made. Ariel and Middlemarch wards only took planned admissions and patients were assessed prior to admission by staff from the wards. At the time of the inspection, none of the wards had full occupancy due to the hospital being relatively new. Dunsmore PICU worked towards moving patients back to acute wards as soon as the patient was well enough. Their average length of stay from April 2017 to July 2017 was 25 days. Managers reported that between April 2017 and October 2017 they had discharged 50 patients. The average length of stay would be between four to eight weeks. Average length of stay information was not available for the other wards as the hospital had not been open long enough. Patients could stay for 12 to 18 months as long as they were engaging in the recovery programmes provided.
- Ariel Ward had five enhanced care beds for patients with a personality disorder and co-morbid disordered eating. These patients needed a higher level of care and there was a waiting list for one of these specialised beds of up to 12 months. Patients had to want to engage with the therapeutic environment to be eligible for a bed on this ward.
- As a national service, the hospital would provide beds within their local catchment area if the referral was appropriate.
- Patients always had their own bed to return to on Ariel and Middlemarch wards following leave as their focus was on recovery and rehabilitation.
- Patients were not moved between wards unless this was justified on clinical grounds for example if a patient on Ariel Ward did not have a personality disorder they could move to Middlemarch Ward.
- Patients would be discharged at a time to suit their needs.
- Patients could be transferred to the PICU if the need arose or to another ward within the organisation if that was more appropriate for the needs of the patient for example closer to family.
- Discharge from the PICU could be delayed if a suitable placement was not available however, staff on this ward stated that at times delays had been detrimental to patients mental health when they had to wait for a bed elsewhere. This had included increased incidents of self-harm.

### The facilities promote recovery, comfort, dignity and confidentiality

- As a purpose built new hospital the wards had a wide range of rooms and equipment available to support patients. They had a separate therapy suite, which included a kitchen, and arts area, a large hall, a gym a beauty salon, a library and a multi faith room. The wards also had kitchen areas for patients to use, laundry facilities and community areas.
- The wards had quiet areas and visitor's space was at the entrance of the ward. Families raised a concern that when in the visitors area of Dunsmore PICU they were cut off from the ward and were unable to ask for help or leave the area to use the toilet. The only way to attract

the attention of staff was by phoning reception. They felt this was not safe for them or their relative as they could be left there for some considerable time without being monitored.

- Patients had access to their own mobile phones although this was individually risk assessed. They wards also provided a room with a private phone for patients to use.
- All wards had access to secure outside space, which was not overlooked from outside the hospital. Doors to the outside space were locked but staff would open this on request to ensure patients who needed supervision received this.
- The patients we spoke to stated that the food was not always of good quality or did not meet their needs particularly on Ariel Ward. Patients had taken to ordering in their own shopping and sometimes in large quantities, which had taken up quite a lot of storage space. Patients stated that this was because they did not like the food being offered. Staff were working with patients to monitor this and to limit the amount of spare food stored on the wards. Staff felt it was important where possible for patients to use leave to purchase items as this helped them with budgeting. The menus had recently changed and staff felt this had improved what the hospital was providing for patients. This had been done in response to feedback from the patients and in consultation with them.
- Patients could make hot drinks as and when they needed to on Ariel and Middlemarch wards and on Dunsmore PICU staff made drinks on a regular basis.
- Patients could bring items in to personalise their rooms and we saw this had happened on the wards. All rooms had a lockable cupboard and additional safe storage for larger items was available on the ward. Some patients had keys to their rooms but this was risk assessed on an individual basis and dependant on the level of observations the patient was on.
- Patients and staff reported that activities had been quite limited on the wards and not always suitable for the individual needs of patients. The occupational therapy team had worked to improve the activity programme but patients had become demotivated and due to previous staffing issues had not been encouraged and supported to participate. The activity programme did not cover weekends and patients had little to occupy their time. Due to the design of the hospital, patients on Middlemarch Ward, which was long stay and rehabilitation, felt the ward was more set up for acute patients not those needing rehabilitation and we observed that this was the case . The television was behind a screen and there was no access to the remote control. Staff reported that this was due to the current risk levels of patients but that it was kept under review and that patients could have televisions in their rooms based on their individual risk assessment. Patients we spoke to did not seem to be aware of this.

**Meeting the needs of all people who use the service**

- The wards had disabled access and facilities and there was a lift to Ariel Ward, which was on the first floor.
- Information leaflets were freely available to patients and could be printed in other languages if requested. Information included how to access advocacy and how to make complaints.
- Staff reported that they could access interpreters and signers for deaf people through Cygnet and that this was easy to do.
- The hospital provided a choice of food to meet the dietary requirements of religious and ethnic groups.
- Although the hospital had a multi-faith room that was well laid out to meet the needs of all religions it was away from the ward and patients could only access it with support from staff. It had not been used and there were no options for multi-faith areas on the wards which patients could access without support. The hospital did not access the services of a local chaplain although staff said they would support patients with this if requested.

**Listening to and learning from concerns and complaints**

- The wards had received 29 complaints up to the end of July 2017. Six complaints had been upheld and seven had been partially upheld. Nine complaints were still under investigation. No complaints had been referred to the ombudsman.
- Patients knew how to complain and received feedback from their complaints. Families and carers we spoke to felt there had been a lack of communication from the hospital in regards to complaints made. Most complaints involved concerns about staffing levels and the use of agency staff and communication between the hospital and carers.
- Staff knew how to support patients to make complaints and who to speak to about this.

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

Requires improvement

- Staff received feedback from complaints through handover, ward meetings and supervision.

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

Requires improvement

### Vision and values

- Staff knew and agreed with the vision and values of Cygnet Health Care. Most staff we spoke to said these mirrored their own values and it was a good company to work for.
- Team objectives reflected the values and manager used these during supervision.
- Staff knew who the senior management team was within the hospital and key staff who visited from the wider Cygnet team.

### Good governance

- We found there had been some issues with governance within the hospital. Recruitment and retention of staff had been difficult with a high turnover of staff leaving or being dismissed. The hospital had used a lot of agency staff but this had improved with the use of block booking agency staff who knew the hospital. Supervision had been missed for many staff before the new ward managers had been appointed and some staff had felt unsupported while working with a complex patient group. Supernumerary staff such as occupational therapy assistants had to support the work on the wards when staffing numbers were low which affected patients receiving activities. Staff had not had the opportunity to be involved in audits. Complaints had not always been investigated in a timely manner and communication with relatives had been poor although the hospital had taken steps to improve this. At times patients stated they had felt unsafe on the wards because of the staffing issues. Training figures had been low particularly in areas such as the Mental Health Act. The senior management team had a plan in place for making improvements but it was too soon at the time of the inspection to see the impact this would have.
- The hospital did not have an equality and diversity lead and this would support them to ensure that the needs of patients and staff as individuals had been met.
- Managers used key performance indicators such as training levels and supervision with staff. Managers produced a weekly report, which was sent to the senior management team and used in the integrated governance meetings. Items on the report included agency usage, recruitment, serious incidents, seclusion, sickness, annual leave and training.
- The ward managers, although new, felt they had the authority and support from the senior management team to do their jobs. They had access to administration support and Dunsmore PICU had a ward clerk who supported the team.
- Staff could discuss items for the hospital risk register with managers and these would be considered and added through the integrated governance meeting.

### Leadership, morale and staff engagement

- Staff sickness between April 2017 and August 2017 was 6% for Ariel Ward, 7% for Middlemarch Ward and 19% for Dunsmore PICU. Managers reported with improved management and supervision at ward level this had started to improve.
- Managers reported there were no cases of bullying and harassment cases among the staff teams.
- Staff stated they knew how to use the whistleblowing policy but would prefer to speak directly to senior managers who were supportive and listened to their concerns. They did not feel they would be victimised for raising issues.
- All staff we spoke to except one stated that since the new ward managers had started morale had improved although it was still early days. People who had considered leaving felt they would stay as they had started to enjoy and feel supported in their roles.
- Staff supported each other but some had been working in difficult circumstances and managers acknowledged that they needed to work on building their teams.
- Staff demonstrated that they had been open and transparent with patients and had explained things to them when incidents occurred.
- Staff could give feedback on the service during supervision although some felt they had not been there long enough to do this.

### Commitment to quality improvement and innovation

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

Requires improvement

- The hospital was not involved in any national quality improvements but felt their focus should be on making sure basic day-to-day running of the hospital was of a standard that ensured patient safety. The senior management team demonstrated that they had the experience and skills to make improvements going forward. They showed that lessons had been learnt from issues when the hospital had first opened particularly around recruiting staff with the skills and experience to support improvement within the hospital.

# Outstanding practice and areas for improvement

## Areas for improvement

### Action the provider MUST take to improve

- The provider must ensure that good governance is in place to make sure all the issues raised within the report and listed as 'shoulds' have an action plan in place.
- The provider must ensure that people using the visitor's room on Dunsmore PICU could easily access help and support or leave the room when they need to.

### Action the provider SHOULD take to improve

- The provider should ensure that clinical audits are carried out and recorded in order to enable staff to learn from the results and make improvements to the service.
- The provider should ensure that all staff are aware of the fire evacuation protocols and how this affects the risks to individual patients.
- The provider should ensure that staff on all wards have completed up to date Mental Health Act training.
- The provider should ensure that clinical checks are made for patients following rapid tranquilisation or record why this has not happened.
- The provider should ensure that staff on Middlemarch Ward store medication in its original containers and that records for the administration of medication are completed.
- The provider should ensure that audits completed by the external pharmacist are followed up and responded to.
- The provider should ensure that the activities programme is fully embedded and that staff understand their role in ensuring patients can access this.
- The provider should ensure that the retention and recruitment of staff including key individuals to deliver dialectical behavioural therapy remain a key priority.
- The provider should ensure that cleaning records for clinic rooms are completed, signed and dated.
- The provider should ensure that they have an equality and diversity lead among the senior management team and that patients have access to facilities to meet their cultural needs.
- The provider should ensure that communication with families and carers is clear and robust and that they understand the protocol for making complaints.
- The provider should ensure that staff continue to reduce the number of restraints used on patients through the use of de-escalation and distraction techniques.

This section is primarily information for the provider

# Requirement notices

## Action we have told the provider to take

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

| Regulated activity | Regulation |
|---|---|
| Assessment or medical treatment for persons detained under the Mental Health Act 1983<br><br>Treatment of disease, disorder or injury | Regulation 17 HSCA (RA) Regulations 2014 Good governance<br><br>The hospital did not have robust governance structures in place to ensure all issues raised within the report were acted upon and improvements made. These included lack of clinical audits, not all staff having completed Mental Health Act training, clinical checks following the use of rapid tranquilisation on patients. storage of medication on Middlemarch ward, follow up by staff of audits by the external pharmacist, having the activities programme fully embedded and staffing understanding their role supporting patients to access this, recruitment and retention of staff including staff to provide dialectical behavioural therapy. The provider should ensure they have an equality and diversity lead to ensure patients cultural needs are being met, communication with families and carers should be improved in relation to complaints and staff should continue to reduce the number of restraints used on patients. The hospital should continue to review its fire evacuation plan.<br><br>This was a breach of Regulation 17 (1) (2)(a)(e)(f) |

| Regulated activity | Regulation |
|---|---|
| Assessment or medical treatment for persons detained under the Mental Health Act 1983<br><br>Treatment of disease, disorder or injury | Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment<br><br>The visitors room on Dunsmore PICU did not have the necessary equipment for visitors to access help or exit the ward because of the airlocks on either side of the room when they needed to. The could not attract the attention of ward staff.<br><br>This was a breach of Regulation 15 (1) (c) |