Cygnet Acer Clinic

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

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

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

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

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

Summary of findings

Overall summary

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

- The service did not consistently provide safe care. Staff did not always maintain complete records of clinical cleaning and equipment maintenance checks. This included cleaning of portable physical healthcare equipment and checks of emergency equipment.
- There were discrepancies between the systems used to monitor staff attendance within the service. This made it difficult to confirm the exact number of staff on duty to maintain safe staffing levels.
- Staff did not always follow the provider's observation policy and procedures to ensure patients risks were safely managed. This included missed observations and inaccurate records of observations.
- Staff did not always keep complete records of medicines management. This included records of drugs liable for misuse and medicine self-administration records.
- Staff treated patients with compassion and kindness, but did not always respect their privacy and dignity, Patients raised concerns about staff attitudes towards them and engagement with them. We saw staff did not always maintain the confidentiality of patient information.
- The governance of the record keeping in the hospital was not effective. Although the service had made improvements in the safety of the service since our previous inspection, the systems used to accurately identify, understand, monitor and reduce or eliminate risks required improvement.

However:

- Safety risks were being addressed. The service had addressed safety issues identified in the last inspection and the wards had been subject to a thorough Manchester ligature risk assessment and remedial works to reduce identified risks.
- Staffing levels for qualified nurses had increased since the last inspection.
- Staff provided a range of treatment and care for patients based on national guidance and best practice. This included access to psychological therapies, support for self-care and the development of everyday living skills and meaningful occupation. Staff supported patients with their physical health and encouraged them to live healthier lives. Staff used recognised rating scales to assess and record severity and outcomes.
- Staff understood and discharged their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005.
- Staff planned and managed discharge well and liaised effectively with services that would provide aftercare. As a result, discharge was rarely delayed. The service worked to a recognised model of mental health rehabilitation.

Summary of findings

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Summary of this inspection

Background to Cygnet Acer Clinic

Cygnet Acer Clinic provides care and treatment for 28 female patients with personality disorders and who self-harm. Some patients also have a mental illness, learning disability, substance misuse problems or an unrelated physical health condition. The service has 28 beds, 14 beds on Upper House and 14 beds on Lower House. At the time of our inspection, there were 21 patients in the hospital; nine at Upper House and 12 at Lower House. All of the patients at Upper House were detained under the Mental Health Act. Seven out of the 12 patients at Lower House were detained under the Mental Health Act and the other five patients were informal.

Cygnet Acer Clinic is registered to provide:

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

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

Cygnet Acer Clinic has been inspected four times since 2015. The last inspection was a focused inspection in August 2019, looking at the safe and well led domains which were rated as inadequate. Enforcement action was taken consisting of a notice of decision imposing conditions and regulatory notices relating to Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Regulation 12(2)(b)(h).

Our inspection team

The team that inspected the service comprised three CQC inspectors, two inspection managers, two specialist advisors with a professional background in mental health nursing and clinical psychology and an expert by experience. An expert by experience is somebody who has experience of using or supporting somebody else to use the services we inspect.

Why we carried out this inspection

We carried out a comprehensive inspection of this service earlier than our scheduled mental health inspection programme in order to check that the conditions outlined in the notice of decision had been met and whether improvements had been made.

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 both wards at the hospital, looked at the quality of the ward environment and observed how staff were caring for patients;
- spoke with 12 patients who were using the service;

Summary of this inspection

- spoke with one carer/family member of a patient who was using the service;
- spoke with the registered manager of the service and the head of care for Lower House;
- spoke with 15 other staff members; including doctors, nurses, support workers occupational therapist, psychologists, assistant psychologists and social worker;
- received feedback about the service from 12 care co-ordinators or commissioners;
- attended and observed two morning meetings, a handover meeting, a clinical governance meeting and an incident review meeting;
- attended and observed a patient community meeting and a morning meeting;
- looked at 12 care and treatment records of patients;
- looked at the medication charts of 15 patients;
- carried out a specific check of the medication management on both 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

During our inspection, we spoke to 12 patients who were using the service.

Three patients said that when management were not present, staff stayed in the office. Two patients said they did not feel safe. Two patients expressed concern that agency staff did not know their names and one patient reported concerns about staff attitude. However, most patients said staff were supportive and talked to them and reported positive relationships with staff.

Four patients said they were not provided with an information pack about the service on admission or involved in the development of their care plan.

Three patients had found the activities offered as not suitable. Five patients reported activities being cancelled.

Three patients said the service did not involve them in decision making about the service. Three informal patients said their right to leave the ward was not supported.

Three patients reported that staff involved and kept their families informed. Communication agreements between patients, families and the staff were positive. However, one patient said that their family were not involved or kept informed. Another patient reported the hospital had shared information with their family outside of the planned communication agreement between the hospital and their family.

Food choices catered for vegans and allergies. However, seven patients expressed concerns about the meal times and three patients said the menu needed to be reviewed.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Inadequate 

We rated safe as **requires improvement** because:

- Staff did not always maintain complete records of clinical cleaning and equipment maintenance checks. This included cleaning of portable physical healthcare equipment and checks of emergency equipment.
- There were discrepancies between the systems used to monitor staff attendance within the service. This made it difficult to confirm the exact number of staff on duty to maintain safe staffing levels.
- Staff did not always follow the provider's observation policy and procedures to ensure patients risks were safely managed.This included missed observations and inaccurate records of observations.
- The number of self harm incidents remained concerning, although the number of incidents had declined from the previous inspection.
- Staff did not always keep complete records of medicines management. This included records of drugs liable for misuse and medicine self-administration records.

However:

- All wards were clean, well equipped, well furnished, well maintained and fit for purpose.
- Staff had made improvements to the assessment and management of risks to patients and themselves well. Staff worked towards achieving the right balance between maintaining safety and providing the least restrictive environment possible in order to facilitate patients' recovery. The ward staff participated in the provider's restrictive interventions reduction programme.
- Staff knew the patients and had met the training required in the conditions imposed.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse, and they knew how to apply it.

Are services effective?

Requires improvement 

We rated effective as **requires improvement** because:

Summary of this inspection

- Staff did not always develop care plans that reflected the risks highlighted in the patient's risk assessment. Staff did not always document patients' physical health screening or support given around health promotion in patients' care plans.
- There was poor attendance at staff team meetings where key information could be shared amongst staff.
- Not all informal patients we spoke to were aware of their right to leave at their will.

However:

- Staff provided a range of treatment and care for patients based on national guidance and best practice. Staff used recognised rating scales to assess and record severity and outcomes.
- The ward teams included or had access to the full range of specialists required to meet the needs of patients on the wards. Staff from the different disciplines worked together as a team to benefit patients. They had effective working relationships with staff from services providing care following a patient's discharge and engaged with them early in the patient's admission to plan discharge.

Are services caring?

Requires improvement 

We rated caring as **requires improvement** because:

- Patients raised did not feel safe. They raised concerns about staff attitudes towards them and engagement with them. We saw staff did not always maintain the confidentiality of patient information.
- Not all patients were involved in the development of their care plan or the review of their care and risk plans these plans, including prior to key meetings.
- Staff did not always inform and involve families and carers appropriately.

However:

- Staff understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition.
- Staff ensured that patients had easy access to independent advocates.

Summary of this inspection

Are services responsive?

Good

- Staff planned and managed discharge well. They liaised well with services that would provide aftercare and were assertive in managing the discharge care pathway. As a result, patients did not have excessive lengths of stay and discharge was rarely delayed.
- The design, layout, and furnishings of the ward/service supported patients' treatment. Each patient had their own bedroom with an en-suite bathroom and could keep their personal belongings safe. There were quiet areas for privacy.
- The wards met the needs of all patients who used the service, including those with a protected characteristic. Staff helped patients with communication, advocacy and cultural and spiritual support.
- Staff supported patients with activities outside the service, such as work, education and family relationships.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team and the wider service.

However:

- Not all rooms were soundproof which meant that patients and staff outside of the room could hear conversations clearly.
- Over half of the patients we spoke with reported issues with the time that the kitchen served their evening meal.

Are services well-led?

Requires improvement

We rated well-led as **requires improvement** because:

- The overall governance of the record keeping in the hospital was not effective. Although the service had made improvements in the safety of the service since our previous inspection, including governance and incidents review meetings, the systems used to accurately identify, understand, monitor and reduce or eliminate risks required improvement.
- The service did not always maintain accurate records of patient care and treatment, equipment or records of which staff were in the hospital at any given time. Staff did not consistently use audits effectively for example in relation to observations to identify areas for improvement and this gave managers poor assurance of patient wellbeing.
- Staff did not report involvement in or awareness of research or quality improvement projects. The service did not participate in national audits or accreditation schemes relevant to the service.

Summary of this inspection

However:

- Managers were responsive in supporting changes following our last inspection. Managers had started to develop a new care model. Patients and staff knew who they were and could approach them with any concerns.
- Most staff felt respected, supported and valued. They felt the service promoted equality and diversity and provided opportunities for career development.
- Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.
- The service engaged well with staff, equality groups, the public and local organisations to plan and manage appropriate services. It collaborated with partner organisations to help improve services for patients.

Detailed findings from this inspection

Mental Health Act responsibilities

Staff received and kept up-to-date with, training on the Mental Health Act and the Mental Health Act Code of Practice and could describe the Code of Practice guiding principles.

As of 14 October 2019, all staff in this service had received training in the Mental Health Act.

The training compliance remained at 100%.

Staff had access to support and advice on implementing the Mental Health Act and its Code of Practice.

Staff knew who their Mental Health Act administrators were and when to ask them for support.

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

Patients had easy access to information about independent mental health advocacy and patients who lacked capacity were automatically referred to the service. An independent mental health advocate visited the service twice a week and we saw evidence in clinical governance meeting reports that patients met regularly with the advocate.

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

Staff made sure patients could take section 17 leave (permission to leave the hospital) when this was agreed with the Responsible Clinician and/or with the Ministry of Justice.

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

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

Three informal patients we spoke with said they were not always allowed to leave at their will, we saw that staff gave informal patients a document informing them of their rights and completed an 'informal patient rights form' every three months as evidence they had told informal patients of their rights.

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

Managers and staff made sure the service applied the Mental Health Act correctly by completing audits and discussing the findings.

Mental Capacity Act and Deprivation of Liberty Safeguards

Staff received and kept up-to-date with, training in the Mental Capacity Act and had a good understanding of at least the five principles.

As of 14 October 2019, all staff in this service had received training in the Mental Capacity Act.

There was a clear policy on Mental Capacity Act and Deprivation of Liberty Safeguards, which staff could describe and knew how to access.

Staff knew where to get accurate advice on the Mental Capacity Act and Deprivation of Liberty Safeguards.

Staff gave patients all possible support to make specific decisions for themselves before deciding a patient did not have the capacity to do so.

Staff assessed and recorded capacity to consent clearly each time a patient needed to make an important decision.

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

Detailed findings from this inspection

Staff made applications for a Deprivation of Liberty Safeguards order only when necessary and monitored the progress of these applications.

The service monitored how well it followed the Mental Capacity Act acted when they needed to make changes to improve.

Long stay or rehabilitation mental health wards for working age adults

Requires improvement

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

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

Inadequate

Safe and clean environment

Safety of the ward layout

Staff completed and regularly updated thorough risk assessments of all ward areas and removed or reduced any risks they identified. During our previous inspection in August 2019, we told the provider they must undertake a comprehensive ligature risk assessment and demonstrate how they managed the ligature risks identified. Ligature risks are fixtures to which people intent on self-harm might tie something to strangle them self. We reviewed these actions at this inspection and found the provider had taken action and completed a thorough review of their ligature risk assessment, through the introduction of the Manchester ligature assessment tool. Overall, we were satisfied the provider had assessed and managed the risks associated with ligatures effectively.

The ward layout did not allow staff to observe all parts of the ward. During our previous inspection in August 2019, we told the provider they must urgently address how staff managed lines of sight on corridors and ensure they introduced convex mirrors to existing in blind spots. We found the provider had taken action and introduced convex mirrors to wards.

The hospital accommodated only female patients. This complied with national guidance about, and expectations governing the provision of single sex accommodation.

Staff had easy access to alarms and patients had easy access to nurse call systems. We observed staff responding to alarm calls in a timely and effective manner.

Maintenance, cleanliness and infection control

Ward areas were clean, well maintained, well-furnished and fit for purpose. Staff kept ward cleaning records up to date and the premises were visibly clean.

Staff followed infection control policy, including hand washing. The provider completed quarterly infection control audits. The most recent audit was completed on 23 September 2019 and the service met the standard of all questions on the audit tool.

Clinic room and equipment

Clinic rooms were fully equipped, and resuscitation equipment was accessible to all staff.

Cleaning records did not always demonstrate when staff had cleaned the clinic room. We noted gaps in the cleaning records for the clinic room at Upper House between 30 August and 4 September 2019. At Lower House, we found no records of cleaning from 7 October to 14 October 2019. However, we noted the clinic room was visibly clean and well ordered.

Staff maintained clinic room equipment well and kept it clean. However, staff were not prompted to clean portable physical health equipment or record that they had done this. Staff told us they did clean equipment, but we did not see any recorded evidence of this.

Staff stored and maintained the emergency equipment in the main staff office to ensure all staff had access to this equipment. Staff were required to check the emergency

equipment on a weekly basis. At Lower House, we found staff had completed the checks, but had omitted the date of completion from the record on two missing dates between 19 September and the date of our inspection.

We saw staff carry out an emergency response drill at Lower House. Staff responded in a timely and effective manner and the drill was well coordinated and communicated. We reviewed a selection of records for the emergency response drills for Upper House and saw that staff responded quickly and effectively.

All nursing staff carried a bag on their waist containing two types of ligature cutters and a pair of wire cutters. The wire cutters were to snap the metal in bras if they were used as a ligature. Bags also contained a first aid pack and a portable radio to call for assistance when needed. A support worker checked these bags twice daily and recorded the contents of the bags. If any equipment was missing, the support worker completed an incident report form and night staff replenished the bags. The service had spare bags to replace these for staff as required.

Safe staffing

Nursing staff

The service had employed enough nursing and support staff to keep patients safe. Following the last inspection we place a condition that the provider should ensure that there were sufficient numbers of suitably qualified, skilled, competent and experienced clinical staff at all times to meet the needs of patients. The service now had ten whole time equivalent registered mental health nurses and 39 whole time equivalent support workers. At the time of our inspection, the service had four whole time equivalent nurse vacancies with three nurses recruited and undergoing employment checks. The service had three support worker vacancies but all three were also recruited to. These vacancy rates were comparable to the rate reported at the last inspection in August 2019. The service had arranged a recruitment day each month to support staff recruitment.

The hospital had three qualified nurses on each shift. During our previous inspection, we raised concerns about the number of qualified staff within the hospital. We noted that over 75% of nursing staff within the hospital were unqualified and on 60% of shifts, there was only two registered nurses working across the hospital. Since this inspection, the hospital had begun to use contracted agency staff to ensure there were always enough qualified staff on each shift.

However, at the end of our first day of inspection, we raised our concerns about the discrepancies between the systems used to record which staff were in the hospital.

There were discrepancies between the nursing rosters and the fire register records, which made it difficult to confirm the exact number of staff on duty to maintain safe staffing levels. For example, on 29 September 2019, the nursing roster showed that there were three qualified nurses on shift during the day and three qualified nurses on shift during the night. However, the fire register for Lower House for the day shift had not been completed by any qualified nurses suggesting there were none on shift. The fire register for Lower House for the night shift was not filled in by either of the two agency staff and only by the bank member of nursing staff. The provider was also trialling an additional finger print entry system for permanent staff to record when they were in the building. This did not record the attendance of agency staff in the building. We raised concerns about the systems used to record which staff were in the building as no one system alone or in combination gave an accurate picture of where and when staff were on duty. However, upon further review of the staffing data with the provider, it was evident that safe staffing levels were maintained. The provider has taken action since our inspection to improve staff recording of their attendance at the service.

When necessary, managers deployed agency and bank nursing staff to maintain safe staffing levels. All temporary staff received an induction before working on wards. The temporary staff induction pack included the provider's observation and engagement policy and observation training slides. The manager also gave temporary staff a copy of the ligature and environmental risk assessment before working on the ward.

Two out of the 15 staff we spoke with reported high use of agency staff placed them under increased pressure to support patients and manage shifts. This was because agency staff were less familiar with the service. However, whenever possible the hospital manager limited their use of temporary staff and requested staff who were already familiar with the service.

Long stay or rehabilitation mental health wards for working age adults

Requires improvement

The sickness rate for this service was 7.1% between October 2018 and October 2019. This was higher than the 3.5% reported at the last comprehensive inspection in October 2018 and higher than the provider's average sickness rate of 4%.

Managers supported staff who needed time off for ill health.

This service had a turnover rate of 26.1% between October 2018 and October 2019. This was lower than the 39% reported at the last comprehensive inspection in October 2018.

Managers had calculated the number and grade of nurses and healthcare assistants required. Staff and patients told us actual staffing numbers matched planned staffing numbers on almost all shifts.

The ward manager could adjust staffing levels daily to take account of case mix and the manager was never included in the staffing complement. Although the hospital was not at full occupancy at the time of our inspection, the manager confirmed that they had maintained their staffing numbers to ensure the safety of the patients and make the necessary improvements highlighted in our previous inspection.

During our previous inspection, we raised concerns about staff working excess hours and some staff had insufficient rest days between shifts. We told the provider they must implement working time directives and professional guidance to ensure staff were sufficiently rested. Since that inspection, the manager had reiterated to staff that it was not contractual for them to work excess hours and had introduced a human resources clinic to offer support for staff around their working hours. This message had been shared through staff meetings and in supervision with staff. The hospital manager assured us that staff welfare was paramount to the effective running of the hospital and had looked at trends around performance issues and links with staff working hours.

Staffing levels allowed patients to have regular one-to-one time with their named nurse.

Five out of the 12 patients we spoke with told us that staff shortages resulted in staff cancelling escorted leave or ward activities. During the month of September 2019, whilst patients chose to engage in only an average of 21 hours of activity out of 71 hours of meaniful activity offered per week. Each patient had their own activity timetable which meant that meaningful activities were individualised for each patient. For example, attending meal times was included only if it was a relevant activity for a patient.

Staff reported, and we saw during our inspection that the service had enough staff on each shift to carry out any physical interventions safely.

Staff shared key information to keep patients safe when handing over their care to others.

Medical staff

The service had enough medical cover during the day and night and a doctor could attend the hospital quickly in an emergency. The provider used locum doctors when they needed additional medical cover.

Mandatory training

Staff completed and kept up-to-date with mandatory training. During our previous inspection, we placed a condition on the hospital to ensure all staff completed training in personality disorder, suicide prevention and self-harm management, carrying out of observations and undertaking ligature assessments. At this inspection, we found all staff had completed this training. In addition to this, staff had undertaken 98% of the various elements of training the provider had identified as mandatory. This compliance figure was higher than the 85% reported at the last comprehensive inspection in October 2018.

The mandatory training programme was comprehensive and met the needs of patients and staff.

Managers monitored mandatory training and alerted staff when they needed to update their training.

Assessing and managing risk to patients and staff

Assessment of patient risk

During our inspection, we looked at 12 patients' care and treatment records. Records demonstrated staff completed a risk assessment of each patient on admission and updated it regularly, including after any incident.

There were systems in place for staff to review and manage patient risk on a daily basis. Staff assessed patients' level of risk daily. The hospital used a daily risk assessment where patients' behaviours were coded as red, amber or green depending on their current presentation and patterns of behaviour. Staff ensured that any incidents, including those

of self-harm, were reviewed to inform each patient's current level of risk. This colour-coded risk assessment was then recorded in each patient's care notes and their observation folder, to act as a prompt for staff to be aware that the patient may be having a difficult time. Staff also recorded the reason for each patient's current daily risk assessment in colour code. This helped staff to identify early warning signs or an increase in risk presentation for that patient. We saw evidence of these daily risk assessments during morning meetings and noted that each patient's risk was reviewed. The review was based on their current presentation and any significant triggers during the review period. This risk assessment supported staff to determine each patient's required level of observation for that shift.

Staff used the Short-Term Assessment of Risk and Treatability (START) as a framework to assess and manage patient risk. As part of this assessment, the multidisciplinary team had completed a comprehensive psychological formulation of each patient's current behaviours and needs and plans to assist staff to support the patients effectively. When required, staff used the Historical, Clinical Risk Management-20 Version 3 (HCR-20 V3) assessment tool to estimate patients' risk of violence.

Management of patient risk

In three out of the 12 risk assessments we reviewed, staff had not consistently translated patients' individualised risk assessments in the patients' care plans or risk management plans. For example, we saw in one patient's risk assessment that in response to an incident of swallowing as a form of self harm, the patient's risk assessment had moved from green to red and this was reflected on the patient's observation chart and care notes. However, the patient's care plan did not mention this behaviour or detail how staff should manage this behaviour. We also noted that this had been recorded in the patient's previous START risk assessment due to a previous incident of a similar nature, but there was no detail of how staff should manage this behaviour in the care plan. We saw another example where a patient had engaged in a form of self-harming behaviour that they had not displayed before and although staff had noted this risk behaviour, the patient's subsequent START risk assessment did not detail this incident. In another care record we saw staff had not reviewed a choking risk assessment as often as stated in the provider's risk review policy.

Staff knew about any risks for each patient and acted to prevent or reduce risks. Staff risk assessed each patient on an individual basis using a person-centred approach. This meant that each patient's level of risk for different activities was dependent on their own behaviours and current mental state. The service encouraged positive risk taking. For example, where patients who had tied a ligature within the service were not prevented from using Section 17 leave into the community as their risk was not directly related to this activity, and in fact this was a positive activity for this patient to engage in at difficult times.

Following our previous inspection, we asked the service to review patient suitability for the hospital. The service had completed this review at the time of this inspection. Although the number of incidents of self-harm had decreased from 611 in August 2019 to 459 in September 2019 the figures were of concern. The provider reported that incidents remained high due to patients being admitted and discharged from the service, which temporarily unsettled some of the patient group. Managers told us that they benchmarked the incidents against similar Cygnet locations. Staff reviewed incidents through a monthly incident monitoring meeting where the multidisciplinary team looked at trends and themes around incidents. These meetings highlighted that some of the incidents of self-harm from September 2019 involved patients who had since been transferred to a provider who accepted patients with a higher level of need. We observed the incident review meeting and saw the team demonstrated a good understanding of the changes in each patient's incidents of self-harm and developed strategies to support patients for the upcoming month. This included a review of which staff members were best able to support each patient and consider how best to involve patients' families and community teams.

Staff did not always follow the provider's policies and procedures when they observed patients. This included minimising risk from potential ligature points. We saw staff did not routinely complete the front sheets of observation records. This meant that staff did not use the observation record to record patient risk and reason for each patient's prescribed level of observations or the date of the next review of observations. However, we saw that staff discussed patients' risk observations in the morning daily reviews.

Long stay or rehabilitation mental health wards for working age adults

Requires improvement

Staff did not consistently follow the observational policy. We noted gaps in patient's recorded observations. For example, for one patient on hourly observations between 25 September and 30 September 2019, we noted 15 missing observation records and three occasions where the observations had been completed but not signed, in line with the provider's policy.

The provider's high-level engagement and observation protocol recommended staff should check the patient at irregular intervals and in a pattern that could not be predicted by the patient. For example, if the maximum level interval was 15 minutes, this meant staff needed to undertake the task at irregular intervals of no more than 15 minutes. The patient would therefore be less able to predict the time intervals or pattern which may decrease their opportunity to engage in associated risks. Overall, we saw that on most occasions staff recorded observations at irregular intervals, in line with the provider's policy. However, on review of the high level observations on Upper House, we saw the observations for one patient on 9 October 2019 were recorded at predictable intervals such as 17:00, 17:15 and 17:30, which is not in line with the provider's policy. Staff did not always use the 24 hour clock in their recording of patient observations, which made it difficult to establish whether the patient was observed during the day or night.

Staff did not always accurately record the time when observations had taken place. For example, we saw staff had recorded the same observation time for two patients with bedrooms on different floors. Our review of closed-circuit television (CCTV) footage, showed staff did complete these observations, but had recorded the times inaccurately. We saw that staff did not always carry the observation record with them whilst completing observations. For example, we reviewed the observations of one patient from 00:00 through to 06:00 on 11 October 2019. We saw in ten of the 24 observations completed, staff did not have the observation record with them at the time of completing the observation and none of the observations checks seen on the CCTV footage matched the time recorded by the observing staff member. This meant that staff were unable to accurately document the wellbeing of each patient at any given time. After the on-site inspection, the provider reported to the CQC that the inaccurate timings of observation records and CCTV were due to a calibration error of the CCTV, not staff records. The provider has implemented daily calibration checks to ensure similar errors cannot occur again in future.

The service had begun to train staff in the Safewards model. Safewards is a model of care designed to reduce conflict (aggression, rule breaking) and containment (coerced medications, restraint and seclusion) in adult mental health inpatient units. At the time of our inspection, it was too soon to evaluate the impact of this training on the service.

Staff followed the provider's procedures when they needed to search patients or their bedrooms for restricted items. Staff individually risk assessed patients to determine which patients needed to be searched on return from leave. The reasons for patient searches were documented in care records.

Staff applied blanket restrictions on patients' freedom only when justified. Examples of blanket restrictions patients faced were the removal of extension cables from bedrooms, shortening of appliance cables to one metre and removal of ovens and hobs from all bedroom kitchenettes. These restrictions had been introduced since our previous inspection, where we raised concerns about patient safety and access to items that patients could use to engage in self-harm behaviour. The hospital had developed reducing restrictive practice plans for both Upper and Lower House, as the level of restriction differed between the two sites according to the level of patient acuity. For example, there were more restrictions at Upper House because overall, the patients receiving care and treatment there were at greater risk of engaging in self-harming behaviour than those at Lower House. In addition, all patients had a reducing restrictive practice plan which highlighted any additional restrictions placed on that patient according to their level of risk. Staff reviewed these daily as part of the morning risk meeting.

The provider reported no incidents of seclusion or long term segregation at Cygnet Acer Clinic between October 2018 to October 2019. The provider had a policy and procedure for seclusion and another for long-term segregation. All staff reported they did not use seclusion and long-term segregation.

Long stay or rehabilitation mental health wards for working age adults

Requires improvement

Staff adhered to best practice in implementing a smoke-free policy. The service offered smoking cessation support and nicotine replacement therapy

Three of the patients who were not detained under the Mental Health Act told us they were not always allowed to leave the unit at their will. However, care records demonstrated they were able to do so. The provider had considered the option of giving informal patients fob access in and out of the building so they could leave and enter the building without the assistance of staff. However, they concluded this would be unsafe as it would result in a lack of oversight over who was in and out of the hospital at any given time.

Use of restrictive interventions

Since our previous inspection on 28 August 2019, there had been 47 restraints at Upper House, none of which involved face-down restraint. There had not been any restraints at Lower House during this time.

The service participated in the provider's restrictive interventions reduction programme and clearly documented where restrictions were in place, both within the service and in line with patient-specific care plans.

Staff used restraint only after de-escalation had failed and staff were trained to use the correct techniques. Staff used a range of techniques to support patients at difficult times, including verbal de-escalation and distraction and grounding techniques. Grounding techniques help keep someone in the present and can be helpful in managing overwhelming feelings or intense anxiety. We saw evidence staff were aware of which techniques helped to support and calm each patient during difficult times. Staff reported that if they were unable to manage a patient's challenging behaviours on the ward, they contacted the commissioners who would source and transfer the patient to a psychiatric intensive care bed.

Staff understood and where appropriate worked within the Mental Capacity Act definition of restraint.

Staff followed National Institute of Health and Care Excellence guidance when using rapid tranquilisation.

Safeguarding

All staff had received training on how to recognise and report abuse, appropriate for their role.

Staff kept up-to-date with safeguarding training and were aware of the designated on-site safeguarding officer and their role.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act.

Staff knew how to recognise adults and children at risk of or suffering harm and worked with other agencies to protect them. Staff knew how to make a safeguarding referral and who to inform if they had concerns.

A safeguarding referral is a request from a member of the public or a professional to the local authority or the police to intervene to support or protect a child or vulnerable adult from abuse. Commonly recognised forms of abuse include: physical, emotional, financial, sexual, neglect and institutional.

Each authority has their own guidelines as to how to investigate and progress a safeguarding referral. Generally, if a concern is raised regarding a child or vulnerable adult, the organisation will work to ensure the safety of the person and an assessment of the concerns will also be conducted to determine whether an external referral to Children's Services, Adult Services or the police should take place.

Staff followed the provider's procedures to keep children visiting the ward safe. Both wards had designated visitors' room for visitors with children to visit patients on the ward.

Staff access to essential information

All information needed to deliver patient care was available to all relevant staff when they needed it and was in an accessible form. This included when patients moved between teams. Agency staff who regularly worked at the hospital had an account to enable access to the provider's online training system, their own email account and access to patients' care notes. Agency staff who did not regularly work at the hospital had a generic electronic login account so that they could access the information they needed about the patient group.

The service used a variety of electronic and paper records to document patient care and treatment. Staff told us this did not cause them any difficulty in entering or accessing information.

Medicines management

Long stay or rehabilitation mental health wards for working age adults

Requires improvement

Staff followed systems and processes when safely prescribing, administering, and storing medicines.

However, we found issues with the recording of medicines management. We found evidence of missed entries by staff for the recording of administration of drugs that are liable for misuse.

The provider had a four-stage programme of medicine self-administration available to patients. We found issues with staff recording of the medicine self-administration records of four patients on Lower House. Concerns included missing dates of commencing or suspending medicines self-administration, missing records of staff prompts to patients. We saw incomplete records of random checks by staff to ensure patients remained safe to self-administer medicines. In one record we found no documented risk assessment or clinical decision for the patient to be self-medicating. This was not in line with the provider's policy. We saw one example of where poor staff recording had resulted in a medicines administration incident.

In all four of the prescription charts we reviewed on Lower House for patients who were self-medicating, we found errors in the records kept by staff. In one patient's record, we found staff had not signed for the administration of the medicines. In this record we found that the patient's risk assessment on 8 October 2019 documented that the patient's self-medication had been suspended, but on 10 October 2019 staff had recorded on the patient's chart that they were self-medicating. Staff confirmed this had not been shared at handover. In another patient's record, we found missing random checks, in line with the provider's policy, on two occasions between 29 August 2019 and 14 October 2019. In this same record, we noted there was no record of the risk assessment or clinical decision for the patient to be self-medicating, as per the provider's policy. In another patient's record, we did not find a complete record of prompts for the patient to attend the clinic for staff to issue their medication or random checks by staff, as per the provider's policy. We were unable to identify the date on which the patient commenced self-medicating. In a separate patient's record, we found missing records of the date on which the patient commenced self-medicating and later suspended self-medicating, as well as missing records for the prompts and medication issued between 6 October and 12 October 2019.

The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely.

Decision making processes were in place to ensure people's behaviour was not controlled by excessive and inappropriate use of medicines.

Staff reviewed the effects of each patient's medication on their physical health according to National Institute for Health and Care Excellence guidance.

Track record on safety

Between 11 October 2018 and 11 October 2019 eight serious incidents took place in the service. We have reviewed these incidents as part of our engagement with and ongoing monitoring of the service. The service had notified all of these incidents to the Care Quality Commission, as required. Since our previous inspection, there had been one serious incident involving a patient who self harmed and required admission at a local acute hospital.

Following the previous inspection the provider had complied with the conditions to undertake a comprehensive review of all serious incidents and check that these have been notified to the Commission. They had ensured that incident patterns and trends were analysed to show an individual and unit picture e.g. time, location, type, so as to inform staff to make managerial decisions.

Reporting incidents and learning from when things go wrong

Staff knew what incidents to report and how to report them. Staff reported all incidents they should report. Staff reported serious incidents clearly and in line with the provider's policy.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong.

Managers ensured staff were debriefed and supported staff after any serious incident. The psychology team within the hospital offered both individual and group debriefs. Nursing and psychology staff offered individual and group debriefs to patients, depending on the nature of the

Long stay or rehabilitation mental health wards for working age adults

Requires improvement

incident. Patients and staff could choose who they wanted to do this. The provider offered several supportive mechanisms for staff including referrals for counselling, an employee assistance helpline and group support sessions.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations.

Staff received feedback from investigation of incidents, both internal and external to the service. We saw staff met to review incidents at the daily morning meeting. However, the recording of the sharing of these lessons was not consistent. This meant it was difficult to determine what the lessons learned were and what action had been taken in response to the lessons.

Managers told us they shared learning with their staff about incidents that happened at the provider's other locations.

Staff met to discuss the feedback and look at improvements to patient care.

There was evidence that changes had been made because of feedback. We saw the service had taken on board feedback from our previous inspection and had acted to improve the safety of the service. Following a thorough review of the trends and themes around the incidents in the service, the service had looked at ways to improve patients' access to therapeutic activities and reduce incidents. Staff had identified that most incidents had occurred at night or during weekends. As a result, the service had recruited an assistant psychologist and a therapy coordinator to work shifts covering evening and weekends. This enabled patients to access group activities and more structured therapies at the times that had been identified as more challenging for patients, in the hope that this may help to reduce incidents. It was too soon to evaluate the impact of the additional staff.

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

(for example, treatment is effective)

Requires improvement

Assessment of needs and planning of care

We looked at 12 patients' care and treatment records. These records demonstrated staff completed a comprehensive mental health assessment of each patient either on admission or soon after.

All patients had their physical health assessed soon after admission and regularly reviewed during their time on the ward. However, patient records contained a lack of physical health screening tools or assessments to support patients with existing physical health conditions. This included nutritional assessments and continence assessments.

Overall, staff developed care plans that met the needs of patients identified during assessment. Care plans were personalised, holistic and recovery-oriented and were updated regularly. However, care plans did not always reflect the patient's risks as identified in their risk assessment. This meant it was not always clear in care plans how staff should manage specific risks, such as specific self-harming behaviours.

Best practice in treatment and care

We looked at 12 patients' care and treatment records. Records demonstrated staff provided a range of care and treatment interventions suitable for the patient group. The interventions were those recommended by, and were delivered in line with, guidance from the National Institute for Health and Care Excellence. These included medication and psychological therapies and activities, training and work opportunities intended to help patients acquire independent living skills.

The service had reviewed its therapeutic activity timetable since our previous inspection and we saw this had improved to incorporate a greater range of meaningful therapeutic activities and that patients' attendance and engagement in these activities was more accurately monitored. However, three of the 12 patients we spoke with told us the activities offered were not suitable for their needs. The timetable was designed to ensure that at least one of the activities on the timetable at any given time was open, which meant that it was accessible to all patients. Staff told us that the daily auditing of patients' involvement in therapeutic activities was time-consuming and impacted on their time to engage in other activities.

Staff ensured that patients had good access to physical healthcare, including access to specialists when needed. The doctor saw patients at least monthly during clinical review meetings and we saw evidence that the doctor

frequently met with patients in between these meetings. Staff developed care plans for patients with specific physical health needs and for those who were anxious about their physical health.

Medical and nursing staff supported a monthly well women's clinic. Staff encouraged patients to attend this clinic to allow staff to monitor and improve their physical health. A district nurse attended the service regularly to support patients with their physical healthcare. All patients were registered with a local GP practice, optician and dentist in the community.

The service had engaged with the local emergency department and the GP practice to improve patients' access to and experience of care at these health services. The service had developed training for these health services to educate them about personality disorder and how this may impact on patients' presentation at the local emergency department or GP surgery. The service had developed grab sheets to assist staff from the service to handover key information to staff at these other health services.

Staff supported patients to live healthier lives. For example, through participation in smoking cessation schemes, healthy eating advice, offering patients flu jabs and screening for cancer and dealing with issues relating to substance misuse. However, care plans lacked details about how the service supported patients to live healthier lives.

Staff encouraged patients to maintain a healthy lifestyle through participation in a range of physical exercises as part of their therapeutic timetable. This included swimming, horse-riding and walking groups. Staff promoted healthy eating by encouraging patients to engage in "shop and cook" groups with occupational therapy staff and by sharing recipes through a local healthy eating group.

Staff used recognised rating scales to assess and record the severity of patients' conditions and care and treatment outcomes. Outcome measures are tools that document patient progress and engagement in the rehabilitation process. These included the Global assessment of Progress and the Health of the Nation Outcome Scale that staff completed every four weeks.

Staff used technology to support patients effectively.

Audits were not consistent in identifying issues. For example during our previous inspection, we told the provider they must review the observation policy and audit how this was implemented.

We noted that because this audit had not identified the issues we found in relation to missed observations or inaccurate timings of observations, it was not effective in driving improvement.

Staff participated in clinical audit, benchmarking and quality improvement initiatives. The hospital benchmarked their service against other similar services both within and outside of the local region.

Skilled staff to deliver care

The clinical team included or had access to the full range of specialists required to meet the needs of the patients in the service. This included a responsible clinician who was a consultant psychiatrist, a speciality doctor, nurses, support workers, clinical and forensic psychologists, assistant psychologists, occupational therapists, therapy coordinators and a social worker. The team also used the skills and expertise of the provider's other local services, including a local acquired brain injury unit, to provide specialist assessment and support to the patient group.

Managers ensured staff had the right skills, qualifications and experience to meet the needs of the patients in their care, including bank and agency staff. Managers gave each new member of staff a full induction to the service before they started work.

Managers supported staff through regular, constructive appraisals of their work. All staff had received an appraisal within the last 12 months, as outlined in the provider's appraisal policy.

All staff had received regular supervision. Staff received supervision every three months in line with the provider's policy. This included clinical and managerial supervision. Supervision is a meeting between staff to discuss case management, to reflect on and learn from practice, and for personal support and professional development.

Staff team meetings, particularly those specifically for nurses, were poorly attended by staff. Minutes of these team meetings and other clinical meetings showed the team had tried different approaches to improve attendance and discussed this issue at clinical governance

meetings to try to identify innovative ways to improve attendance. To ensure messages were shared effectively across the service, the manager had introduced monthly bulletins and email updates.

Members of the multidisciplinary team had access to profession-specific meetings, including regional meetings for allied health professionals such as psychologists and occupational therapists.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge.

Managers made sure staff received the necessary specialist training for their roles. Following the last inspection the condition that all staff had received training in observations, self harm and personality disorder had been met. The hospital's psychology team provided training around autistic spectrum disorders and how this diagnosis may impact patients with a personality disorder. The psychology team also facilitated training around positive behaviour support and how staff can use these models to understand patients' behaviour and develop strategies to improve the quality of the patient's life.

Managers dealt with poor staff performance promptly and effectively.

Managers recruited, trained and supported volunteers to work with patients in the service.

Multi-disciplinary and inter-agency team work

Staff held regular and effective multidisciplinary meetings. The multidisciplinary team met daily to review patient risk and required levels of observations. There were clinical review meetings twice a week and monthly incident review meetings. Each patient was seen every four weeks by the full multidisciplinary clinical team but could meet with the team more often if they had a specific request. We saw evidence of good multidisciplinary team working and examples of collaborative decision making.

Staff shared clear information about patients and any changes in their care, including during handover meetings. We observed a handover meeting and saw staff handed over key information to the staff coming on shift. This included patient's daily risk assessment score, current level of observation, any incidents during the last 24 hours and an update on each patient's current mood and mental state. Staff shared information about upcoming activities, they developed plans and shared advice about how best to engage with patients whose mood appeared low. Staff demonstrated a good understanding of the needs and preferences of the patient group.

Ward teams had effective working relationships with external teams and organisations. We saw staff had developed working relationships with community healthcare professionals to support patients through their admission and discharge from the service to make the transfer process smoother for the patient

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

Staff received and kept up-to-date with, training on the Mental Health Act and the Mental Health Act Code of Practice and could describe the Code of Practice guiding principles.

As of 14 October 2019, all staff in this service had received training in the Mental Health Act.

The training compliance reported during this inspection was the same as the figure reported at the last comprehensive inspection in October 2018.

Staff had access to support and advice on implementing the Mental Health Act and its Code of Practice.

Staff knew who their Mental Health Act administrators were and when to ask them for support.

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

Patients had easy access to information about independent mental health advocacy and patients who lacked capacity were automatically referred to the service. An independent mental health advocate visited the service twice a week and we saw evidence in clinical governance meeting reports that patients met regularly with the advocate.

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

Long stay or rehabilitation mental health wards for working age adults

Requires improvement

Staff made sure patients could take section 17 leave (permission to leave the hospital) when this was agreed with the Responsible Clinician and/or with the Ministry of Justice.

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

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

Three informal patients we spoke with said they were not always allowed to leave at their will, Most informal patients knew that they could leave the ward freely and the service displayed posters to tell them this. Although we saw that staff gave informal patients a document informing them of their rights and completed an 'informal patient rights form' every three months as evidence they had discussed rights with informal patients.

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

Managers and staff made sure the service applied the Mental Health Act correctly by completing audits and discussing the findings.

Good practice in applying the Mental Capacity Act

Staff received and kept up-to-date with, training in the Mental Capacity Act and had a good understanding of at least the five principles.

As of 14 October 2019, all staff in this service had received training in the Mental Capacity Act.

There was a clear policy on Mental Capacity Act and Deprivation of Liberty Safeguards, which staff could describe and knew how to access.

Staff knew where to get accurate advice on the Mental Capacity Act and Deprivation of Liberty Safeguards.

Staff gave patients all possible support to make specific decisions for themselves before deciding a patient did not have the capacity to do so.

Staff assessed and recorded capacity to consent clearly each time a patient needed to make an important decision.

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

Staff made applications for a Deprivation of Liberty Safeguards order only when necessary and monitored the progress of these applications.

The service monitored how well it followed the Mental Capacity Act acted when they needed to make changes to improve.

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

Requires improvement

Kindness, privacy, dignity, respect, compassion and support

Staff were discreet, respectful, and responsive when caring for patients. However, one patient told us that because staff wore identification lanyards when supporting patients in the community, this could make it difficult for patients to engage in community-based activities without members of the community knowing they were receiving support from a staff member.

Staff directed patients to other services and supported them to access those services if they needed help.

However, one patient raised concerns about staff attitudes towards patients and two other patients said that agency staff often did not know the names of the patients for which they were providing care and treatment. Three of the 12 patients we spoke with told us that staff spent large amounts of time in the office rather than engaging with patients at times when managers were not present. Not all patients felt safe. We saw evidence in staff meeting minutes that these issues had been discussed amongst staff.

Staff understood and respected the individual needs of patients, including their personal, cultural, social and religious needs.

Staff said they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards patients without fear of the consequences.

Long stay or rehabilitation mental health wards for working age adults

Requires improvement

Overall, staff maintained the confidentiality of information about patients. However, on Lower House we noted the wipe board in the clinic room displayed patient identifiable information and this board was visible from where staff dispensed patients' medicines. The board contained the dates of each patient's depot and blood tests against each patient's initials.. There was no mechanism in place to cover this board when patients attended the clinic for examinations or medicines.

Involvement in care

Involvement of patients

Staff introduced patients to the ward and the services as part of their admission. Staff gave patients a welcome pack on admission and new patients were offered a buddy. However, four of the patients we spoke with said they did not receive a welcome pack on admission. Staff ensured patients were seen by the full multidisciplinary clinical team within their first week of admission.

Staff did not consistently involve all patients in care planning and risk assessment. four of the patients we spoke with said they were not involved in their care plan and one patient said they had attended two review meetings without having seen their care pack as requested.

Staff always invited patients to attend their multidisciplinary team review meetings, unless there were specific risk issues which needed to be discussed without the patient. Staff reported, and records demonstrated this was rare and based on clinical decision making.

Staff communicated with patients so that they understood their care and treatment, including finding effective ways to communicate with patients with communication difficulties.

Staff took minutes of each of the community meetings and printed these off for patients to review within communal areas.

Staff involved patients in decisions about the service, when appropriate. For example, patients had developed a book of phrases they do and do not like for new staff to review when they started working at the hospital.

Three of the 12 patients we spoke with said they had not been given any opportunities to be involved in decisions about the service. A patient representative was also recruited to attend clinical governance meetings. However, there were no patients present in the clinical governance meeting we observed during our inspection. Some patients said they could give feedback on the service and their treatment and staff supported them to do this. For example, through multidisciplinary team review meetings, community meetings, the people's council, the complaints process and the patient survey..

Staff supported patients to make advanced decisions about their care. Where appropriate, staff encouraged patients to complete an advance statement. Staff documented the patient's early warning signs and directed staff on the best way to support the patient when they experienced a deterioration in their mental state. Staff documented when patients were offered and declined an advance statement. We saw some patients had a crisis plan displayed on their door which said how staff can best support them if they are in crisis.

Staff ensured that patients could access advocacy. Patients were supported by the independent mental health advocate through one to one sessions as well as support at clinical meetings and review meetings.

Involvement of families and carers

Most patients believed staff supported, informed and involved families or carers. Two patients told us that the communication agreement that staff had developed in conjunction with them was positive. However, one patient told us staff did not involve their family in decisions about their care or keep them updated about changes to their care. Another patient reported that staff had shared information with their family outside of the planned communication agreement. We also spoke to a family member of a patient who was using the service who told us that communication from the hospital was poor and that they had not been involved in decisions about their family member's care. They told us they had tried to engage with the service, but staff had not been responsive to their requests.

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

Long stay or rehabilitation mental health wards for working age adults

Requires improvement

Good

Access and discharge

Bed management

This hospital offered a national service; therefore, patients were admitted from across England. The average length of patient stay on both wards varied between 12 to 18 months however patients can remain at this hospital for a longer period. All beds are commissioned by local clinical commissioning groups. Referrals are received from secure services, acute admission wards and psychiatric intensive care wards. Managers made sure bed occupancy did not go above 85%.

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

Patients were moved between wards only when there were clear clinical reasons, or it was in the best interest of the patient. Staff did not move or discharge patients at night or very early in the morning.

The hospital staff liaised closely with other mental health service providers and commissioners to maintain links with local psychiatric intensive care units and acute mental health wards in case a patient required more intensive care.

Discharge and transfers of care

In the last 12 months, there were five delayed discharges from the service. The only reasons for delaying discharge from the service were due to finding suitable placements.

Staff planned for patients' discharge, including good liaison with care managers/co-ordinators. We saw evidence of this through our enhanced engagement with the service since our last inspection in August 2019. Staff from the hospital supported patients' assessments for other services and on visits to alternative services.

Staff supported patients during referrals and transfers between services, including if they required treatment in an acute hospital or temporary transfer to a psychiatric intensive care unit. Staff supported patients with transfers and their discharge plans in a person-centred, individualised way. For example, we saw cases where patients had expressed their anxiety to staff about moving from Upper to Lower House as part of their pathway through the service. Staff responded to this by offering reassurance and developing personalised care plans that were flexible to each patients' needs and requests. This enabled patients to make progress whilst remaining at Upper House, for example, by having fob access to the kitchen area to increase their independence.

Staff worked hard to reduce the pressure on patients around discharge and transfers of care and empowered them to ensure their preferences were heard. Similarly, we saw examples of person-centred care around patient transfers, including staff enabling patients to maintain their key worker from Upper house when transferred to Lower House, and vice versa. Staff recognised the importance of this continuity of care for patients and worked hard to maintain this wherever possible. The service followed national standards for transfer.

The facilities promote recovery, comfort, dignity and confidentiality

Each patient had their own bedroom with an en-suite bathroom. We saw patients could personalise their rooms.

Patients had a lockable drawer within their bedside cabinet to store their personal possessions. Patients could keep copies of their care plans here to protect their confidentiality.

Staff used a full range of rooms and equipment to support treatment and care.

The hospital had quiet areas on the ward and a room where patients could meet visitors. However, we observed issues with the soundproofing of rooms which meant that patients and staff outside of the room could hear conversations clearly.

Patients could make a phone call in private. All patients had access to a mobile phone.

The service had an outside space that patients could access easily. At Upper House, access to the garden was through the lounge door only and this was always monitored by staff. At Lower House, a staff member was allocated to monitoring the garden at all times, but patients could access the garden without staff supervision. The staff member was allocated to the garden to provide

therapeutic support to patients when in the garden, rather than to monitor risk. Patients always had access to the garden, although staff encouraged patients to maintain a healthy sleep hygiene routine.

Patients could make their own hot drinks and snacks and were not dependent on staff to do so.

The service offered a variety of good quality food.

Patients' engagement with the wider community

Staff made sure patients had access to education and work opportunities, and supported patients to engage in these activities. For example, patients were enrolled in local colleges and engaged in a range of volunteering activities. Whilst the service encouraged patients who were able to attend college in the community to do so as part of their rehabilitation, the service had also arranged for a tutor from a local college to attend the hospital to offer maths, literacy and information technology sessions to patients.

The service promoted social inclusion and tried to reduce stigma around mental health problems within their local community. For World Mental Health Day, staff encouraged patients to decorate some giant pebbles with inspirational quotes about their journey in mental health services and scatter these around the local community. The hospital had also reached out to other services in the local community to help improve their understanding of mental health and

specifically personality disorder. The service had engaged with the local GP service, emergency department staff team and the police service to improve community awareness of mental health. The team had linked with the local acute hospital to offer some training to junior doctors about personality disorders.

Meeting the needs of all people who use the service

The service had facilities for disabled people and those with communication needs or other specific needs. The hospital had two bedrooms on each ward that were located on the ground floor and had wet rooms and wider door frames to support wheelchair users. The hospital were dealing with a complaint of how to support patients with mobility requirements and the use of a mobility scooter.

Staff ensured patients could obtain information, including treatments, local services, patients' rights and how to complain. We also saw information on display about staying safe on social media, information sharing and a board to display what activities and staff were on that day. During a morning meeting, staff discussed the need to share some information with a patient about a recent diagnosis of one of the patient's family members. However, we noted an absence of information for patients about healthy living, health promotion and support for mental health.

The service had information leaflets available in languages spoken by the patients and the local community. We also saw examples of information available in easy-read formats.

Managers made sure staff and patients could get help from interpreters or signers when needed.

The service provided a variety of food to meet the dietary and cultural needs of individual patients. However, seven out of the 12 patients we spoke to told us they were unhappy with the time that their evening meal was served. Staff served patients their evening meal at 4.30pm. We raised this with the hospital manager who explained that this was under review in line with the working hours of the kitchen staff.

Staff ensured that patients had access to appropriate spiritual support and patients told us this was easily accessible.

Listening to and learning from concerns and complaints

The service received 14 complaints between 1 January and 11 October 2019. One of these complaints was upheld, four were partially upheld and nine were not upheld. None were referred to the Ombudsmen.

Patients, relatives and carers knew how to complain or raise concerns. Staff displayed information about how to raise a concern in patient areas. Staff understood the policy on complaints and knew how to handle them.

The service had effective processes in place for managing complaints and staff followed the provider's complaints policy. Managers investigated complaints and identified themes. During clinical governance meetings, staff reviewed the feedback that patients had shared with the advocate about the service. We saw evidence that the

Long stay or rehabilitation mental health wards for working age adults

Requires improvement

advocate supported patients to effectively resolve their concerns and the clinical team were keen to capture all these concerns as well as formal complaints to improve learning.

When patients complained or raised concerns, they received feedback.

Managers shared feedback from complaints with staff and learning was used to improve the service. We saw examples where staff made direct changes to their practice as a result of patients' feedback or complaints. For example, patients raised concerns about not having enough time to look through their Care Programme Approach reports prior to their meeting. In response to this, staff were asked to prepare their reports earlier to give patients time to review these.

Staff protected patients who raised concerns or complaints from discrimination and harassment.

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

Requires improvement

Leadership

Leaders had responded responsively to make changes following the last inspection and were visible to staff.

Staff and patients reported leaders were visible in the service and approachable for patients and staff.

Leadership development opportunities were available, including opportunities for staff below team manager level.

Vision and strategy

Not all staff knew and understood the provider's vision and values or how they were applied in the work of their team. Managers were in the process of revising the care model following our last inspection.

Staff had the opportunity to contribute to discussions about the strategy for their service, especially where the service was changing. Staff described feeling consulted about changes to the service and reported the leadership team were receptive to their suggestions.

Staff could explain how they were working to deliver high quality care within the budgets available.

Culture

Not all staff felt able to raise concerns without fear of retribution and we were given information suggesting that some staff felt pressurised to make inaccurate records. Staff knew about the whistle-blowing process and the role of the bullying and harassment officer.

The service's staff sickness and absence were higher than the provider target.

Staff felt respected, supported and valued and reported feeling positive and proud about working for the provider and their team.

Managers dealt with poor staff performance when needed.

We saw examples of good team working amongst staff on the wards and within clinical review meetings.

Staff appraisals included conversations about career development and how it could be supported.

Staff reported that the provider promoted equality and diversity in its day to day work and in providing opportunities for career progression.

Staff had access to support for their own physical and emotional health needs through an occupational health service. Staff reported good use of this service.

The provider recognised staff success within the service. For example, staff nominated each other for the provider's 'Random Acts of Kindness' awards. We also saw that staff read out compliments for each other during morning meetings and these were recorded.

Governance

We found issues with the overall governance of the service. Specifically, in relation to the quality and accuracy of record keeping and oversight of these records. We noted inaccuracies or discrepancies between records of patient observations, patient self-medication processes, cleaning and maintenance of physical healthcare equipment, the cleaning of the ward environment and in staffing registers.

Audits, such as observations were not always effective in identifying issues and therefore did not provide overall assurance of improvement.

Long stay or rehabilitation mental health wards for working age adults

Requires improvement

Staff struggled to engage in team meetings, although there was a clear framework of what must be discussed at a ward, team and directorate level in team meetings to ensure that essential information, such as learning from incidents and complaints, was shared and discussed. However, the service had struggled to engage staff in team meetings and as a result had shared key information through emails and supervision. This meant that clinical staff did not use a group forum to share lessons learned and ways to improve practice. Although managers had tried several ways of improving staff attendance at team meetings, this had not been successful and as a result there had been occasions where there had been no team meetings for several months.

The service had responded accordingly to the enforcement conditions placed upon the service following our previous inspection. We saw evidence that these changes had been implemented in a timely manner and the management had successfully engaged the staff team to develop and embed these changes. Staff had implemented recommendations from reviews of deaths, incidents, complaints and safeguarding alerts at the service level.

We saw evidence that the service held regular and clinical governance meetings. The consultant psychiatrist supported the team in sharing lessons with other local services due to their role as regional clinical governance lead. The service also had regular operational governance meetings with other services under the same provider within the region.

We reviewed the lessons learned documentation file which did not contain any information on how the lessons learnt were shared or what actions had been taken to implement the changes required. We saw that staff were sent bulletins through emails, bulletins and handover meetings.

Members of the multidisciplinary team participated in clinical audits relevant to their role and staff described the outcome of these audits and how they supported improvement in the service.

Staff understood the arrangements for working with other teams, both within the provider and external, to meet the needs of the patients.

Management of risk, issues and performance

Managers benchmarked the number of incidents and self harm with other Cygnet locations, these levels although declining remained a concern.

Staff maintained and had access to the risk register at ward or directorate level. Staff at ward level could escalate concerns when required. Staff concerns matched those on the risk register.

The service had plans for emergencies, for example, adverse weather or a flu outbreak. This was line with the provider's business continuity plan.

Information management

Systems were not effective in recording who was on the premises on duty.

Information governance systems did not always include confidentiality of patient records. We found patient identifiable information displayed on a board in a clinic room on Lower House that was visible by other patients and this compromised patient confidentiality. However, we saw several other examples of effective information governance that was designed to protect patient confidentiality, for example, no patient identifiable information was contained in paperwork that was shared corporately.

The service used systems to collect data from wards and directorates that were not over-burdensome for frontline staff. Staff had access to the equipment and information technology needed to do their work. The information technology infrastructure, including the telephone system, worked well and helped to improve the quality of care.

Team managers had access to information to support them with their management role. This included information on the performance of the service, staffing and patient care.

Information was in an accessible format, and was timely, accurate and identified areas for improvement.

Staff made notifications to external bodies, including the Care Quality Commission, as needed.

Engagement

Staff, patients and carers had access to up-to-date information about the work of the provider and the services they used through the intranet and bulletins. The minutes of meetings were shared with relevant staff in a timely manner.

Long stay or rehabilitation mental health wards for working age adults

Requires improvement

Patients and carers had opportunities to give feedback on the service they received in a manner that reflected their individual needs. Managers and staff had access to the feedback from patients, carers and staff and used it to make improvements.

Patients and carers were involved in decision-making about changes to the service.

Directorate leaders engaged with external stakeholders, such as commissioners and Healthwatch. Commissioners completed quality visits regularly.

Learning, continuous improvement and innovation

The service did not participate in national audits or accreditation schemes relevant to the service Staff were given the time and support to consider opportunities for improvements and innovation and this led to changes. However, none of the staff we spoke with were aware of or involved in opportunities to participate in research.

Innovations were taking place in the service. For example, the hospital had developed strong working links with the local police service and the local emergency department to help these local services to understand the hospital's clinical model and patient population.

We saw evidence that staff were engaged in making improvements to the service and this was a regular feature of clinical meetings. However, staff we spoke with were not aware of specific quality improvement methods or projects.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure staff maintain accurate records of patient care and treatment, including patient observations, patients' self-administration of medication and the checks of emergency equipment. Regulation 17 HSCA (RA) Regulations 2014 Good governance.
- The provider must ensure the system(s) used to monitor staff attendance at the unit are clear, and where more than one system is used, that there are no discrepancies between the staff numbers on site at any given time. Regulation 17 HSCA (RA) Regulations 2014 Good governance.
- The provider must ensure staff use audits effectively to identify errors and drive improvement. Regulation 17 HSCA (RA) Regulations 2014 Good governance.
- The provider must ensure staff follow the provider's policies and procedures for the use of observation. Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment.
- The provider must ensure patients' care plans reflect the needs and behaviours highlighted in each patient's risk assessment. Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment.
- The provider must ensure that specific risk assessments, such as a choking risk assessment, are reviewed in line with the frequency outlined in the assessment. Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment.
- The provider must ensure staff protect patient confidentiality in all areas of the hospital. Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect.
- The provider must ensure patients are involved in and are aware of their involvement in their care plans. Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment.

Action the provider SHOULD take to improve

- The provider should ensure staff clean all portable physical health equipment and maintain accurate records of this.
- The provider should ensure all informal patients are aware of their right to leave the hospital at their will.
- The provider should ensure staff document patients' access to physical health screening and health promotion information in their care plans.
- The provider should consider reviewing the time the hospital staff serve patients their evening meal.
- The provider should consider how the service can improve attendance at team meetings to ensure essential information is communicated effectively and develop team working.
- The provider should consider reviewing the soundproofing of rooms used for visiting.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect **Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect.** How the regulation was not being met: The service did not protect patient confidentiality in all areas of the hospital. This was a breach of regulation 10 (1) (2) (a)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 12 CQC (Registration) Regulations 2009 Statement of purpose **Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment** How the regulation was not being met: The provider did not ensure staff followed their policy and procedure for the use of observations. This was a breach of regulation 12 (1) (2) How the regulation was not being met: The provider did not always ensure patients' care plans reflected the needs and behaviours highlighted in each patient's risk assessments. This was a breach of regulation 12 (1) (2) (a) (b)

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.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **Regulation 17 HSCA (RA) Regulations 2014 Good governance** How the regulation was not being met: The provider did not always maintain accurate records of patient care and treatment, including patient observations, records of patients' self-administration of medication and records of the checks of emergency equipment. This was a breach of regulation 17 (1) (2) (c) (d) How the regulation was not being met: The provider did not maintain accurate records over which staff were in the hospital at any given time. This was a breach of regulation 17 (1) (2) (c) (d) How the regulation was not being met: The provider did not use always audits effectively to identify errors or drive improvement. This was a breach of regulation 17 (1) (2) (c) (d) (e) (f)