Cygnet Hospital Coventry

Quality Report

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

Ratings

Overall rating for this location	**Inadequate**
Are services safe?	**Inadequate**
Are services effective?	**Requires improvement**
Are services caring?	**Inadequate**
Are services responsive?	**Requires improvement**
Are services well-led?	**Inadequate**

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

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

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

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

Summary of findings

Overall summary

We did not change the ratings of Cygnet Hospital Coventry at this inspection because this was an unannounced focused inspection to check specific concerns that staff had raised with the CQC. The ratings of the previous inspection therefore remain in place.

At the time of this inspection the hospital had conditions in place on the providers registration which were previously imposed after the CQC comprehensive inspection in July and August 2019. The conditions we placed upon the provider's registration in 2019 required the provider to close one ward and cap admissions to existing wards. Following the inspection in March 2020 and further enforcement action, the provider voluntarily closed another ward. They also made the decision prior to this inspection in June 2020 to temporarily close the hospital by the end of July 2020. The provider was hoping that the temporary closure of the hospital would enable them to address the culture of the hospital and to develop a staff team which worked well together to meet the needs of the patients.

At this inspection we inspected specific areas of the safe, effective, responsive and well led domains. We wanted to check that patients were being cared for safely during the run up to the temporary closure of the hospital and were largely assured this was the case although there was more to do. This is what we found:

- Documentation for patient observations was not fully completed, although we were assured that patients were being observed correctly and safely.
- Staff completing risk management plans had not documented all identified patient risks and how they were to be managed. This meant staff might not know of appropriate interventions to use to keep patients safe and minimise risk.

However:

- The service had enough nursing and medical staff to keep patients safe from avoidable harm. This was because staff had been temporarily redeployed from other Cygnet hospitals after the decision to temporarily close the hospital. However, there was still a high use of agency staff.
- Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.
- 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. The provider had good arrangements in place to identify and deal with safeguarding.
- The ward team had access to the full range of specialists required to meet the needs of patients on the ward. Managers made sure they had staff with a range of skills needed to provide good safe care. Managers provided an induction programme for new staff.
- The provider was working closely with clinical commissioning groups and other relevant stakeholders in preparation for the hospital closing to ensure patients were transferred to appropriate placements that met their individual needs.
- The service had had a high turnover of managers in the last 12 months and the provider had decided to close due to long standing issues regarding the culture of the service. However, at the time of this inspection the manager and senior team had the skills, knowledge and experience to perform their roles, had a good understanding of the service they managed, and were visible in the service and approachable for patients and staff.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Acute wards for adults of working age and psychiatric intensive care units	Inadequate 	

Summary of findings

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Summary of this inspection

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Inadequate

Cygnet Hospital Coventry

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

Summary of this inspection

Background to Cygnet Hospital Coventry

Cygnet Hospital Coventry is part of the Cygnet Healthcare group. The group provides health care services nationally. The hospital is purpose built, providing inpatient mental health care and treatment for women. It opened in April 2017. It has three wards. The Spires, Ariel and Middlemarch and a transitional living unit attached to one ward called St Mary's Court. The Spires was previously called Dunsmore ward and changed its name after the last comprehensive inspection in July and August 2019. The ward has been closed to admissions since September 2019.

Cygnet closed Ariel ward in April 2020. Patients from the ward were moved on to other services, in line with their clinical need and progress, or moved to Middlemarch to continue their treatment pathway. Middlemarch has 16 beds. St Mary's Court is attached to Middlemarch and has seven studio apartments providing transitional step-down support. At the time of this inspection there were 11 patients in Middlemarch and six patients in St Mary's Court.

The last comprehensive inspection of this hospital took place in July and August 2019, when it was rated inadequate overall. The ratings for that inspection were inadequate in safe, requires improvement in effective, inadequate in caring, requires improvement in responsive and inadequate in well led. We used our legal powers under the Health and Social Care Act and placed conditions on the provider's registration as a result of the concerns we found during that inspection.

An unannounced focused inspection was carried out in February 2020 following concerns raised by patients about how staff carried out night time observations. Observations were being completed effectively when we carried out that inspection. We did not rate the hospital at that inspection.

An unannounced focused inspection was carried out in March 2020 based on concerns we received from patients and families. They had told us there were not enough staff of the right skill level and experience to provide patients with the support they needed. Some told us they did not feel safe because staff did not always respond to them in the right way. They told us the number of patient incidents had increased and staff had not carried out a patient search in the right way. We did not rate the hospital at that inspection. The conditions that were placed on the provider's registration remained in place.

We carried out this focused inspection based on further concerns we received from staff, specifically regarding not having enough staff with the right skills to ensure patients were safe.

Cygnet have told us they intend to temporarily close the hospital by the end of July 2020. The hospital and clinical commissioning groups are working together to transfer patients to other care settings. We did not rate the hospital at this inspection. The rating from the last comprehensive inspection remains in place.

Our inspection team

The team that inspected the service comprised one CQC inspection manager, two inspectors, one specialist advisor and one expert by experience. An Expert by Experience is a person with lived experience or is the carer of a person with lived experience of using health and care services.

Why we carried out this inspection

We carried out this inspection because we had concerns about the care and treatment provided at Cygnet Hospital Coventry.

Summary of this inspection

This was an unannounced focused inspection to look at the concerns we identified at our last inspection and whether patients were safe. Hospital staff did not know we were coming. We carried out the inspection over one day.

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?

This was a focused inspection so we looked at specific issues, not the five key questions.

Before the inspection visit, we reviewed information that we held about the location and asked a range of other organisations for information.

During the inspection visit, the inspection team:

- visited each ward at the hospital, looked at the quality of the ward environment and observed how staff were caring for patients
- spoke with six patients who were using the service
- spoke with the hospital manager
- spoke with 12 other staff members; including nurses, occupational therapy assistants, psychologist assistants and health care workers
- looked at six care and treatment records of patients
- looked in detail at incident records, observation records and staff rotas
- carried out a specific check of the medication management on Middlemarch ward
- looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the service say

Patients told us they had seen improvements within the service over the last two months, specifically the increase in staffing levels. However, they were anxious about the hospital closure and did not feel that they had enough information about where they would be transferring too.

Two patients told us they found it distressing when hearing patients crying when they received their treatment through a nastro gastric tube.

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 inspected specific areas of this key question. We did not inspect all areas or rate the key question of safe at this inspection. This is what we found:

- All wards were safe, clean, well equipped, well furnished, well maintained and fit for purpose.
- The service was following the latest guidance from the Department of Health regarding infection control procedures and the use of personal protective equipment, due to the Covid 19 pandemic.
- The service had enough nursing and medical staff to keep patients safe from avoidable harm. This was because staff had been temporarily redeployed from other Cygnet hospitals after the decision to temporarily close the hospital. However, there was still a high use of agency staff.
- 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.
- The service used systems and processes to safely prescribe, administer, record and store medicines. Staff regularly reviewed the effects of medications on each patient's physical health.
- The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

However:

- Documentation for patient observations was not fully completed, although we were assured that patients were being observed correctly and safely from other findings on the inspection.
- Identified patient risks and how they were to be managed were not always documented within the risk management plan. This meant staff might not know of appropriate interventions to use to minimise patient risk.

Are services effective?

Requires improvement

We inspected specific areas of this key question. We did not inspect all areas or rate the key question of effective at this inspection. This is what we found:

Summary of this inspection

- The ward team had access to the full range of specialists required to meet the needs of patients on the ward. Managers made sure they had staff with a range of skills needed to provide safe care. Managers provided an induction programme for new staff.

Are services caring?

We did not inspect this domain.

Inadequate

Are services responsive?

Requires improvement

We inspected specific areas of this key question. We did not inspect all areas or rate the key question of responsive at this inspection. This is what we found:

- The provider was working closely with clinical commissioning groups and other relevant parties to ensure patients were transferred to appropriate placements that met their individual needs.

However:

- Patients did not feel they were kept informed of transfer plans by hospital managers, commissioners and care co-ordinators from their home area. Managers told us they did not want to give patients information until they were certain it was confirmed, to allay any distress.

Are services well-led?

Inadequate

We inspected specific areas of this key question. We did not inspect all areas or rate the key question of well-led at this inspection. This is what we found:

- Leaders had the skills, knowledge and experience to perform their roles, had a good understanding of the services they managed, and were visible in the service and approachable for patients and staff. Improvements had been made within the service in the two months leading up to our inspection.
- The service had had a high turnover of managers in the last 12 months and the provider had decided to close due to long standing issues regarding the culture of the service. However, the majority of staff now felt respected, supported and valued, especially in the last two months and since the decision to close the hospital had been made. They generally felt able to raise concerns without fear of retribution.

Detailed findings from this inspection

Mental Health Act responsibilities

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

This was a focused inspection to look at specific concerns that had been raised with us. We did not inspect how the provider carried out their responsibilities under the Mental Health Act 1983 at this inspection.

Mental Capacity Act and Deprivation of Liberty Safeguards

This was a focused inspection to look at specific concerns that had been raised with us. We did not inspect how the provider carried out their responsibilities under the Mental Capacity Act 2005 at this inspection.

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Acute wards for adults of working age and psychiatric intensive care units	Inadequate	Requires improvement	Inadequate	Requires improvement	Inadequate	Inadequate
Overall	Inadequate	Requires improvement	Inadequate	Requires improvement	Inadequate	Inadequate

Notes

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

Inadequate

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

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

Inadequate

Safe and clean environment

All wards were safe, clean well equipped, well furnished, well maintained and fit for purpose.

Safety of the ward layout

Staff completed and regularly updated thorough risk assessments of all wards areas and removed or reduced any risks they identified.

Staff could observe patients in all parts of the wards. Staff positioned themselves throughout the ward areas so they could observe patients. Patients bedrooms had concave mirrors to ensure blind spots were visible to staff.

Staff knew about any potential ligature anchor points and mitigated the risks to keep patients safe. The hospital was a reduced ligature site, and patient risk assessments mitigated any outlying risks.

Staff had easy access to alarms and patients had easy access to nurse call systems.

Maintenance, cleanliness and infection control

Ward areas were clean, well maintained, well furnished and fit for purpose.

Staff made sure cleaning records were up-to-date and the premises were clean.

Staff followed infection control policy, including handwashing. The service completed Covid 19 audits, so they were assured that staff were following the Department of Health and Social Care guidance and the provider's protocols, policies and procedures. The service had a plentiful supply of personal protective equipment (PPE), antibacterial hand gels and places to dispose of used PPE.

The hospital had daily calls with other Cygnet hospitals to discuss Covid 19 issues and requirements. This meant they kept up to date with the constantly evolving national guidance.

We inspected during the Covid 19 pandemic and saw that staff were generally adhering to the Department of Health and Social Care guidelines regarding the use of personal protective equipment (PPE) and infection control procedures to reduce the risk of spread of the virus. However, we saw during lunchtime that one staff member did not always dispose of their face mask and wash their hands as advised in the provider's infection control and PPE guidance for healthcare v8.

Clinic room and equipment

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

Staff checked, maintained, and cleaned equipment. We saw 'I am clean' stickers within the clinic room.

Safe staffing

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

Nursing staff

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

Inadequate

At the time of inspection the service had enough nursing and support staff to keep patients safe due to staff from other Cygnet hospitals being relocated to help and support during the transition to closure. Since Ariel ward had closed, staff had been relocated to either Middlemarch ward or St Mary's court. We reviewed staff rotas for Middlemarch ward from the 1 to 14 June 2020 and saw that staffing numbers for both day and night shifts ranged from 10 to 15 staff. This averaged at 12 staff per shift. Four staff were allocated to patient observations for two days, which reduced to two staff throughout the period we reviewed. This meant there was at least eight staff available for other tasks. Staffing levels had improved since our last inspection.

Since the hospital had announced the intended closure, extra staff had been brought in from other Cygnet sites. This was to ensure patients were kept safe and supported during the transition period and because the provider was aware some staff may leave abruptly due to gaining other employment. Patients and staff told us that staffing levels felt safe, and patients' needs were being met. Staff told us that the new staff increased the level of experience and skills to the ward, as there were more qualified staff and senior healthcare support workers.

Since our last inspection, one staff member was tasked as staff coordinator, which meant they had an oversight of all staffing requirements across the hospital.

The service continued to use high levels of agency nurses however they had been working in the service for a number of months which ensured consistency and were 'block booked'. Between 1 June and 14 June 2020, agency or bank staff covered 27% of all shifts on Middlemarch ward.

In the same period, agency staff covered 68% of all shifts for qualified nurses and 19% of all shifts for health care assistants. The provider had been unable to recruit permanent qualified nurses, despite attempting to do so for many months. There is a national shortage of qualified nurses.

The ward manager could adjust staffing levels according to the needs of the patients. At the time of inspection there was enough staff for patients to have regular one to one sessions, receive escorted leave and engage in activities.

Managers made sure all bank and agency staff had a full induction and understood the service before starting their shift.

The service had enough staff on each shift to carry out any physical health interventions safely. We observed staff performing physical health interventions and saw this reflected within the patient care records.

Staff shared key information to keep patients safe when handing over their care to others. Handover notes were comprehensive and easily accessible.

Medical staff

The service had enough daytime and night time medical cover and a doctor available to go to the ward quickly in an emergency. However, patients we spoke with told us they did not feel they saw their doctor often enough.

Managers made sure all locum staff had a full induction and understood the service before starting their shift.

Mandatory training

Most staff had generally completed and kept up-to-date with their mandatory training. The compliance for mandatory and statutory training courses at 23 June 2020 was 87%. The compliance for other, required courses was 67%. Of the training courses listed, five failed to achieve over 75% compliance.

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. However, since the outbreak of Covid 19, all training had been suspended apart from immediate life support. This meant not all staff were compliant with their required training needs, although this was due to an unprecedented pandemic and the need to prioritise resources in other areas.

Assessing and managing risk to patients and staff

Staff assessed and managed risks to patients and themselves well and followed best practice in anticipating, de-escalating and managing challenging behaviour. The ward staff participated in the provider's restrictive interventions reduction programme.

Assessment of patient risk

Staff completed risk assessments for each patient on admission, and reviewed this regularly, including after any incident. We reviewed six patient care records. Patients' risk statuses had been updated daily. Patients were risk rated,

either red for high risk or green for low risk, which was displayed easily for staff to see. Risk assessments included information on nursing observations, leave from hospital, physical health, diet, room access, self-harm; this varied dependant on a patient's individual needs.

Management of patient risk

Patient care records were generally comprehensive and staff knew about any risks to each patient and acted to prevent or reduce risks. However, recording of how to manage patient risks was not always consistent. We tracked one patient following an incident of self-harm in the form of headbanging. The recommendations following the managers incident review was that the risk assessment and care plan should be appropriately updated to reflect the incident. Although we saw that it had been appropriately recorded within the risk assessment, we could not see an associated management plan of how staff should manage this risk and what interventions should be deployed during and following an episode of headbanging.

However, at least two patients were using headbanging as a self-harm technique. We were assured that staff were managing these incidences well and had implemented appropriate interventions such as physical health and neurological checks following such an event. This was reflected within patient care notes.

Documentation for patient observations was not fully completed, although we were assured that patients were being observed correctly and safely.

We tracked one patient whose observation levels had increased during a night shift and saw that staff had quickly adapted to the change in the observation level, in accordance with their care plan. However, the front sheet which recorded level of risk and detailed what the patient was at risk of was not fully completed. This was the case for nine out of the ten observation records we reviewed. This had not impacted on patient safety, although the recording had not improved since the last inspection.

Staff and patients said the service felt 'safer' over the last two months. They felt the environment was calmer and incidents had reduced due to an increase in staffing.

Safeguarding

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.

Safeguarding procedures and recording was clear and effective. Staff received training on how to recognise and report abuse, appropriate for their role. Staff kept up-to-date with their safeguarding training.

Staff knew how to recognise adults and children at risk of or suffering harm and worked with other agencies to protect them. They worked with the local authority to support patients through safeguarding procedures. The local authority did not have any concerns about the provider's ability to identify and manage safeguarding concerns or enquiries. 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 access to essential information

Staff had easy access to clinical information and it was easy for them to maintain high quality clinical records.

Patient notes were comprehensive and all staff could access them easily. Records were stored securely.

Electronic handover sheets contained enough information to keep patients safe. They included staff who were on duty and their associated tasks. For example, it was clear who was responsible for medicines, first aid, ligature cutter checks and who were the fire and incident responders. Patients risk status was also clearly displayed.

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

Inadequate

Medicines management

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

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

Staff reviewed patients' medicines regularly and provided specific advice to patients and carers about their medicines.

Staff stored and managed medicines and prescribing documents in line with the provider's policy and staff followed current national practice to check patients had the correct medicines.

The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely. We reviewed three patient medicine charts. Any allergies were noted. We reviewed a recent medicine error. It had been dealt with appropriately and lessons learnt were identified.

Staff reviewed the effects of each patient's medication on their physical health according to National Institute of Clinical Excellence guidance. Patients received regular physical health checks and had appropriate interventions such as blood tests to ensure medicines were being effective and were within appropriate ranges for efficacy.

Reporting incidents and learning from when things go wrong

The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

Staff knew what incidents to report and how to report them. There was a clear process for reporting and investigating incidents. Staff could access the incident reporting system easily and managers reviewed and updated them regularly. Records of incidents could be found within the patient care records, daily handover sheets and the communication book.

The provider was managing incidents well. We looked in detail at three completed incidents whilst on inspection and were assured they had been investigated appropriately and lessons learnt had been noted and shared. When actions had been required, they had been completed.

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 investigated incidents thoroughly.

Staff met to discuss the feedback and look at improvements to patient care. This was reflected within staff meeting minutes we reviewed.

There was evidence that changes had been made as a result of feedback. For example, a medicine incident had prompted the provider to adapt the layout of the clinic room, to prevent patients reaching in and taking objects.

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

(for example, treatment is effective)

Requires improvement

Skilled staff to deliver care

The service had a full range of specialists to meet the needs of the patients on the ward. Patients had access to all members of the multidisciplinary team to ensure they received an appropriate package of care.

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. Staffing consisted of a mix of experienced and less experienced staff. However, all staff received an appropriate induction, comprehensive training package and supervision.

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

Inadequate

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

Inadequate

We did not inspect this domain

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

Requires improvement

Staff carefully planned patients' discharge and worked with care managers and coordinators to make sure this went well. Since the announcement of the closure of the hospital, managers and staff were liaising closely with clinical commissioning groups to ensure patients were transferred to appropriate placements. Decisions about patient transfers and discharge had to be made quickly due to the imminent closure.

Patients said they did not feel involved in the decision making and did not receive enough information about their transfer. Managers wanted to be cautious about the information given to patients unless they had definite plans and placements had been agreed. This was to help manage patient's expectations and avoid unnecessary distress. Managers knew this was a difficult period for patients and there would be an impact on their well-being, but they could not share information in some cases because they did not know the full transfer plans of commissioners. Managers worked well with the local, host clinical commissioning group who were co-ordinating scrutiny of all patient care pathways. Most commissioners acted promptly in seeking discharge or transfer, however a number of patients were still at the hospital in the final week of closing. This had an impact on patients and families but managers and staff at Cygnet worked well to support this process.

Staff were providing support to patients to help them during the period of uncertainty and transition. The psychology and occupational therapy department continued to engage patients with meaningful activities and sessions to help them deal with their anxieties and feelings regarding the closure of the hospital.

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

Inadequate

Leadership

There had been several managers in last few months. The service had appointed a new manager since our last inspection, although the manager had been working within the hospital briefly beforehand. The clinical lead started work at the service in March 2020. Staff and patients felt significant improvements had been made in the last two months. These were attributed to the leadership strategy. Leaders had a good understanding of the services they managed and were working hard to make improvements.

Leaders were visible in the service and approachable for patients and staff. Significant concerns had been raised by patients and staff in the past, therefore managers and senior staff wanted to engage with patients and staff in a meaningful way. For example, the manager attended patient community meetings and ensured concerns were actioned.

Staff described feeling shocked and sad when they heard that the hospital would be closing, however they said managers had been accessible and were being open, honest and transparent about the closure.

Culture

At the time of inspection, managers knew they needed to close the service. Managers told us they had been unable to change the longstanding negative culture of the service despite attempts to do so over the last 12 months.

At the time of this inspection most staff said they did feel respected, supported and valued, but this had been more apparent in the last two months. They could see changes being made to the service were for the benefit of patients, and the recent increase of staff had improved conditions for staff and patients.

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

Inadequate

Staff spoke of recent changes which made them feel respected and valued. For example, health care assistants now attended patients multidisciplinary meetings to provide feedback, which was considered a positive action. Staff were able to pick a meal for themselves, rather than receiving what food was left over.

Overall, staff felt they worked well together and supported each other, specifically since the announcement of the closure of the hospital had been made.

However, not all staff felt their opinions were respected by the wider multidisciplinary team. Staff spoke of a divide between ward staff and members of the multidisciplinary team, which some felt caused resentment.

Most staff felt able to raise concerns without fear of retribution. Most staff said they could raise concerns although one staff member felt the organisation would find out and retaliate in some way and were afraid of the repercussions.

Staff knew how to use the whistle-blowing process. Staff or ex staff had sent CQC several whistle-blowing concerns in the few months before this inspection. The majority related to staffing levels and patient safety. Managers took the concerns seriously and had engaged an external provider to investigate and provide feedback, with the aim to make improvements where required. The findings were still pending at the time of our inspection. On another occasion, a senior manager from Cygnet arranged a focus group, inviting all staff to attend and share any concerns. This was poorly attended by ward staff. It had been hastily arranged therefore not all staff could have made the necessary arrangements to attend.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve
The provider MUST ensure all documentation regarding observation charts are completed fully**.**

Regulation 17 (2) (c) HSCA 2008 (Regulated Activities) Regulations 2010 Good Governance

The provider MUST ensure risk management plans are developed when risks have been identified.

Regulation 12 (2) (a) HSCA 2008 (Regulated Activities) Regulations 2010 Safe Care and Treatment

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
Accommodation for persons who require nursing or personal care 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 **The provider MUST ensure all documentation regarding observation charts are completed fully.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **The provider MUST ensure risk management plans are developed when risks have been identified.**