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

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.

Overall summary

- The ward had a blind spot behind the manager's office created by changes to the ward. Staff were aware of this but could not monitor this area easily on a busy ward. Although there were no ligature points in this area and it was covered by close circuit television, this was not routinely monitored. There had been an incident on the day of the inspection where a patient had tied clothing around their neck to self-harm. Staff who informed us of this later issued a statement with a different version of how this happened. During a second visit to the ward to view close circuit television we found this incident was not responded to for a significant period and paperwork relating to this incident such as the incident form, handover notes and the daily risk forms for patients had not been completed for the day it occurred. We raised our concern regarding the blind spot at the inspection and formally wrote to the provider following inspection about our concern. The provider acted quickly to fix a convex mirror that supported observation of the corridor.
- Staff did not complete observations in line with Cygnet Healthcare's observation and engagement policy. In particular, intermittent 15-minute observations were carried out at the same time pattern throughout the day allowing patients to know when these would happen. Paperwork used to record observations had not been updated since the changes to the ward had been made so it was difficult to know which area of the

Summary of findings

ward staff were referring to when recording information. The sheets had been photocopied many times which made it difficult for staff to read the print on them.

- The ward had a higher number of beds than was recommended in the National Association of Psychiatric Intensive Care Units (NAPICU) Design Guidance for Psychiatric Intensive Care Units, published in 2017. This meant that staffing levels were also high, and the ward was extremely busy with very few quiet areas for patients.
- Due to the high level of complex needs of patients on the ward, staff completing observations of patients were often reacting to incidents rather than engaging with patients.

However:

- The ward environment was clean. The ward had enough nurses and doctors. They minimised the use of restrictive practices, managed medicines safely and followed good practice with respect to safeguarding.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, and understood the individual needs of patients. They actively involved patients and families and carers in care decisions.

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		see detailed findings

Summary of findings

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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, which provides mental health care nationally.

The hospital in Coventry opened in April 2017. It has three wards and seven transitional living units called St Marys Court. The wards are Dunsmore psychiatric intensive care unit (PICU), Middlemarch Ward which provides high dependency inpatient rehabilitation and Ariel Ward which supports patients with a personality disorder. All wards are for women.

This inspection focussed on Dunsmore psychiatric intensive care unit, which has 16 beds. It takes emergency and crisis admissions. At the time of the inspection the ward was providing support to 15 patients.

The hospital was last inspected in June 2018. This was a comprehensive inspection which looked at all three wards. At that time, they were rated as good in all domains. This inspection will not change that rating as we only looked at one ward.

The hospital has a registered manager.

Our inspection team

The team that inspected the service comprised four CQC inspectors

Why we carried out this inspection

We carried out a focussed inspection of this service following a coroner's report in February 2019 into the death of a patient on Dunsmore PICU. The hospital had made significant changes to the ward following the death in February 2018 and the subsequent report from the coroner. The inspection focussed on the safe, caring and well-led domains and was carried out across an afternoon and evening so that the inspection team could observe the ward during the key times that the inquest identified. The inquest highlighted that observations had not been carried out as set out in the care plan of the patient who died.

This was an unannounced inspection, so staff did not know we were coming.

We did not rate the service at this inspection because we did not inspect the whole hospital, only Dunsmore PICU.

How we carried out this inspection

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

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

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

During the inspection visit, the inspection team:

- visited Dunsmore Ward at the hospital, looked at the quality of the ward environment and observed how staff were caring for patients
- completed a follow up visit to review close circuit television and records relating to one incident
- spoke with five patients who were using the service
- spoke with the registered manager and managers or acting managers for Dunsmore Ward

Summary of this inspection

- spoke with four other staff members; nurses and healthcare support workers
- attended and observed a mindfulness session
- looked at two care and treatment records of patients in detail and cross-referenced incidents to CCTV
- carried out a specific check of the medication management on the 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

We spoke with five patients. Of these, two gave their opinions of the ward. Both stated that the ward was better now the number of agency staff had reduced and that permanent staff always had time for them. One stated that they were unclear about plans for their discharge from the ward and that their special diet was not varied enough.

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?

- The ward had a blind spot following alterations to the ward. CCTV covering this area as a means of monitoring and maintaining safety was not effective as staff did not always respond immediately to patients at risk in this blind spot area.
- Not all incidents were recorded as incidents and the appropriate forms completed. This resulted in daily risk forms not being updated and handover not including this information.
- Staff did not carry out 15-minute observations in line with Cygnet Healthcare's observation and engagement policy. Managers had not updated the observation sheets used by staff following the changes to the ward environment, so it was unclear which area of the wards staff refereed to. The sheets had been photocopied multiple times so staff could not easily read the print on them.

However:

- The ward was clean, well equipped, well-furnished and well maintained.
- The service had enough nursing and medical staff, who knew the patients and received basic training to keep patients safe from avoidable harm
- 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.
- Staff had easy access to clinical information and it was easy for them to maintain high quality clinical records – whether paper-based or electronic.
- 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.

Are services effective?

We did not inspect this domain

Summary of this inspection

Are services caring?

- Staff treated patients with compassion and kindness. They respected patients' privacy and dignity. Most of the staff understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition.
- Staff involved patients in care planning and risk assessment and actively sought their feedback on the quality of care provided. They ensured that patients had easy access to independent advocates.
- Staff informed and involved families and carers appropriately.

However:

- Due to the high level of observations staff often had to react to incidents which meant that they did not always engage fully with patients.

Are services responsive?

We did not inspect this domain

Are services well-led?

- During the inspection we found that there were issues relating to governance of the ward as the ward manager was on leave. An incident form had not been completed and the daily risk management plan for patients had not been updated. Staff had not recorded the daily handover notes on to the system for all staff to see.
- The number of beds on the ward was higher than that recommended in guidance by the National Association of Psychiatric Intensive Care Units (NAPICU) Design Guidance for Psychiatric Intensive Care Units, published in 2017. This meant that with the needs of the patients staffing levels were also high which made the ward very busy with little space for quiet reflection by patients or staff.

However:

- The provider acted quickly to a letter we sent expressing our concerns and they provided an action plan to address and manage the risk to patients we identified at this inspection. This included fixing a convex mirror to reduce the risk of a blind spot, improving staff adherence to the observation and engagement policy, increased scrutiny and audit of patient records, and aligning patient numbers to national guidance.
- Staff knew and understood the provider's vision and values and how they were applied in the work of their team.

Summary of this inspection

- Staff felt respected, supported and valued. They reported that the provider provided opportunities for career progression. They felt able to raise concerns without fear of retribution.
- Our findings from the other key questions in the safe and caring domains demonstrated that governance processes operated effectively at ward level and that performance and risk were managed in these areas.

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

Safe	
Effective	
Caring	
Responsive	
Well-led	

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

Safe and clean environment

- Staff completed regular assessments of the environment. Staff said they were aware of the blind spots within the ward area and stated these were mitigated by individualised care plans and enhance observations for patients at risk. However, we found on the day of inspection that daily risk assessments for patients had not been completed and handover notes which would have detailed the risk for each patient were missing. The ward had close circuit television cameras which covered some areas although in the court yard there were two areas which could not be seen on the cameras when we checked. Close circuit television was not monitored throughout the day and was used for reviewing individual incidents and audits carried out by managers.
- The ward had undergone some structural changes so that the ward office was in a more central location allowing staff clearer views of the ward areas. The ward managers office had also moved, and we saw that there was a blind spot between the ward managers new office and the old one which was being turned into a sensory room. It was covered by close circuit television, but this was not monitored. CCTV was used to support learning and investigations following incidents.
- Following the inspection, the hospital reported that a death had occurred on Dunsmore Ward. This was still in the early stages of investigation, but the hospital had identified evidence from the close circuit cameras which showed that observations of this patient who had become physically unwell had not be followed in line with Cygnet Healthcare's policy. The patient had been on 15-minute observations but this did not take place and a period of 32 minutes had passed between the patient engaging with staff and being found and treatment started.
- The hospital provided a service for women only so there were no issues in compliance around mixed-sex accommodation.
- Staff and patients had access to alarm call buttons and we observed staff responding promptly to this when activated.
- The ward had a seclusion room that was purpose built and had suitable facilities for this purpose including mood lighting and access to outside space.
- The hospital managed infection risk well. Staff kept themselves, equipment and the premises clean. They used control measures to prevent the spread of infection.
- The clinic room was clean and well maintained. Staff checked equipment checked regularly and all medication including that used for emergencies was in date and stored appropriately.
- The service planned for emergencies and staff understood their roles if one should happen.

Safe staffing

- The ward establishment figures were 9.35 whole time equivalent qualified staff and 28.89 whole time equivalent healthcare support workers. The hospital had introduced a senior support worker role which was included in these figures. The hospital used a matrix to work out the establishment figures but had over recruited to this ward to ensure that enhanced observations could be covered by staff who knew the patients well. The ward had made recent changes so that there were always three qualified staff on duty during the day when previously this had been two. They were introducing a new shift from 4pm to 10pm so that there would be additional staff on the ward at a time

which they had identified as higher risk due to patients being more active. Staff sickness rates for the period from 01 December 2018 to 31 May 2019 were 5% and turnover was at 45%. Managers used a continuous programme of recruitment which meant that staff had been replaced in a timely way.

- The ward manager could adjust the skill mix to meet the needs of the patients. Use of agency staff had significantly reduced due to the recruitment of additional staff and both staff and patients stated that this had made an improvement to how the ward worked. At the time of the inspection there were 14 staff on duty and of these only two were agency staff. This included a qualified staff member who had worked shifts on the ward for over 12 months and a healthcare support worker.
- Staff were always present in communal areas of the ward and we noted that the ward office was not in use for most of the time as staff were engaged in supporting patients.
- Staff reported that where possible one to one time with patients took place, but this could be challenging depending on the high-level needs of the patients on the ward. The ward was large with 16 beds and due to the need of the patients this meant staffing levels were also high. The National Association of Psychiatric Intensive Care Units (NAPICU) Design Guidance for Psychiatric Intensive Care Units, published in 2017, recommends a maximum size of 14 beds. We observed that the ward was extremely busy and with so many people in that environment it was difficult to identify quiet space for patients to relax. The hospital had introduced a second lounge, but this was also busy and noisy. Staff managed to engage some patients in a mindfulness session in a group room which was successful and well managed. They have plans to open a sensory room to help provide quiet space.
- There were enough staff who were suitably trained to provide physical interventions such as observations and restraint. One newer member of the team had not completed their training for physical interventions, so they were not left on their own with patients on the ward.
- The ward had adequate medical cover provided by a consultant and a speciality doctor. Staff could also speak to doctors on the other wards if cover was needed. The hospital operated an on-call system out of hours. Patients had access to a GP who visited the hospital weekly.
- The service provided mandatory training in key skills to all staff and made sure everyone completed it. At the time of the inspection all training was above 75% and most were 100% completed. The only figure below 75% was for basic life support training at 72% however the hospital has provided evidence that staff who needed to complete this training had done so the day after the inspection. Figures for immediate life support training were 100%. Training figures showed that 52% of staff had completed nationally recognised training that takes a positive approach to working with patients with challenging behaviours and other staff will have the opportunity to complete this training.

Assessing and managing risk to patients and staff

- Staff reported that there had been an incident where a patient had tried to self-harm by tying a ligature around their neck in this area on the day we visited the ward, however, the hospital could not find an incident form for this. We completed a follow up visit to look at the close circuit television and review paperwork relating to this patient. We found the incident had taken place for 15 minutes before staff acted to support the patient. During the 15 minutes the patient was seated facing the wall, so the piece of clothing used was not visible. Staff had walked past the patient and approached them briefly but had not fully engaged with them until the patient changed position and they could see what was taking place. We could see the patient was well supported following the incident. We reviewed the records for this patient and found just a short mention in the daily record with no details. An incident form had not been completed. The daily handover notes could not be located and there was no updated daily risk assessment for this patient despite the fact her notes showed that her risk had increased from the night before. Managers were also unable to locate the observation records for this date but provided them after the inspection. They showed that intermittent observations had been carried out at exactly 15 minutes intervals throughout the day allowing patients to know when they would take place. We found this was also the case on the observation records we reviewed during the

first visit of the inspection. This was not in line with Cygnet Healthcare's policy which says that observations times should vary so that they are not predictable to patients.

- On the day of the inspection daily risk plans and handover notes had not been completed so staff could not know if risk had changed for individual patients. However, we found that other records were clear, up-to-date and available to all staff providing care.
- Staff were aware of and dealt with any specific risk issues relating to individual patients. These included for those who had specific health issues such as diabetes or epilepsy.
- Staff did not always follow Cygnet Healthcare policies relating to observations. In particular this related to 15-minute observations which were carried out at regular intervals throughout the day. Staff had received training around the observation and engagement policy, but this had not changed practice which made the ward unsafe for patients. We reviewed the observation paperwork used by staff and found that the paperwork did not reflect recent changes to the ward layout, meaning it was not easy to identify the areas where observations had taken place. The observation sheets were also quite faded as they had been reproduced many times from a photocopy. We discussed this with managers at the time of the inspection and they agreed to rectify this as soon as possible.
- The hospital used the term sterile rooms to describe the patient bedrooms which had items removed to make them safe for patients at risk of self-harm. The hospital had a clear description of what this meant and staff we spoke with were clear that items were only removed on an individual basis following a risk assessment and discussions within multi-disciplinary meetings. Staff reviewed the use of the sterile room daily for each patient.
- Some patients did not always have access to their rooms during the day dependent on their level of risk. This was individually care planned. Staff carried out searches of patients who had been on leave with their consent to ensure they had not brought in sharp items or lighters etc on to the ward. The hospital was a non-smoking environment, so staff ensured that patients had access to information on smoking cessation.
- There were no informal patients on this ward and the doors were locked to ensure the safety of the patients.
- In the six months from 01 December 2018 to 31 May 2019 there had been 270 episodes of restraint of which 33 were in the face down position. The provider was good at reporting prone restraint even for short periods. Staff are trained to move patients into a position of their choosing and avoid where necessary face down restraint. There had been 100 incidents where rapid tranquilisation was given to patients and 30 incidents where the seclusion room had been used. The ward staff reported that there had been no patients in long-term segregation.
- Staff understood and where appropriate worked within the Mental Capacity Act definition of restraint. All staff received training in this area and support from managers if they needed it.
- Staff followed guidance from the National Institute for Health and Care Excellence when using rapid tranquilisation and ensured physical health checks were carried out following each episode of rapid tranquilisation being used.
- Staff used seclusion as a last resort if all attempts to de-escalate situations had not worked. Staff completed a seclusion pack for each time the seclusion room was used, and we saw that these had been audited to ensure staff understood the need for accuracy. They would be passed back to staff for missing signature and dates to be completed to support learning and improved practice.

Safeguarding

- All staff received training in safeguarding for adults and children. At the time of the inspection the training figures were 97%.
- 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. They worked with other organisations to support patients such as the local authority.
- Staff gave examples of cases where they had informed safeguarding team of a concern and were supported by the team of social workers working within the hospital to follow these up. They understood the need to safeguard patients with protected characteristics such as age, race or religion under the Equality Act 2010.

- Staff followed safe procedures for families who wanted to visit with children. These visits took place in a room at the end of the ward and outside of the main ward area. Visits would be supported by staff when necessary.

Staff access to essential information

- We found that staff had not updated records around daily risk for patients on the day of the inspection, so staff did not have up to date information on this particular day, however, we saw evidence that this had been completed on other days and was accessible to staff on the ward. The hospital used electronic records to store patient information and staff had their own log in information for accessing the records.

Medicines management

- The service prescribed, recorded and stored medicines well. Patients received the right medication at the right dose at the right time. The hospital used an external pharmacy for checking the medication and they provided the hospital with regular audits and feedback.
- Staff reviewed medication for patients in line with guidance from the national institute for health and care excellence especially for those patients who were prescribed a high dose of antipsychotic medication.

Track record on safety

- There had been two deaths on the ward since February 2018 and in the first case the inquest had highlighted and issue with the way observations had occurred. In the second death the hospital had identified that the way staff had completed observations was not in line with the policy. This was also the case in the incident reviewed by the inspection team on close circuit television. When raised with managers the hospital responded quickly and took appropriate action around this issue.
- Managers gave example of incidents and adverse events which were discussed in the integrated governance meetings. Learning from this was shared with staff so that actions could be taken to improve practice. Following a serious incident in 2018 action plans were put in place around staffing and recording of information from reviews about patients. Managers had worked to ensure the learning and improved communication had been shared with staff and embedded within the delivery of care in the ward environment.

Reporting incidents and learning from when things go wrong

- Managers reported that staff had reported 555 incidents in from 01 December 2018 to 31 May 2019. The highest number of these had been for self-harm and violence.
- Staff recognised incidents and reported them appropriately in most cases although we found one incident where this had not happened. An incident form had not been completed and the patient's record did not show the details of the incident and how it had happened. Managers investigated incidents that had been reported 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 received feedback from the investigation of incidents and ensured this was used to improve practice. Staff discussed incidents in daily meetings, team meetings and individually in supervision.
- Staff could access additional support through an external organisation provided by Cygnet Healthcare such as counselling if this was needed.

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

(for example, treatment is effective)

We did not inspect this domain.

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

- Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness. A patient we spoke with said that staff would always listen and given them the time they needed. The patient said that having more permanent staff had improved this.
- Staff supported patients to understand their care and treatment and they were supported and encouraged to attend reviews with the doctors.
- Staff provided emotional support to patients to minimise their distress. We observed that although the

ward was busy some staff spent time talking to patients and engaging with them in activities and discussions. Staff undertaking enhanced observations tended to do less of this and on occasions seems to be only reacting to a patient once an incident had started rather than trying to use engagement to prevent incidents occurring.

- Staff understood the individual needs of their patients and could talk with ease about each patient on the ward. They took in to account each patients cultural, social and religious needs although one patient we spoke with stated that they did not feel they received enough choice at mealtimes because of their special diet. Hospital managers were informed and agreed to look in to this.
- Staff stated they could raise concerns about disrespectful, discriminatory or abusive behaviour towards patients without fear of the consequences.
- Staff understood patient confidentiality and how to ensure this was respected.

Involvement in care

- Staff used the admissions process to inform and orientate patients to the ward. New patients were on advanced observations initially and so staff were on hand to answer any questions they had.
- Patients had been involved in their care plans and staff communicated with patients so that they understood their care and treatment. Some patients we spoke with were quite unwell and did not feel clear about what the plans involved.
- Patients could give feedback on their care. On the ward there was a large area of the wall which patients could post their thoughts and feelings on. In the office we saw thank you cards that patients had given to staff.
- Patients could discuss their plans for treatment if they became more unwell in the reviews of their care.
- Patients had access to advocacy and an advocate visited the ward on a weekly basis or when requested by a patient.
- Staff involved families and carers in a patient's treatment with the consent of the patient.

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

(for example, to feedback?)

We did not inspect this domain.

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

Leadership

- The hospital had managers at all levels with the right skills and abilities to run a service providing good quality sustainable care.
- Managers had an understanding of the ward and the issues faced by staff in supporting patients with high levels of risk. They had a visible presence on the ward and demonstrated a good knowledge of each patient.
- Staff had been encouraged to take on more responsibility and to apply for more senior roles within the ward environment. This included the introduction of a senior support worker role.

Vision and strategy

- Cygnet Healthcare had a vision for what it wanted to achieve and workable plans to turn it into action developed with involvement from staff, patients, and key groups representing the local community.
- Staff understood and shared the vision and values of the organisation and stated they were committed to them. They demonstrated this through the way they worked, and the care and support provided to patients.

Culture

- The staff we spoke with stated they felt supported and valued by managers and could raise concerns if they needed to. They understood that they could raise concerns to external bodies such as the Care Quality Commission anonymously if they needed to but stated that they hadn't needed to do this. However, a staff member had told us about an incident in the blind spot on the ward. When asked about this by managers the version of events was changed although it is not clear why the staff member did this. When reviewing close circuit television, the incident took place as we had initially been told it had.

- Managers dealt with poor performance when they needed to and gave examples of how they had supported staff who had found the environment and patient group on Dunsmore Ward challenging.
- The teams worked well together and supported each other. The staff we spoke with stated that this had improved with the increase in permanent staff on the ward.

Governance

- We found an issue with the governance of this ward on the day of the inspection. In the ward managers absence. Staff had not completed paperwork such as the daily handover sheet or the completed the daily risk plans for patients. However, the ward was well staffed to ensure they could keep patients safe and the environment was clean with suitable furnishings. We found that managers had learnt from incidents and implemented changes to improve the ward for both patients and staff.
- The ward had an action plan following the death in February 2018 and had implemented the actions. They included an improved electronic recording system for patient records and changes to the physical environment of the ward to make better use of the space and give staff clearer views of areas where risks could potentially be higher. This had however left a blind spot behind the manager's office and managers had not updated the observation recording form in line with changes to the ward.
- The number of beds on the ward was not in line with the National Association of Psychiatric Intensive Care Units (NAPICU) Design Guidance for Psychiatric Intensive Care Units, published in 2017. This recommends a maximum ward size of 14 beds. Due to the level of staffing required to carry out observations including one patient who had to be observed by three staff the ward was extremely busy and noisy and staff spent large amounts of time reacting to incidents rather than engaging in a meaningful way with patients.
- We wrote to the provider with our concerns and they have responded with an action plan. The provider acted quickly to address our concerns.

Information management

- Staff had access to an electronic recording system which allowed them to access information about patients easily. Staff on the ward attended twice daily meetings where risk and changing needed of patients was discussed in detail to ensure all staff were clear about this.

Learning, continuous improvement and innovation

- The hospital was committed to improving services by learning from when things go well and when they go wrong, promoting training, research and innovation.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that incidents are recorded as they occur and that paperwork relating to patients at risk such as the daily handover sheets and risk management plans are completed and recorded in a way that is accessible to all staff. Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2014
- The provider must ensure that intermittent 15-minute observations take place in line with Cygnet Healthcare's policy and are recorded to reflect this. The provider must also ensure that all staff are familiar with the engagement policy and have received training in how to engage with patients while providing enhanced observations. Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2014
- The provider must consider reducing the number of patients on the ward in line with national guidance to provide a more therapeutic environment with lower levels of stimulation for patients. Regulation 17 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Action the provider SHOULD take to improve

- The provider should ensure that all daily observation sheets are filed correctly so that they can be checked when managers are reviewing incidents and the close circuit television.
- The provider should ensure that the observation sheets have codes that cover all areas of the ward for staff to be clear about where the observation took place. They should ensure all copies of the form are printed in a way that means staff can read the print on them.

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 12 HSCA (RA) Regulations 2014 Safe care and treatment Following alterations to the ward environment there was a blind spot behind the managers office and next to the new sensory room which was not yet in use. Patients using this corner were at increased risk of self-harm when not being fully supervised by staff. Staff did not fully complete paperwork relating to a specific incident in the blind spot. They had not completed the daily risk record or handover notes which would have identified that a patient had an increased level of risk. The patient's notes did not reflect the details of the incident and an incident form had not been completed. Staff did not carry out 15-minute intermittent observations in line with Cygnet Healthcare's policy. Completing these in a regular pattern allowed patients to anticipate when they would take place. This was a breach of regulation 12 (1) (2) (a)(b)(c)(d)

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 Managers did not ensure that governance of the ward including the completion of risk records and incident forms were completed in the absence of the ward manager.

This section is primarily information for the provider

Requirement notices

Staff disclosed information to the inspection team which was later changed when investigated by managers. The provider must ensure that there is an open culture where staff can speak freely on this ward.

The ward had more beds than the number recommended in national guidance. The high-level needs meant high levels of staff which meant the ward was noisy, overcrowded and was not a therapeutic environment

This was a breach of Regulation 17 (1)(2)(a)(b)(c) (3)(a)(b)