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

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

Letter from the Chief Inspector of Hospitals

I am placing the service into special measures.

Services placed in special measures will be inspected again within six months. If insufficient improvements have been made such that there remains a rating of inadequate overall or for any key question or core service, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. The service will be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary another inspection will be conducted within a further six months, and if there is not enough improvement we will move to close the service by adopting our proposal to vary the provider's registration to remove this location or cancel the provider's registration.

Professor Ted Baker
Chief Inspector of Hospitals

Overall summary

Due to the concerns we found during this inspection, we used our powers under section 31 of the Health and Social Care Act to take immediate enforcement action and placed conditions on the provider's registration. The conditions we placed upon the provider's registration have closed Dunsmore ward and capped admissions to the other wards.

Our rating of this service went down. We rated it as inadequate because:

- The service did not provide safe care on Dunsmore ward. There were high levels of patient self-harm, even for patients on close observation levels. The wards did not have enough nurses and support workers who knew patients well enough to keep them safe. Staff assessed and managed risk on Dunsmore ward by increasing restrictive practices. Dunsmore ward was loud, chaotic and not a therapeutic environment. Managers had introduced a new patient observation and engagement form across the hospital but not all staff were undertaking observation robustly or completing the documentation correctly. The ward environment on Dunsmore was dirty, unhygienic and poorly maintained; the seclusion room on Dunsmore ward particularly dirty with stains on the walls and ceiling and an offensive smell coming from the shower drain. Middlemarch ward was also dirty but was better maintained. Ariel ward was clean and well maintained. Emergency alarms went unheeded because there were not enough staff to respond to them.
- Staff did not always protect patients' dignity when providing care or protect their privacy when discussing them. Patients, who were all female, did not feel that staff always respected their privacy and dignity. A number of them did not feel safe at the hospital because the majority of staff were male, who had little knowledge of the patients' individual needs. There was limited access to meaningful activities during the evenings and weekends. Accessing a hot drink was only possible with staff support, which was difficult at times due to limited staff availability. Accessing the toilet was also difficult for some patients due to limited staff availability. Patients had complained for a number of months that temporary staff did not know them or their needs well enough, referring to them by room number and not by their name.
- The service was not well led in all areas. Dunsmore ward was chaotic, noisy and staff were not able to maintain a calm environment. Leaders of the service were out of touch with what was happening on the front line, and they could not identify or did not understand the risks and issues described by staff. Staff and patients had been telling managers for more than five months that a lack of regular staff was a

problem, but no effective action had been taken. Since opening, staff turnover had been high and was not being effectively addressed. Internal audits showed that the ward environments were in need of cleaning and maintenance, but nothing had been done to address it. Staff engaged in clinical audit to evaluate the quality of care they provided but findings to bring about improvement were not always implemented.

- There was little acknowledgement by managers that staff and patients were experiencing the negative consequences of having a large number of temporary staff and a high turnover of permanent staff. Many of the permanent staff were relatively new to the service. Staff used terms such as “burn out” and “firefighting” to describe their experience of working at the hospital. Some patients expressed their concern for staff.

However:

- The service had enough doctors and patients had access to a range of staff. Staff followed good practice with respect to safeguarding.
- Staff developed holistic, recovery-oriented care plans informed by a comprehensive assessment. On Middlemarch and Ariel wards a range of treatments suitable to the needs of the patients was provided in line with national guidance and best practice.
- Staff understood and discharged their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005.
- Most permanent staff treated patients with compassion and kindness. They generally involved patients and families and carers in care decisions.
- The service managed beds well and patients were discharged promptly once their condition warranted this.

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		The ratings for this service went down. The report contains the detailed findings.

Summary of findings

Contents

Summary of this inspection

Background to Cygnet Hospital Coventry

Cygnet Hospital Coventry is part of the Cygnet Healthcare group. The group provides health care nationally.

The hospital is purpose built, providing inpatient mental health care and treatment for women. It opened in April 2017. It has three wards and a transitional living unit attached to one ward.

Dunsmore ward has 16 beds and is a psychiatric intensive care unit (PICU). Middlemarch ward has 16 beds and provides high dependency inpatient rehabilitation. St Mary's Court is attached to Middlemarch ward and has seven studio apartments providing transitional support. Ariel ward has 16 beds and provides care and treatment specifically for women with a diagnosis of personality disorder. Ariel ward also provides care and treatment for women with a diagnosis of disordered eating and personality disorder.

The hospital was last inspected in June 2019. That was a focussed inspection following an inquest into the death of a patient on Dunsmore ward in February 2018. The inquest reached an open conclusion in April 2019. The June 2019 report did not produce a rating because it was a focussed inspection, looking solely at Dunsmore ward.

The hospital was first inspected in October 2017, which was a comprehensive inspection. The hospital was then rated "requires improvement" overall, with a rating of good in effective and caring. A further comprehensive inspection was undertaken in June 2018. We rated the hospital 'good' overall and for each key question.

The hospital has a registered manager.

Our inspection team

The team that inspected the service comprised one CQC inspection manager, three inspectors and three specialist advisors. This was an urgent, short notice inspection, which meant we were not able to include an expert by experience. An Expert by experience is a person with lived experience or is the carer of a person with lived experience.

Why we carried out this inspection

We carried out this inspection because we had concerns about the care and treatment being provided at Cygnet Hospital Coventry. The unannounced, focussed inspection in June 2019 on Dunsmore ward resulted in the CQC writing to the provider regarding our concerns about patient safety. Subsequent to our letter, another incident occurred as a result of poor patient observations. This resulted in this inspection of July and August 2019.

This was an urgent, unannounced comprehensive inspection to look at these concerns. Hospital staff did not know we were coming.

We carried out the inspection over four days, including a night and a weekend.

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?

Summary of this inspection

- 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 each ward at the hospital to look at the quality of the ward environment and observe how staff were caring for patients
- spoke with 19 patients who were using the service and five carers
- reviewed two patient comment cards
- spoke with the clinical manager, regional operations director, regional medical director, regional quality assurance manager and each ward manager
- spoke with 28 other staff members including maintenance staff, a social worker, nurses healthcare support workers, a doctor and a psychology assistant
- attended and observed a day into night shift handover, a patient's care programme approach meeting, a ward round meeting and a hospital-wide daily risk meeting
- looked in detail at 12 patient care and treatment records and two seclusion records
- spoke with commissioners and the local authority safeguarding senior practitioner
- looked in detail at incident reports
- carried out a specific check of the medicines 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 19 patients and five family carers. All but one patient was well enough to share their views about their experience of the hospital.

Almost all of the patients told us they did not feel comfortable with the large number of temporary staff who worked at the hospital. They explained this was because many were men who were of a different background and culture to them. Two patients told us that agency staff often spoke to each other in a language they did not understand. Almost all of the patients said it was common for staff, particularly at night, to open their bedroom door or their bedroom viewing panel to carry out observations without informing them by knocking on the door. They told us this made them feel uncomfortable and some said it made them feel unsafe, particularly if they were getting changed or were using their bathroom. However, they told us that most of the regular hospital staff did knock on their door before entering or opening their viewing panel.

Almost all patients and carers told us they thought the wards were understaffed, with not enough staff to respond to their needs when they needed support.

One patient told us this was their second admission to Dunsmore ward and their first experience was much better because there were more permanent staff, who knew her better.

All patients told us there were not enough regular staff who knew them well enough to understand their care and treatment needs. Some told us this really frustrated them because it meant staff had to check paperwork to understand their care plan, which for issues such as accessing their bedroom, or a bathroom caused them unnecessary delays and heightened their anxiety and agitation levels. Two patients told us these sorts of delays made them so angry they often triggered an incident.

Patients told us they usually had to wait for staff assistance when they wanted a drink. This was because hot water drinking facilities were operated by staff. They told us the wards were very noisy, with banging doors particularly the entrance doors, unanswered ward telephones and nurse call alarms, which they said often sounded throughout the day and into the night.

Patients on Dunmore and Middlemarch wards told us the wards were not clean, particularly the chairs.

Summary of this inspection

Patients on Dunsmore ward told us they were all subject to restricted access to the outdoor space because one patient had harmed themselves out there. A patient on Middlemarch ward told us they felt they were subject to unnecessary blanket restrictions, such as access to the quiet room, because of the risks for just one patient. They thought this was unfair to patients who did not pose similar risks.

Almost all patients said they participated in activities and therapy sessions on the wards. They enjoyed these, believed them to be suitable for their needs but wished there were more activities available to them on an evening and at weekends. Most patients were able to access their section 17 leave but some said this was cancelled sometimes due to short staffing.

Patients were confident in the help they received for their physical health and routinely saw the visiting GP when they needed to. Patients who needed to attend local hospitals for treatment said they were given the right support. However, one patient told us there were really long waits to see a physiotherapist.

All patients said they knew how to speak with the visiting advocate. Some complained about poor access to wifi and said the hospital was experiencing difficulties making this available to them. Most liked the food, but some felt more changes to the menu would be nice.

Patients were positive and complimentary about staff but some said they did not get all the one to one support they were care planned to receive, especially if their named nurse worked nights. One patient comment card was wholly positive about the treatment programme.

We spoke with five family carers. None were satisfied with the level of communication from the wards. All told us they could attend planned patient meetings but they said staff did not always keep them informed of important patient progress or when their relative had been physically unwell. One carer told us that arranging visits with accompanying children was difficult because there was only one room available for the whole hospital and this was often fully booked. All told us that they had to book visits in advance, which could be difficult at times because the visiting rooms became fully booked. Two carers told us the visiting rooms were often dirty, with cups and food left by the previous visitors.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

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.

The use of the Mental Health Act was consistently good across the service. Almost all patients were detained under the Mental Health Act 1983 when we carried out the inspection.

The documentation we reviewed in patients' files was detailed, up-to-date and all relevant paperwork was present.

Doctors completed consent to treatment and section 17 leave paperwork effectively. Some patients told us that they did not always get their planned section 17 leave because of staff shortages. Staff routinely and regularly explained patients' rights to them.

There was easy access to an independent mental health advocate to support patients if they needed one.

Staff received training in the Mental Health Act during their induction followed by annual updates.

Mental Capacity Act and Deprivation of Liberty Safeguards

Staff demonstrated a thorough knowledge of the principles of the Mental Capacity Act.

Supporting patients to make decisions was embedded within the service. We saw evidence in patient records that demonstrated staff promoted patients' human rights in decision making. Understanding capacity and the right for individuals with capacity to make an unwise decision was clearly understood. Staff supported patients to make decisions and did not make assumptions that a patient lacked capacity because the decision was unwise.

There were no patients subject to a Deprivation of Liberty Safeguards at the hospital when we carried out our inspection.

Staff received training in the Mental Capacity Act as part of their induction process.

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	N/A
Overall	N/A	N/A	N/A	N/A	N/A	N/A

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

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

Staff carried out regular risk assessments of the care environment. Ward layouts allowed staff to observe all parts of ward, supported by mirrors. Managers were planning to introduce "zonal" staffing to further support patient observations. Zonal staffing systems nominate individual staff to provide care in specific areas of a ward environment. At the previous inspection in June 2019 we identified a blind spot on Dunsmore ward, which managers had addressed by installing a security mirror. The service used closed circuit television to monitor communal areas of the ward. The CCTV was not monitored in real time but was used to investigate incidents, to understand issues on the wards and for quality purposes.

Fixed ligature points had been addressed on the wards. Most ligature incidents were carried out by patients using items of clothing. The number of ligature and self-harm incidents on Dunsmore ward were high.

The hospital complied with guidance on eliminating mixed-sex accommodation.

Staff had easy access to personal alarms and patients had access to nurse call systems, including in bedrooms and bathrooms. They carried out regular audits to monitor response times to alarms. These showed staff answered alarms quickly, usually in less than one minute. However, during our inspection we observed alarms sounding for more than one minute. Staff and patients told us that sometimes alarms went unheeded because there were not enough staff available to respond to them. This is a high-risk issue because if staff or patients sound an alarm it means they need assistance.

Maintenance, cleanliness and infection control

Ariel ward was clean, had good furnishings and was well-maintained.

Middlemarch ward was clean in places and generally well maintained. The store rooms used to house patient possessions were not well kept. The shelves and floors were piled high with patient possessions, most of which were spilling over the floor. The spaces were hazardous for staff to walk in because they posed significant risk of trips and falls. Patients told us the chairs in the lounge area were dirty and smelled. We did not observe any unpleasant odours on the chairs, but they were not all clean, there was staining to some chairs and debris under the seat cushions. One patient told us their bedroom smelled of damp and they showed us mould in their bathroom, which they said they had reported to staff. The fridge in the ward kitchen was not clean and patient food was not stored in line with best practice.

The therapy kitchen on Middlemarch ward was not clean or well managed. There was out of date food in the cupboards and in the fridge, including eggs. Food storage in the fridge was not in line with best practice. Food in the fridge was not correctly labelled with opened and use by dates and fresh meat was stored on the top shelf. The freezer compartment had no door and was completely frosted over. There were dirty oven gloves on the work top, dirty baking utensils and the windowsill held old newspapers and dust. The oven was dirty, and the oven door was covered in brown grease, obscuring the view of the inside.

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

Dunsmore ward was not clean and not well maintained. Lounge chairs were soiled to the seats and arms. Each one had thick dust and debris under the seats. Debris included fluff, sweet wrappers, crisps, used sticking plasters, crumbs, paper and small pieces of string. The lounge carpet was heavily stained. We told managers about this and they replaced the carpet during the inspection. The chairs were also cleaned beneath the cushions but were not cleaned well. Thick dust remained after they had been cleaned. The arms and cushions of the chairs were not cleaned but managers told us they would ensure effective cleaning took place. The wall to the lounge had been partially painted. Patients pointed out that this was not a nice look for the lounge. The kitchen hatch and work surface area where patients obtained drinks and meals had peeling paint, stained sealant, dirt and debris. The kitchen where staff made patient snacks and drinks was unclean. Each patient had a plastic zip pouch which held their cutlery. These pouches were dirty and stained with food and condiments. We raised this with support staff who cleaned the pouches right away. Cupboard doors were dirty and stained. The fridge seal was broken and contained a viscous red / brown liquid. The fridge shelves were not clean and patient snacks in the fridge were not all labelled. The freezer had defrosted and refrozen, leaving a draw of solid thick ice and congealed ice-cream. There were no lids on the containers storing patients' breakfast cereals. The condiment tray was dirty and sticky. The bin was foot operated but was not clean inside the lid and prevented the kitchen door from opening fully. Rooms used to store patient possessions were overfilled and chaotic. They were hazardous for staff to walk in. The linen cupboard was also used as a storage area and it was hazardous to reach linen from the shelves because of the broken chairs and notice boards taking up space in there. Clean pillows were lying on the floor.

The baby change facility for the visitor lounge was used as a storage area for patient possessions and was not accessible to anyone wanting to use it for the purpose it was intended.

The hospital entrance and staff only areas were visibly clean and well ordered.

Cleaning records for the hospital were up to date and demonstrated that the wards were cleaned regularly. There was a cleaning schedule detailing all areas to be cleaned. We saw domestic staff were busy cleaning throughout the inspection. However, we found significant failings in the quality of cleaning.

Staff adhered to infection control principles, including handwashing. Patients and staff were encouraged to observe good hand hygiene and there were alcohol gel dispensers at the entrances to each ward. Communal toilets were visibly clean and sanitary bins were not overfilled.

Most patients told us their routine requests for maintenance were actioned quickly. However, one patient told us they had been waiting since January for an electrical safety test for a new cool air fan they had bought.

Seclusion room

The seclusion rooms on Dunsmore and Middlemarch ward allowed clear observation and two-way communication, had toilet and shower facilities and a clock. They each had mood-lighting and access to a safe outdoor space.

The clock in the Seclusion room on Middlemarch was not working. We pointed this out to ward staff.

The seclusion room on Dunsmore ward was not clean. There were dried brown stains on the walls and ceiling. There was a dried ball of toilet paper stuck to the wall. The outside wall and door of the en-suite were sticky with dried brown splashes. The drain in the toilet and shower smelled offensively, the smell worsening once the shower was activated. There were dried brown / red marks on the outside of the toilet. The electronic panel to adjust the mood-lighting was smashed, with broken glass in place of a usable screen. The door to the outdoor space was broken and there was a significant hump on the ground which prevented the door from opening fully outward. When pushed, the door jammed fast on the ground. The door did not lock properly. The outdoor space was dirty and walls were stained. We did not believe the seclusion room on Dunsmore ward was fit for purpose and immediately reported this to the clinical manager who arranged for the facility, including the drain to be cleaned as a matter of urgency. We returned several days later and found the space was much cleaner but still showed signs of sticky brown liquid on the en-suite door and sticky lumps of

debris on the floor which we were able to remove easily. The facility had been cleaned but not deep cleaned. Managers had placed an order to repair the broken door to the outdoor space.

Clinic room and equipment

Clinic rooms and clinic dispensaries were fully equipped with accessible resuscitation equipment and emergency drugs that staff checked regularly. However, these checks did not take place between 18 April and 3 May on Middlemarch ward, between 7 and 28 April on Ariel ward and between 15 March and 19 April 2019 on Dunsmore ward. Staff told us these checks should take place each week.

All relevant staff had received immediate life support training. All but two staff who required basic life support training had received it.

Staff maintained equipment well and kept it clean. Any 'clean' stickers were visible and in date. Equipment that needed professional calibration was done so in line with manufactures' guidelines. There were gaps in the clinic room check records for Middlemarch ward totalling four weeks between March and July 2019. Staff were not able to locate the records for Ariel ward. The clinic room on Dunsmore ward was checked only six times between 16 April and 28 July 2019. Staff told us the checks should be carried out weekly.

Not all relevant patient medicines displayed opened and use by dates. Some stock medicines we checked were passed their expiry date. There was an excess of stock medicines on Dunsmore ward and the medicines trolley was overfilled. There were excess medicines stored in a refuse bag on Ariel ward.

We looked at a recent sample temperature checks for medicines fridges. The temperatures on Ariel ward exceeded the recommended maximum on three days. Staff took no action to deal with this on one of those days.We checked the clinic rooms on each of the wards. On each ward the member of nursing staff facilitating our checks did not know some basic facts about their clinic room including where the spare keys were kept, how often clinic room checks were carried out, who carried out expiry of medicines checks and who audited to ensure clinic room checks were being done.

Safe staffing

The hospital used a sliding scale of core staffing establishment, which was determined by the number of patients on each ward, not by the acuity of need of the patients. They did not use an acuity and dependency measurement tool to determine the number of nursing and support staff required for each shift. Additional healthcare support workers were allocated to each shift if individual patients were prescribed increased observations to manage their risks. This meant that the number of staff present on the wards varied considerably.

During the inspection, we observed just one registered mental health nurse and two healthcare support workers on Middlemarch ward for 16 patients. This was because one patient was in the acute hospital needing staff to provide observation and engagement duties and another patient was out on leave from the hospital. During this period, we noted that patients had to wait for drinks, the telephone rang for long periods but was not answered and emergency assistance alarms went unheeded, which meant staff requiring assistance did not get a timely or safe response. The hospital had introduced a night co-ordinator role which was a nurse they told us would be placed on Dunsmore ward, because that ward was where most additional support was required. However, staff on the other wards told us the night co-ordinator would remain on their usual ward and would not attend Dunsmore ward unless specifically requested to.

Dunsmore ward had trialled a reduction in daytime qualified nursing staff from three to two for 16 patients. We were pleased that managers listened to staff when they identified that this was not sufficient to manage the complex nature and number of patients on the ward and day time registered nurses were increased back to three per shift. The provider had carried out an analysis of staffing on Dunsmore ward following the inquest into the death of a patient which noted that staffing had played a part in the patient's death. The provider's analysis found staffing was in line with national guidelines for a psychiatric intensive care ward.

However, the inspection team found that staffing on Dunsmore ward was not safe. The use of bank and temporary staff was too high. Temporary staff were not block booked in advance, so some worked only a small number of shifts. This meant they were not familiar with patients or the ward environment, which left patients and

staff feeling unsafe. Two members of staff told us they believed low staffing made the ward dangerous and they believed another serious incident could occur. Several patients told us they felt unsafe. They were not able to get a drink or visit the toilet when they needed to because there were not enough staff. Due to the high numbers of patients requiring enhanced observations, there were high numbers of heath care support workers, nurses and members of the multidisciplinary team on the ward. Combined, this meant the ward was very busy and chaotic. Patients on all of the wards told us that unless they were on enhanced observations, they could not get the support they needed when they needed it. Some patients told us that on Ariel ward they had to de-escalate other patients because there were not enough staff to do it. One patient on Dunsmore ward told us they had to untie a ligature from another patient because staff were not able to respond.

Our observations of Dunsmore ward were that it was chaotic, loud and not therapeutic. Emergency alarms rang frequently, sometimes not being answered quickly, telephones rang loudly across the ward and the acuity of patients meant there were large numbers of staff and patients on the ward. Staffing was made up of 64% bank and agency staff for the day shifts when we were present on the wards in July and 55% for the night shifts. Male staff accounted for 44% of staff on the ward. This rose to 60% for one night shift during the inspection period. Female patients told us they felt less comfortable and some felt unsafe with such high numbers of male staff on the ward. The small number of staff who patients were familiar with attracted patients in groups of up to five seeking support and information. This was overwhelming for staff and prevented them from effectively carrying out essential tasks.

Managers told us they had over-recruited to support worker roles on Dunsmore ward to ensure that enhanced observations would be covered by staff who knew the patients well. However, we found, and patients confirmed, that staff carrying out enhanced observations were not all familiar with patients. Some patients told us this was a trigger for them to increase incidents because they were frustrated when temporary staff did not understand their assessed needs and risks and they were reluctant to speak with them. Some staff told us that temporary workers were reluctant to engage with patients because they were worried that their lack of knowledge about them might lead them to say “the wrong thing” and upset patients, which they did not want to happen.

Managers told us they used a continuous programme of recruitment so that staff could be replaced in a timely way. However, we looked at data across the year and found that nurse vacancies had remained consistently high. Figures from May 2019 showed 11 vacancies for registered mental health nurses across the hospital with an additional four working their notice. At the time of this inspection, there were 14.5 registered nurse vacancies. Five of these had been provisionally filled, with staff undergoing pre-employment checks.

Turnover of nursing and support worker staff was high. For the year August 2018 to August 2019 turnover on Middlemarch was 64%, 44% on Dunsmore and 33% on Ariel. Turnover across all staff groups was high, averaging 55% for the same period. Turnover of doctors was extremely high at 67%.

Average sickness rates for the year August 2018-19 were 6%, with the highest on Middlemarch ward at 10%.

The hospital had introduced a senior support worker role to each ward, which was included in shift establishment figures. Another member of support staff had been designated as shift security nurse, but the role was not performed by a registered nurse.

There was not always a qualified nurse in the communal areas of the wards. There were always staff present in communal areas but if they were designated to provide enhanced observations, they were not available to support other patients and were not able to facilitate their patient to have a hot drink or snack if they wanted one.

Staff did not spend lengthy periods of time in the office and those who were carrying out essential office-based tasks did their best to support patients who knocked the door seeking support.

Staffing levels meant that not all patients were able to access their planned one to one time with their named nurse. One patient told us it was particularly difficult if their named nurse worked nights.

Staffing levels meant that patient leave from the hospital was cancelled or postponed sometimes. The hospital did not monitor figures for cancelled leave.

Staff, patients and records showed that not all staff were suitably trained to provide physical interventions such as restraint and observations and engagement. One member of staff told us they were encouraged to begin working on the ward before they had completed their training. Patients told us some temporary staff used restraint techniques which hurt them, including twisting their arms. We were told that agency staff may be trained in different violence reduction techniques to regular staff which meant that patients would not be held or restrained in a consistent way.

The hospital had adequate medical cover, including out of hours. However, turnover of doctors was high at 67% between August 2018 and August 2019. At the time of our inspection there was no medical director and there were two vacancies for speciality doctors which were being covered by locums. The hospital operated an on-call system out of hours. Patients had access to a GP who visited the hospital weekly and were supported to attend local hospitals for emergency and routine physical healthcare issues.

Mandatory training

Staff told us that regular staff routinely completed mandatory training. This included basic and immediate life support, Mental Health Act and Mental Capacity Act. At the time of this inspection, 89% of staff had completed the required mandatory training. There were no figures available for August, September or October 2018. However, average mandatory training completion rates for the remaining 9 months stood at 91%.

Assessing and managing risk to patients and staff

Assessment of patient risk

We looked at 12 patient records during this inspection. In each record we saw that staff had completed a risk assessment for each patient on admission to the hospital, which they reviewed and updated regularly. They used a recognised risk assessment tool.

Management of patient risk

Managers and senior ward clinicians attended a daily patient risk meeting where they considered changes in risk and agreed updated management plans.

Staff were aware of and dealt with any specific risk issues, such as wound care, epilepsy and diabetes.

Staff identified and responded to changing risks to, or posed by, patients. Risk assessments were updated by the multidisciplinary team. Staff used handover meetings to share this information. However, some staff felt communication was not as effective as it should be when they came to work on the wards.

We observed that there was no time allocated for temporary staff to read patient risk assessments or care plans before they were expected to carry out their allocated duties and agency staff did not have access to the electronic patient record system to appraise themselves of essential risk information. There were high numbers of temporary staff who did not know patients well. Ariel ward was the only ward where staff had introduced a system for staff and patients to get to know each other at the start of the shift. In July 2019, one shift was covered completely by temporary staff and almost 20% of shifts had more than 80% of staff who were temporary, so it was important for staff and patients to get to know each other. On Dunsmore ward, temporary staff constituted 40% of the nursing and healthcare team in 90% of the shifts that month. Half of the shifts on Middlemarch ward were covered by over a third of temporary staff during the same period. Neither of these wards allowed time for staff to get to know patients or read their care plans and risk assessments before working on the wards.

Staff did not always follow hospital policies or best practice relating to observation and engagement. We analysed observation and engagement records. We found the forms were complex and not easy to follow. Following our recent concerns, the hospital had updated the forms but not all staff had been shown how to complete them. We found a number of errors in the completion of these records. There were gaps which indicated that observations were not always carried out in line with care plans. Incomplete and inaccurate completion of patient observation and engagement had been key in at least three incidents of avoidable harm.

Staff followed good policies and procedures for searching patients or their bedrooms.

The wards in this service struggled to participate in the provider's restrictive interventions reduction programme. Staff applied most blanket restrictions on patients' freedom only when justified and these were generally individually risk assessed. However, blanket restrictions were in place when we carried out this inspection, some of

which had been introduced following a serious incident. Patients on Dunsmore ward were prevented from accessing the outdoor courtyard space following a patient harming herself out there because staff had not carried out her observation and engagement care plan effectively. Patients were frustrated by this reduced access. Patients on Middlemarch ward were prevented from accessing the quiet rooms without staff support. They were frustrated by this and felt they were being subjected to blanket restrictions because of the risks posed by one patient.

Staff adhered to best practice in implementing a smoke-free policy. Patients were encouraged to use smoking cessation support. Those who had leave and wished to smoke were supported to do this off the hospital premises.

Informal patients could leave the hospital when they wanted to.

There were 62 incidents of seclusion in the 12 months leading up to this inspection. The highest were on Dunsmore ward, with 55 incidents. The lowest was Middlemarch ward with one.

There was one recorded incident of long-term segregation since the hospital opened in 2017.

There were 1501 episodes of restraint in the 12 months leading up to this inspection. Ariel ward accounted for the highest use of restraint at 863, 45% of which related to one patient. Of the 1501 incidents of restraint, 110 were in the prone position. The highest number of prone position restraint took place on Dunsmore ward, at 66. One patient accounted for 36 of these restraints, across two of the wards. Although the provider had a policy in place about the use of prone restraint, we did not see any plans to reduce the use.

There were 296 incidents of staff administering intramuscular rapid tranquilisation during the same period, the highest number of which took place on Dunsmore ward with 234. There were 13 incidents of staff administering oral rapid tranquilisation, all of which took place on Dunsmore ward.

Staff told us they used restraint only after de-escalation had failed and regular staff used correct techniques. However, patients and staff told us that temporary staff were trained in different techniques, some of which hurt. One patient described her arm being twisted and another her leg being kicked from behind, causing her to fall, for which she had received an apology after reporting it. Staff told us not all temporary staff had received the correct training so were not able to effectively and safely support them when they needed help to restrain a patient. There was no evidence that managers or staff considered the use of unapproved restraint techniques as potential acts of assault.

Staff followed NICE guidance when using rapid tranquilisation. They monitored the use of rapid tranquilisation and reported it each month to managers.

Staff used seclusion appropriately and followed best practice when they did so. However, the seclusion room on Dunsmore ward was not fit for purpose and had not been effectively cleaned, despite which it had been used.

Staff kept records for seclusion in an appropriate manner. However, it was not always clear from the records why the seclusion episode had been terminated.

Staff kept appropriate records of patients' care and treatment. Records were clear, up-to-date and available to all permanent staff providing care. However, temporary staff had limited access to these records. Shift handover meetings gave a summary of each patient's risk but not all staff working on the wards were present for the handover because some were allocated to a ward after the meeting had taken place. Temporary staff were not given time to read a patient's care plan and risk assessment before undertaking enhanced observation and engagement duties. Some staff told us they did not have enough time in the working day to update essential information and had to stay late and complete it in their own time.

Dependent on their level of risk, some patients did not always have access to their rooms during the day. 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 or other risk items on to the ward.

Safeguarding

All staff received training in safeguarding for adults and children. At the time of the inspection the training compliance 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 could describe how they had identified and raised safeguarding concerns and how the hospital social work team dealt with them. They understood the need to safeguard patients with protected characteristics such as age, race or religion under the Equality Act 2010.

However, managers had allowed a culture to develop whereby the use of agency and bank staff was so high that not all patients felt safe on the wards or felt their privacy and dignity was upheld. Managers had not considered the implications or impact of this to determine if it fell within the definition of safeguarding, as defined in section 42 of the Care Act 2014. We would have expected some acknowledgment of this culture and some analysis by managers.

Staff followed safe procedures for families who wanted to visit the hospital with children. Social work staff carried out specific child visiting assessments. Visits with children took place in a designated and suitable room outside of the main ward areas. Visits were supported by staff when necessary.

Staff access to essential information

Staff kept appropriate records of patients' care and treatment. Records were clear, up to date but available only to permanent members of staff providing care. Not all agency nurses were able to access the system. The hospital used electronic records to store patient information and permanent staff had their own security details to access the records.

Staff observed good information governance protocols and kept patient information securely. However, we did find one patient record contained two entries relating to a different patient.

Medicines management

The service prescribed, recorded and stored medicines reasonably well. Patients received the right medication at the right dose at the right time. Although one patient told us they had been given too much medication and had received an apology for this. One family member told us their relative had run out of medication, so had gone without it for a weekend because it had not been ordered on time. The hospital used an external pharmacy agency to audit medicines management.

Not all relevant patient medicines displayed opened and use by dates. Some stock medicines we checked were passed their expiry date. There was an excess of stock medicines on Dunsmore ward and the medicines trolley was overfilled. There were excess medicines stored in a refuse bag on Ariel ward. 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 high dose antipsychotic medication. However, prescription charts did not show evidence of patient views.

Track record on safety

There had been two serious incidents in the two months leading up to this inspection. One patient had died and had not been observed in line with their care plan. This meant she did not receive medical attention as quickly as she might have done if the observations had been carried out as prescribed. Another patient was not observed in line with her prescribed care plan and went on to harm herself. She was found before significant harm was sustained but she was found by accident, not because staff were alerted by the control measures they had in place. These serious incidents and in view of the fact a patient had died as a result of self-harm in February 2018, on which the inquest concluded in April 2019, meant we were concerned about safety at the hospital. Our concerns led to us carrying out this urgent, unannounced inspection.

Reporting incidents and learning from when things go wrong

All staff knew what incidents to report and how to report them. There was a clear process for reporting and investigating incidents, but some staff told us there was not enough time to effectively report all incidents.

Some incident investigation reports were unclear and not completed to a high standard. We found recommendations that bore no link to the incident report in more than one that we looked at. Some incident reports did not give full descriptions of incidents. We found one serious incident report that did not detail the full facts leading up to the incident. This was concerning and led us to question how

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

open and transparent incident investigations were. A member of staff told us they did not believe managers were always open and transparent when completing investigation reports.

Ward staff understood the duty of candour. They were open and transparent, and gave patients and families an explanation if and when things went wrong.

Staff did not always receive feedback from investigation of incidents, but there was a lessons learned newsletter for them to read.

Managers held meetings for staff to discuss feedback and changes. Most were able to identify some changes that had taken place as a result of lessons learned but two staff felt managers did not make enough changes to make the hospital a safer place.

There was evidence that changes had been made as a result of feedback but this was not always embedded across the hospital.

The provider had implemented changes to observation and engagement records and procedures following two serious incidents. However, we found there were still failings in the way staff recorded individual patient observation records.

Staff were not routinely de-briefed and did not all receive support after a serious incident.

Are acute wards for adults of working age and psychiatric intensive care unit services effective?
(for example, treatment is effective)

Requires improvement

Assessment of needs and planning of care
We looked in detail at 12 patient care records. They demonstrated good practice in the areas reported on below.

Staff completed a comprehensive mental health assessment of the patient in a timely manner at, or soon after, admission.

Staff assessed patients' physical health needs in a timely manner after admission and throughout their admission.

Staff developed care plans that met the needs identified during assessment.

Care plans were personalised, holistic and recovery oriented.

Staff updated care plans when necessary.

Best practice in treatment and care
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, activities, training and work opportunities intended to help patients recover or acquire living skills. Psychological therapies on Ariel ward included a pre-treatment plan to prepare patients for the relevant therapy required to help them move forward. Nursing staff led on dialectical behaviour therapy. However, families told us there was not enough psychological therapy for their relatives.

Staff ensured that patients had good access to physical healthcare, including access to specialists when needed. The hospital has a physical healthcare lead nurse and a visiting GP who provided ongoing assessment and support for patients. However, access to physiotherapy was noted by a patient and a member of staff to be difficult.

Staff assessed and met patients' needs for food and drink and for specialist nutrition and hydration. However, some patients told us they often had to wait to get a drink if they were being nursed on enhanced observations and there were no other staff available to get them a drink. Others told us they may have to wait for their nasogastric feed to be supplied because there were not enough trained staff to do it at. One relative told us their daughter often had to miss planned activities to receive the feed or would receive it later than scheduled due to staffing issues. Food and fluid monitoring was put in place when patients required it. The hospital had a policy for enteral feeding, specific to patients with disordered eating. The policy was due for review at the time of this inspection.

Staff supported patients to live healthier lives through participation in smoking cessation schemes, healthy eating advice, managing cardiovascular risks, screening for cancer, and dealing with issues relating to substance misuse.

Staff used recognised relevant rating scales to assess and record severity and outcomes specific to depression, anxiety and disordered eating. They also used the Health of the Nation Outcome Scales.

Some staff participated in clinical audit which included clinical records and restrictive interventions led by a practice development nurse on site. There was a programme of audit locally and regionally which included quality assurance visits from a specialist team. They made recommendations to ward and hospital managers but these were not always implemented or not implemented in a timely manner. The audits had informed managers that the seclusion room on Dunsmore ward was in need of cleaning and repair. They had also identified that patient fridges needed to be cleaned and the fridge seal on Dunsmore ward needed to be cleaned or replaced. The audit for each ward identified that staffing continued to be an issue.

Skilled staff to deliver care

The team included the full range of specialists required to meet the needs of patients on the wards. As well as doctors and nurses, there was an occupational therapy team, clinical psychologists, social workers and a pharmacy service. Ariel ward had a contract with an independent dietitian who visited the ward each week and was available for telephone consultations at other times. There was a fitness instructor and activity workers who supported patients across each ward. A local GP visited the hospital each week and patients routinely saw them for their physical healthcare needs. Speciality doctors at the hospital supported patients well with their day to day physical healthcare needs. However, most of the multidisciplinary team carried vacancies. The senior social worker was leaving during our inspection, a psychologist was going on maternity leave and the medical director post was vacant.

Most permanent staff were experienced, qualified and had the right skills and knowledge to meet the needs of the patient group but there were not enough staff working on the wards who knew patients well. Healthcare support workers were given basic training when they took up post but there was no detailed training available for them. There was no programme to support them to continue to develop and acquire new skills.

Managers provided new staff with appropriate induction which included classroom and online learning. Staff were required to undertake training in conflict resolution and violence reduction before they could work unsupervised on the wards. However, a number of staff and patients told us that not all temporary staff had completed the correct training or had completed the training before they started working on the wards. Some permanent staff told us they were expected to begin working on the wards before they had fully completed their induction training.

Managers provided staff with supervision (meetings to discuss case management, to reflect on and learn from practice, and for personal support and professional development) and appraisal of their work performance. Managers ensured that staff had access to regular team meetings. However, we did not see any evidence of reflective practice sessions for healthcare support workers or nurses. This would support them in their roles and aid their development.

All eligible staff had received an appraisal in the last 12 months.

The percentage of permanent staff that received regular supervision was 90%. Temporary staff did not receive regular supervision. This meant that large numbers of staff working with patients were not given full support or monitoring.

Managers identified the learning needs of staff and provided some with opportunities to develop their skills and knowledge. They had introduced a role of senior support worker to provide opportunities for healthcare support workers.

There was limited evidence that managers ensured staff received the necessary specialist training for their roles. There were not enough staff trained to insert nasogastric feeding tubes for patients requiring them. Managers relied on staff coming into the hospital on their day off to do this. We saw no evidence of ongoing learning and development opportunities for nursing staff to support them with continued accreditation.

Managers dealt with poor staff performance promptly and effectively.

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Multidisciplinary and interagency team work
Staff held regular and effective multidisciplinary meetings. These were well attended and documented by staff. However, we attended one that was significantly delayed because the registered nurse was too busy on the ward, so was late attending.

Staff shared information about patients at handover meetings within the team when staff shifts changed. However, these meetings did not give incoming staff time to fully acquaint themselves with patients and their needs.

The ward teams had effective working relationships with care co-ordinators and community teams, inviting those staff to key patient meetings and involving them in discharge planning for patients.

Adherence to the Mental Health Act and the Mental Health Act Code of Practice
Staff were trained in and had a good understanding of the Mental Health Act, the Code of Practice and the guiding principles.

The use of the Mental Health Act was consistently good across the service. Almost all patients were detained under the Mental Health Act 1983 when we carried out the inspection.

The documentation we reviewed in patient files was detailed, up to date and all relevant paperwork was present. Staff stored copies of patients' detention papers and associated records (for example, Section 17 leave forms) correctly and so that they were available to all staff that needed access to them.

Doctors completed consent to treatment and Section 17 leave paperwork effectively. However, some patients told us there were not always enough staff available to make sure they were able to take their planned Section 17 leave. Staff routinely and regularly explained patients' rights to them.

Staff requested an opinion from a second opinion appointed doctor when necessary.

Staff had easy access to local Mental Health Act policies and procedures and to the Code of Practice.

Staff had easy access to administrative support and legal advice on implementation of the Mental Health Act and its Code of Practice. Staff knew who their Mental Health Act administrators were.

There was easy access to an independent mental health advocate to support patients if they needed one.

Staff carried regular audits to ensure that the Mental Health Act was being applied correctly.

Good practice in applying the Mental Capacity Act
Staff demonstrated a thorough knowledge of the principles of the Mental Capacity Act, in particular the five statutory principles.

Supporting patients to make decisions was embedded within the service. We saw evidence in patient records that demonstrated staff promoted patients' human rights in decision making. Understanding capacity and the right for individuals with capacity to make an unwise decision was clearly understood. Staff supported patients to make decisions and did not make assumptions that a patient lacked capacity because the decision was unwise.

For patients who might have impaired mental capacity, staff assessed and recorded capacity to consent appropriately. They did this on a decision-specific basis with regard to significant decisions. When patients lacked capacity, staff made decisions in their best interests, recognising the importance of the person's wishes, feelings, culture and history.

There were no patients subject to a Deprivation of Liberty Safeguards at the hospital when we carried out our inspection.

Staff received training in the Mental Capacity Act as part of their induction process.

Staff knew where to get advice from within the provider regarding the Mental Capacity Act, including deprivation of liberty safeguards.

The hospital had arrangements to monitor adherence to the Mental Capacity Act.

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

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

Inadequate

Kindness, privacy, dignity, respect, compassion and support

Most staff attitudes and behaviours when interacting with patients showed that they were discreet, respectful and responsive, providing patients with help, emotional support and advice at the time they needed it. However, because Dunsmore ward and Middlemarch ward were very busy and had a high proportion of temporary staff we saw that patients were not always able to get the help they wanted when they needed it. This meant patients queued up to speak to regular staff when they saw them. We saw groups of patients waiting for a regular member of staff and crowding around to speak to them as soon as the member of staff appeared. We also saw patients knocking at the office doors for staff and having to wait because the nurse was busy helping others, making telephone calls for patients or completing essential tasks.

Regular staff supported patients to understand and manage their care, treatment or condition. They answered questions, provided information and listened to patient worries. Staff encouraged them to attend ward review and clinical meetings.

Regular staff directed patients to other services when appropriate and, if required, supported them to access those services, including statutory and voluntary sector agencies. However, one patient told us, and staff confirmed there were very long waits to see a physiotherapist if patients needed one.

Patients said regular staff treated them well and behaved appropriately towards them but they were not always confident in temporary staff because those staff did not know them or know their needs. This caused frustration with some patients. Some said this could be the trigger for an incident, because they felt they were not understood or listened to. Some said they were uncomfortable with the high numbers of male agency staff from different cultures and backgrounds to them. They were uncomfortable and not all felt safe with male members of staff carrying out their observations when they were using the shower and toilet or when they were getting changed or sleeping in their rooms.

Most patients told us that not all temporary staff knocked their bedroom doors before entering their rooms or opening their viewing panels to carry out observations. Some patients had asked for female only staff to be assigned to their observations but this was not always adhered to.

Not all staff understood the individual needs of patients, including their personal, cultural, social and religious needs. This was because there was high use of agency and bank staff across all of the wards. These staff might work only a few shifts at the hospital so never got to know the patients well. They were also not given any time at the start of a shift to read patient care plans. They were given a brief handover and then assigned their duties, which often involved direct observation and engagement with patients. We were told that some temporary staff did not ask for patient's names but just asked them for their room number. Some patients said they felt that temporary staff were just checking to see that they were alive. Staff on Ariel ward managed this by gathering patients and staff together at the start of a new shift and introducing each other. Patients told us this worked well but the other wards had not introduced this.

Staff said they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards patients without fear of the consequences but one carer told us their daughter would complain to her family because she was worried about complaining directly to the hospital in case they treated her differently afterward.

Staff maintained the confidentiality of information about patients. However, we found one instance where an electronic patient record included two entries for a patient with a different name.

Involvement in care

Involvement of patients

Staff used the admission process to inform and orient patients to the ward and to the service. Most were not able to visit the hospital before they were admitted but for those who were not an emergency admission, they were given information about the hospital in advance.

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

Staff involved patients in care planning and risk assessment. We saw evidence of this in care plans and participation in multidisciplinary team reviews. Staff offered patients a copy of their care plan. All but one patient told us they were involved in their treatment plans, even if they did not fully agree with the plan they had been involved and listened to by the staff team.

Regular staff communicated with patients so that they understood their care and treatment, including finding effective ways to communicate with patients with communication difficulties. Temporary staff did not always communicate effectively with patients.

Staff involved patients, when appropriate, in decisions about the service. They could be a ward representative on the hospital patient council and share views with managers. However, managers did not always resolve the issues that patients brought to these meetings. Patients were involved in the induction of staff but were not involved in staff interviews.

Staff enabled patients to give feedback on the service they received. Each ward held a weekly community meeting and patients who attended could give their views, share concerns and ask questions. The meeting minutes were made available for patients who chose not to attend. However, we found that patients had routinely raised concerns which managers had not dealt with effectively. Concerns raised, included the high use of temporary staff, many of whom referred to patients by room number and not by name.

Staff enabled patients to make advance decisions (to refuse treatment, sometimes called a living will) when appropriate. We did not see any advance decisions in the records we looked at but this was available for patients if they wanted to include them.

Staff ensured that patients could access advocacy. The advocate routinely and regularly attended each ward. All the patients we spoke with knew how to access the advocacy service.

Involvement of families and carers

All but one carer told us that staff did not always keep them informed and involved appropriately. They told us when they telephoned the wards they were promised a call back from staff but this did not usually happen, so they would keep calling until they resolved their issue. The carers we spoke with knew that patients had a choice about what information they were willing to share with families and carers. However, they told us they were almost never informed if their patient had been unwell and needed to use a local accident and emergency facility at a local hospital and were not informed of incidents.

Families did not recall being given the opportunity to give feedback about the service but they all felt they would be able to work out how to complain. Most said they had raised issues when they needed to with staff.

Staff provided carers with information about how to access a carer's assessment.

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

Requires improvement

Access and discharge

Bed management

There was always a bed available when patients returned from leave. Their bed remained available to them when they went on extended leave.

Patients were not moved between wards during an admission episode unless it was justified on clinical grounds and was in the interests of the patient. Patients could transfer between wards if their needs changed. Records showed that some staff felt communication could be improved when patients did transfer to another ward.

When patients were moved or discharged, this happened at an appropriate time of day and staff planned this with patients.

Average length of patient stay on Ariel ward was 132 days, 190 on Middlemarch ward and 55 days on Dunsmore ward.

Discharge and transfers of care

Patients did not experience delays in their discharge as a result of hospital process or policy. Any delays in a patient's discharge were due to external reasons, beyond the control of ward staff. Delays may occur due to waiting for appropriate placements to be found for a patient to move on to or waits for external funding to be agreed.

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The service complied with transfer of care standards. Staff planned for patients' discharge, including good liaison with care managers and co-ordinators from the patients' home teams. Patients who were waiting for transfers knew this. Apart from emergency transfers, families and patients were kept informed of the process.

Staff supported patients during referrals and transfers between services – for example, if they required treatment in an acute hospital or temporary transfer to a psychiatric intensive care unit.

Facilities that promote comfort, dignity and privacy

Patients had their own bedrooms and were not expected to sleep in bed bays or dormitories.

Patients could personalise bedrooms and all the patients we spoke with said they did this. However, patients knew that risk management meant that they may not be able to have certain items in their room if these posed a risk to their safety.

Patients had somewhere secure to store their possessions. They could have important items stored in the safe. For other items, such as clothes and electrical items, if they were not able to have these in their bedrooms they were stored on the ward in a locked storage room.

Staff and patients had access to the full range of rooms and equipment to support treatment and care. There were enough rooms for leisure activities, therapies and clinic rooms to examine patients. The hospital had a gym which patients could use with staff support. This was available at weekends too.

On Middlemarch ward, rooms other than bedrooms and the communal living area were only accessible with staff support. Some patients found this overly restrictive for a rehabilitation ward and said this restriction was based on the risk associated with just one of the 16 patients. They felt this was unfair. Patients on Middlemarch and Dunsmore wards did not have a key to their bedrooms. This was not always based upon individual risk assessments. Patients on Middlemarch ward who were assessed as safe to have free access to their bedrooms were actually only able to gain access with staff support, so they propped their doors open with items of clothing so they could go in when they wanted to.

There were limited quiet areas on Dunsmore ward for patients to access independently. It was a noisy and chaotic ward for most of the day and late into the night. Staff had converted the therapy kitchen into another lounge area but this was directly off the main living area so was not a quiet space. There was a quiet room which was accessible with staff support but we did not see this being used during the inspection.

Each ward had access to a visitors' room, one of which was suitable for child visits. However, there was a booking system and visiting was limited to times outside of the therapeutic day, which some families found restrictive even though they understood that prioritising therapy was important for patients. Those who lived a long way away from the hospital found it restrictive. Most families told us it was straightforward to book a visit but there were pressures on the space available and they had to be flexible. Staff tried to make this easier for families by arranging communal visits in the gym. Several families told us the visitor rooms were often dirty, containing food and drinks left behind by the previous visitors.

Patients could make a phone call in private. Most had their own mobile telephones, which were individually risk assessed for access. There were also telephone rooms on each ward, showing local support contact numbers and solicitor information for patients who wanted it. Telephone rooms were locked, and patients could access them with staff support. However, the telephone on Middlemarch ward was not working and a patient told us it had been broken for quite some time.

Each ward had access to an outdoor space. However, there were restrictions on Dunsmore ward which meant patients could only go outside if staff were present. This was because a patient hard harmed themselves when there were no staff present in the courtyard.

The food was of a good quality and most patients liked it. Although one patient told us a member of staff bought all the patients pizza, because they were hungry. Some felt there should be more choice for special diets and others would have liked more choice generally, but most were satisfied with the food.

Patients were not able to make hot drinks and snacks 24/7. Hot drinks required a staff key to operate the drinks machine. We saw patients waiting for a member of staff to be able to get them a hot drink. Some patients found this

frustrating. Snacks were available from the patient kitchen on each ward. Patients could have cereal, snacks and toast with staff support. Patients on Ariel ward had therapeutic support with drinks and snacks.

Patients' engagement with the wider community

When appropriate, staff ensured that patients had access to education and work opportunities. One patient told us they were hoping to take up an education course and another was planning to take up some voluntary work.

Staff supported patients to maintain contact with their families and carers. They co-ordinated home visits for patients who had funding for this from their local clinical commissioning group. For those without the agreed funding, managers agreed to support one home visit. Some patients lived many miles away from home but staff still supported a visit to see family when appropriate.

Staff encouraged patients to develop and maintain relationships with people that mattered to them, both within the services and the wider community.

Meeting the needs of all people who use the service

The service made adjustments for disabled patients. There were bedrooms specifically for patients with restricted mobility and lifts to patient areas. Access to the ward outdoor spaces was level and there were disabled parking bays in the hospital car park. There were good examples of individual support having been provided for LGBT plus patients.

Staff ensured that patients could obtain information on treatments, local services, patients' rights and how to complain. Each ward had information displayed in the communal areas.

The information provided was in a form accessible to the particular patient group. For patients with difficulty reading or assimilating information, staff looked at ways to make this easier for them.

Staff made information leaflets available in languages spoken by patients.

Managers ensured that staff and patients had easy access to interpreters and/or signers if they needed them.

Patients had a choice of food to meet the dietary requirements of religious and ethnic groups. Most said this met their needs but some said they would prefer more choice and variety.

Staff ensured that patients had access to appropriate spiritual support. The hospital had a local agreement with a chaplaincy service. Patients could see the chaplain and could use the multi-faith room if they wanted to.

Listening to and learning from concerns and complaints

The hospital received 45 complaints during the 12 months leading up to this inspection. Of these, 10 were upheld and 7 were partially upheld. Our routine monitoring of complaints handling showed that managers were slow to provide feedback on complaints.

Patients knew how to complain or raise concerns. Several told us they had done this. Most said they had raised issues of concern directly with staff rather than using the formal complaints process.

When patients complained or raised concerns, they did not always receive feedback. One patient told us they had made a complaint in January but were still waiting for a resolution and had asked the advocate to help them resolve it. Two carers told us they had made a complaint but had not received a satisfactory or timely response.

Staff protected patients who raised concerns or complaints from discrimination and harassment. Staff were supportive of patients raising concerns and were open to receiving feedback from patients.

Staff knew how to handle complaints appropriately. There was a policy and process to follow.

We saw some examples where staff had received feedback on the outcome of investigation of complaints and acted on the findings. An example included, making changes to the visiting policy to enable group visits to take place, enabling more patients to receive visitors than the visiting rooms alone could accommodate.

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

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

Inadequate

Leadership

Leaders were out of touch with what was happening on the wards. Leaders did not demonstrate that they had the skills, knowledge and experience to perform their roles. We found serious failings in the way the hospital was run. There was a clear disconnect between the experience of staff and patients on the wards and the hospital leaders. Leaders had not effectively dealt with key issues affecting patients and staff, such as shortages in staff.

Leaders above ward manager level did not demonstrate a good understanding of the service they managed. They could explain clearly how they thought teams were working to provide high quality care but had not carried out routine checks to make sure this was happening. They had been informed of hospital wide problems but had not effectively resolved them. Issues included the reliance on high numbers of temporary staff and patients being referred to by their room numbers and not their names.

Leaders were visible in the service and approachable for patients and staff. They spent time on the wards and most patients knew who the senior leaders were. However, senior leaders did not spend enough time on the wards to fully understand the experience of patients or staff. They did not demonstrate any awareness that some wards were loud and chaotic or were dirty.

Leadership development opportunities were available, including opportunities for staff below team manager. The hospital had introduced a senior support worker role.

Vision and strategy

Staff knew and understood the provider's vision and values and how they were applied in the work of their team. The corporate values were integrity, trust, empower, respect and care. The corporate vision was to prove the best quality and most effective care.

The provider's senior leadership team had communicated the provider's vision and values to the frontline staff in this service. Staff received regular communication via email from the corporate organisation.

Staff had the opportunity to contribute to discussions about the strategy for their service, especially where the service was changing. They were invited to meetings at the hospital to discuss change but not all felt that communication was effective.

Culture

Not all staff felt respected, supported and valued. Terms like "firefighting" and "burnt out" were used to describe how some staff felt. A number of staff said the hospital manager was very approachable and supportive. However, others said they were not given the support they needed, particularly in terms of dealing with the pressures they experienced. Some patients expressed concern for staff because they knew they did not always get their breaks and that some patients were violent toward them.

Staff felt positive and proud about they work they did to support and care for patients. The staff exit interviews we looked at showed that most would recommend the provider as one to work for. However, several showed that staff had not felt valued or supported when they worked at the hospital.

Staff felt able to raise concerns without fear of retribution and some said they had done this. However, some staff told us they had raised issues but nothing had been done to resolve them.

Staff knew how to use the whistle-blowing process and we saw that some had done this.

Managers dealt with poor staff performance when needed. Managers were seen to swiftly deal with a number of issues relating to poor performance. However, they were slower to resolve some issues that patients had raised in relation to the behaviours and practice of some temporary staff, such as not knocking bedroom doors before entering.

The multidisciplinary team worked well together and where there were difficulties managers dealt with them appropriately. However, the wards worked independently and did not appear to share ideas with each other.

Staff appraisals included conversations about career development and how it could be supported. Some staff were supported to work flexibly so they could attend university.

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

A number of staff felt the sickness policy was not wholly supportive but we saw that managers were able to make concessions if staff were off work because they had been injured during the course of their work.

Staff had access to support for their own physical and emotional health needs through an occupational health service. Several told us the hospital manager and other leaders were supportive to them when they needed it. Some staff told us they were not given support directly after incidents and this was also reflected in some staff exit interviews.

The provider recognised staff success within the service. There were staff awards and the organisation shared news and success stories in newsletters. One member of staff told us they were given flowers and a thank you card by the hospital manager when they had worked a long time after their shift was due to end because of short staffing on the ward. However, others told us staff regularly had to work beyond their shift because of staff shortages.

Governance

Leaders met regularly with each other at the hospital along with colleagues regionally and nationally. Records showed these meetings considered key operational issues such as safety, recruitment and budgets.

There were systems and procedures in place that were meant to ensure that wards were safe and clean, but these were not effective. We found dirty wards and not enough staff on duty who knew patients well enough to keep them safe. Senior leaders met regularly with each other and with national colleagues. There was no evidence they met with staff working on the front line to identify and address the problems they faced in their day to day roles.

The provider had carried out an analysis of staffing on Dunsmore ward in May 2019, following the inquest into the death of a patient which had noted that staffing played a part in the patient's death. The analysis found that staffing was in line with national guidelines for a psychiatric intensive care ward. However, the analysis included only one patient view and no views from healthcare support workers, agency staff or nurses staffing the shifts. The inspection team did not agree that staffing on Dunsmore ward was safe or was able to meet the needs of the complex patient group.

There was a system in place to ensure that temporary staff were engaged for regular work. The volume and acuity of patients meant staffing rotas clearly identified a need for extra, temporary staff to carry out enhanced observations on a daily basis. However, managers had not made plans to book the same temporary healthcare support workers or nurses on a regular basis, which could have ensured they were familiar with the ward environment and the patients they would be working with. A permanent member of staff noted that rotas were done from week to week, with frequent changes, which impacted on their work life balance.

Regular staff received supervision and basic training but did not always feel supported to do their jobs. Many described feelings of being overwhelmed, overworked and struggling to cope with the pressure of work. Several told us they were either planning to leave or would like to leave. There were high vacancy levels for nurses and there had been a high turnover of doctors and nurses. Support workers who had been employed for six months were deemed to be long term.

Processes for adherence to the Mental Health Act and Mental Capacity Act were in place and worked well.

Patient care pathways were effective and patients felt treated well by the regular staff who knew and understood their needs. However, a high proportion of staff were temporary, some working just a few shifts periodically, so patients did not feel that on the whole staff knew them.

There was a clear process for reporting and investigating incidents, but some staff told us there was not enough time to effectively report all incidents. Some incident investigation reports were unclear and not completed to a high standard. We found recommendations that bore no link to the incident report in more than one that we looked at. We were not assured these were always completed well or with openness and transparency.

There was a clear framework of what must be discussed at a ward, team and hospital level meetings to ensure that essential information, such as learning from incidents and complaints, was shared and discussed. Managers produced a lessons learned newsletter and most staff had heard of it. Most were able to identify some changes that had taken place as a result of lessons learned but two staff felt managers did not make enough changes to make the hospital a safer place.

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

We were not assured that changes were effective or that managers supported staff to embed changes and improvements across the hospital.

When we carried out the focussed inspection in June 2019, we were concerned about the safety of patients and shared this with the provider. Our concerns related to the way staff carried out routine and enhanced observations and engagement with patients, the way they carried out investigations into incidents, the number of patients on Dunsmore ward (which exceed national guidance) and to a blind spot which they knew about, but had not done enough to address. To address our concerns, managers provided us with a clear action plan of the improvements they were making and would make. However, two more serious incidents occurred, both of which linked directly some of the concerns we had expressed. One patient died, and the service's internal investigation found that the patient had not been observed in line with the care plan. Another patient was found to have been at risk of serious self-harm or death because staff had not conducted observations effectively. At this inspection, we found there were still risks to patients.

The hospital had also been issued with a Level 1 Performance Improvement Notice by NHS Wales National Collaborative Commissioning Unit in May 2019. This was because they had concerns that staff were not able to take their breaks on Dunsmore ward, patient records lacked reference to an incident, there was evidence that not all staff had access to information about important changes to hospital processes.

Staff had implemented some recommendations from previous CQC inspections, reviews of deaths, incidents, complaints and safeguarding concerns. However, some of these had led to restrictions being placed upon all patients, regardless of their individual risk. Other recommendations were shown in actions plans as having been completed, but we found this was not the case. One example was the provision of privacy screens on each ward. The screens had been purchased but, on two out of the three wards, the screens remained in their boxes in storage rooms and staff did not know what they were or why they were there.

There was a programme of local clinical audit but recommendations were not always put in place at ward level. Examples included local quality assurance audits. Findings had been presented to ward managers and senior leaders but recommendations had not been implemented. These included the need for more permanent staff to be secured for all wards, for the fridge seal to be cleaned or changed and for the seclusion room to be cleaned on Dunsmore ward. None of these actions had been carried out by the time we carried out this inspection.

Management of risk, issues and performance

Staff maintained and had access to the risk register at ward and hospital level. Staff at ward level could escalate concerns when required. However, concerns such as short staffing and high use of temporary staff were not addressed.

Staff concerns matched those on the risk register, for example staffing issues. Key staff attended a daily risk meeting to discuss areas of risk and ways of managing risk.

The hospital had plans for emergencies – for example, adverse weather or a flu outbreak.

Some staff and patients told us they believed that cost was more of a priority than patient care.

Information management

The service used systems to collect data from wards that were not over-burdensome for frontline staff.

Most 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 but electronic systems were only accessible to permanent staff. Even the long term temporary staff could not access it. Staff on the ward attended twice daily handover meetings where risk and changing needed of patients was discussed. However, these meetings were attended by a large number of temporary staff who did not know the patients and were given only brief information before they were expected to carry out direct patient observation and engagement duties.

Information governance systems included confidentiality of patient records which in the main were managed well. However, we did find two entries in one record which clearly related to another patient.

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.

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

Staff made appropriate notifications to external bodies as needed including the local authority and the Care Quality Commission.

Engagement

Staff, patients and carers had access to up-to-date information about the work of the provider and the services they used – for example, through the intranet, bulletins, newsletters. Staff also arranged some family days, so families could attend and find out more about what was happening at the hospital.

Patients and carers had opportunities to give feedback about 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 but did not always use it to make improvements.

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

Patients and staff could meet with members of the provider's senior leadership team to give feedback. They could attend a patient council meeting, the minutes of which staff made available for patients to read.

Learning, continuous improvement and innovation

We saw little evidence that staff were given the time and support to consider opportunities for improvements and innovation which could lead to change. One ward manager shared ideas for improvements to the service, but most felt immediate improvements could be made if there were more permanent staff working at the hospital.

The hospital was not involved in any current research.

The hospital was working toward introducing quality improvement methods and had a programme in place to develop this. However, we saw no evidence of innovation or innovative practice taking place at the hospital.

None of the wards participated in accreditation schemes relevant to the services they provided.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

The provider must ensure there are enough staff to safely staff each ward. Staff must be of the right skill, knowledge and experience, who know patients and the ward environments well enough. Staffing must take into account the gender of staff, in relation to patient population, risk and need. Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2014 Staffing

The provider must ensure they have sufficient staff who are trained in the insertion and running of nasogastric feed techniques and ensure feeds are administered according to planned care. Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2014 Staffing

The provider must ensure all staff working at the hospital have the requisite level of training and experience in conflict resolution and de-escalation. Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2014 Staffing

The provider must ensure the respect and dignity of patients is promoted and maintained by all staff. Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2014 Dignity and Respect

The provider must ensure that all staff have a suitable handover of patient need and risk at the start of each shift. Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2014 Safe care and treatment

The provider must ensure that incidents are minimised and where they occur are managed appropriately, recorded and investigated effectively. Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2014 Safe care and treatment

The provider must ensure that patient observation and engagement is carried out in line with policy and best practice. Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2014 Safe care and treatment

The provider must ensure the hospital is clean, hygienic and well maintained. Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2014 Premises and Equipment

The provider must ensure that governance processes at the hospital are fit for purpose to safely run the hospital. Regulation 17 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Good Governance

The provider must act on concerns and make necessary improvements that are highlighted through audit and findings from adverse incidents. Regulation 17 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Good Governance

Action the provider SHOULD take to improve

The provider should ensure that nurses have access to effective ongoing learning and development opportunities. Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2014 Staffing

The provider should ensure that medicines are regularly checked and out of date medicines disposed of in line with guidance. Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2014 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
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing There was not enough staff who understood patient need and risk well enough to keep patients safe, comfortable and free from harm. There was not enough staff with the right skills to safely carry out interventions such as nasogastric tube feeds and restraint in a timely way. Temporary staff did not have access to supervision and there were a lack of development opportunities for healthcare support workers. This was a breach of regulation 18

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 Governance at the hospital was not effective. Leaders were out of touch with what was happening on the front line, and they could not identify or did not understand the risks and issues described by staff. Leaders had not addressed concerns raised with them through audit, adverse events and by staff or patients.

This section is primarily information for the provider

Requirement notices

The provider did not ensure that incidents were minimised, and where they occurred, they were not managed appropriately, recorded or investigated effectively.

This was a breach of Regulation 17

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 Patient dignity was compromised. This was a breach of Regulation 10

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment Dunsmore ward was not clean and not well maintained. The therapy kitchen on Middlemarch ward was not clean and contained out of date food in the patient fridge, freezer and stock cupboard. Ward fridges were not clean and food was not stored in line with best practice. This was a breach of regulation 15

This section is primarily information for the provider

Requirement notices

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 Staff did not complete observation and engagement effectively nor in line with best practice or the provider's policy. This had led to patients coming to harm. The provider was not doing all that was practicable to mitigate such risks. Not all staff received an effective handover before working with patients. This was a breach of regulation 12

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 12 HSCA (RA) Regulations 2014 Safe care and treatment Due to the level of concerns we had, we issued Cygnet Hospital Coventry with a Section 31 Notice of Decision. This meant we imposed conditions on their registration.