Cygnet Health Care Limited

# Cygnet Hospital Maidstone

**Inspection report**

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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

## Ratings

| | |
|---|---|
| Overall rating for this location | Requires Improvement |
| Are services safe? | Requires Improvement |
| Are services effective? | Requires Improvement |
| Are services caring? | Requires Improvement |
| Are services responsive to people's needs? | Good |
| Are services well-led? | Requires Improvement |

# Summary of findings

## Overall summary

Our rating of this location went down. We rated it as requires improvement because:

- The provider did not manage ligature risks well. There were multiple ligature points across the ward which were not sufficiently mitigated. The provider's ligature risk assessment process was not robust enough to remove ligature risks. Staff had not received training on how to complete a thorough and detailed environmental and ligature risk assessment. Due to the nature of the concern, the provider was issued a warning notice immediately after the inspection to address this concern. A warning notice is what we serve to a provider where we identify a concern with the quality of care they are responsible for that requires a current need for significant improvement.
- Staff did not ensure that patients' medicines were managed safely. Staff did not ensure that medicines were safely administered and recorded. Staff did not ensure that the physical health of patients who were administered rapid tranquilisation were sufficiently monitored to mitigate against or reduce the risk of harm. For example, patients were administered overdose of rapid tranquilisation medicines above the recommended limits. Staff did not ensure that controlled drugs were appropriately signed for. On Kingswood ward, staff did not always ensure the emergency bag check list was up to date with the relevant contents in the bag. The index on drugs liable for misuse was not completed. There were no cleaning records or audits in place for clinic room equipment. The emergency bag was not sealed with a standardised fitting which meant that it required cutting with scissors to gain access.
- Not all patients had a care plan that met their holistic needs, and care plans were not always written to reflect patients' views. For example, on Saltwood ward, one patient who had been prescribed medicines for substance misuse disorder did not have a specific substance misuse management plan in place. Some patients told us they had refused their care plans because they did not reflect their views or assessed needs. One patient was discharged from their section following a tribunal, but staff did not have aftercare plans in place. On Kingswood ward, care plans we reviewed did not identify whether a patient had signed or been given a copy of their care plan. In addition, recording of patient involvement was not seen in all care plans.
- The provider did not always ensure the provision of meaningful activities suitable for the rehabilitative needs of patients. On Kingswood ward, there was no focus on recovery- orientated activities within care planning, ward rounds or team meetings. When meaningful activity engagement was recorded as below 25 hours per week on the ward, leaders did not put in place actions to address this. Patients on Saltwood ward told us that planned activities were sometimes cancelled. Some patients reported that their section 17 leave was often cancelled.
- Staff did not always treat patients with kindness and compassion. Four out of six patients we spoke with on Saltwood ward told us that night staff did not always care for them well or treated them kindly. Patients said that staff did not always listen to them or respected their wishes. Two patients on Saltwood ward reported that staff did not respect their dignity or privacy and often walked in on them in the shower. On Kingswood ward, four patients said the night staff were disrespectful, were not caring and did not respect their privacy and dignity.
- Governance processes around quality assurance and audits were not robust enough to mitigate or reduce risks. We saw that there were concerns in prescription charts and care records which had previously been identified in the pharmacy audit but had not been acted upon. When lessons were learnt following an incident, the provider did not ensure that the actions were embedded to reduce such risks. For example, there were two battery swallowing incidents within a 48 period in February 2023. Although the provider took some action, we saw that another battery swallowing incident occurred again in May 2023. The provider did not ensure that actions following Mental Health Act 1983 (MHA) monitoring visits were completed and improvements were fully embedded.

However:

# Summary of findings

- The ward environments were clean. The wards had enough nurses and doctors. They followed good practice with respect to safeguarding.
- Staff developed holistic, recovery-oriented care plans informed by a comprehensive assessment. Staff engaged in clinical audits to evaluate the quality of care they provided.
- The ward teams included or had access to the full range of specialists required to meet the needs of patients on the wards. Managers ensured that these staff received training, supervision, and appraisal. The ward staff worked well together as a multidisciplinary team and with those outside the ward who would have a role in providing aftercare.
- Staff understood and discharged their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005.
- Spoke highly of the culture and the senior leadership team. They felt the senior leaders were very supportive and valued them. Staff reported that managers cared for their wellbeing and gave them opportunities and support to grow in their careers.

# Summary of findings

## Our judgements about each of the main services

| Service | Rating | Summary of each main service |
|---|---|---|
| **Acute wards for adults of working age and psychiatric intensive care units** | Requires Improvement  | Our rating of this service went down. We rated it as requires improvement because:<br>• The ward environments were not safely managed. Staff did not assess and manage ligature risks well. There were fixed ligature anchor and high-risk ligature points across the wards without sufficient mitigations in place to manage the risks. The environmental ligature risk audit programme was not robust enough to mitigate or remove risks.<br>• There were blind spots in the bathroom in the seclusion room on Bearsted ward which were not sufficiently mitigated by either a CCTV or parabolic mirrors. At the previous inspection in 2019, we raised concerns about the safety of the seclusion suite on Bearsted ward with senior managers. We also told them that there were no clear lines of sight in the seclusion suite bathroom. During this inspection we found that these concerns had not been addressed.<br>• Staff did not ensure that medicines were managed safely. Records we reviewed showed that the provider did not always administer people's medicines safely or in line with the prescriber's instructions.<br>• Staff did not ensure that fridge temperatures were monitored appropriately. When temperatures sometimes went above the recommended range there was no record of actions taken or to explain why the temperature was out of range.<br>• Staff did not follow the providers policy or national guidance on conducting and recording physical health monitoring after the use of an intramuscular rapid tranquilisation medicine. We did not see evidence that baseline physical health checks were always completed for people prescribed with HDAT (high dose antipsychotic therapies). |

# Summary of findings

- Staff did not always treat patients with compassion and kindness. They did not always respect patients' privacy and dignity. They did not always understand the individual needs of patients and did not always support patients to understand and manage their care, treatment, or condition. For example, patients reported that some members of staff especially at night were not always discrete, respectful and responsive to their needs.
- The governance processes around the management of patient and ward risks were not robust enough to ensure that ward processes ran smoothly.

However:

- The wards were clean and well maintained. Staff followed infection control policy including handwashing and completed enhanced infection control checklists daily.
- The wards had enough nurses and doctors to provide care and treatment for patients. The ward teams included or had access to the full range of specialists required to meet the needs of patients on the wards.
- Managers ensured that staff received training, supervision, and appraisal. The ward staff worked well together as a multidisciplinary team and with those outside the ward who would have a role in providing aftercare.
- Staff followed good practice with respect to safeguarding. They understood and discharged their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005.
- The service managed beds well so that a bed was always available locally to a person who would benefit from admission and staff ensured that patients were discharged promptly.
- Staff developed holistic, recovery-oriented care plans informed by a comprehensive assessment. They provided a range of treatments suitable to the needs of the

# Summary of findings

patients and in line with national guidance about best practice. Staff engaged in clinical audits to evaluate the quality of care they provided.
- Staff actively involved patients and families and carers in care decisions.

**Long stay or rehabilitation mental health wards for working age adults**

**Requires Improvement**

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

- The service did not have adequate ligature risk assessment audits in place to accurately identify environmental risks and provide suitable mitigations. 35% of staff were awaiting allocation of ligature rescue training. Leaders acknowledged that training and confidence building was needed for managers and staff. Due to the nature of the concern, the provider was issued a warning notice immediately after the inspection to address this concern. A warning notice is what we serve to a provider where we identify a concern with the quality of the care they are responsible for that requires a current need for significant improvement.
- The service did not always have adequate record keeping in place around medicines and clinical equipment. The emergency bag check list was not up to date with the relevant contents in the bag. The index on drugs liable for misuse was not completed. There were no cleaning records or audits in place for clinic room equipment. The emergency bag was not sealed with a standardised fitting which meant that it required cutting with scissors to gain access.
- The service did not always ensure the provision of meaningful activities suitable for the rehabilitative needs of the patient group. In addition, there was not always a focus on recovery orientated activities within some care planning, ward rounds or team meetings. When meaningful activity engagement was recorded as below 25 hours per week on the ward, leaders did not put in place actions to address this.

# Summary of findings

- Data provided on restrictive practices, including restraints and rapid tranquilisation, was not accurate with the data held within incident records. This raised concerns as to the accuracy of recorded restrictive interventions and adequate oversight of these. Although, the provider has since informed us that there had been an error in the data shared at the time of the inspection. They advised that all incidents of rapid tranquilisation and restraints were recorded at their daily flash meeting.
- The service did not hold regular team meetings to ensure information was shared consistently with staff. Leaders acknowledged that the team meeting minutes provided did not always demonstrate sharing of information from governance meetings.
- Some patients did not have a clear plan for discharge and some relatives were not involved and kept informed of recovery progress and discharge planning.
- All care plans we reviewed did not identify whether a patient had signed or been given a copy of their care plan. In addition, recording of patient involvement was not seen in all care plans.
- The service was told about displayed food menus being out of date on a Mental Health Act Review visit in August 2022. The provider reported to have taken action, though we found that all four-week menus were on display, and it was not clear which was the current week.
- The service did not always provide updates to feedback or actions raised by patients, such as those within community meeting minutes.

However,

- The ward environments were clean. The wards had enough nurses and doctors. They followed good practice with respect to safeguarding.
- Staff developed holistic, recovery-oriented care plans informed by a comprehensive assessment. Staff engaged in clinical audit to evaluate the quality of care they provided.

# Summary of findings

- The ward teams included or had access to the full range of specialists required to meet the needs of patients on the wards. Managers ensured that these staff received training, supervision and appraisal. The ward staff worked well together as a multidisciplinary team and with those outside the ward who would have a role in providing aftercare.
- Staff understood and discharged their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, and understood the individual needs of patients.

**Forensic inpatient or secure wards**

**Requires Improvement**

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

- The provider did not manage ligature risks well. There were multiple ligature points across the ward which were not sufficiently mitigated. The providers ligature risk assessment process was not robust enough to remove ligature risks. Staff had not received training on how to complete a thorough and detailed environmental and ligature risk assessment.
- The seclusion suite had blind spots that were not sufficiently mitigated by either a parabolic mirror or CCTV camera and staff could not maintain a continuous line of sight for patients in seclusion.
- Staff did not keep up to date with their mandatory training. For example, only 34% of staff had completed the awareness of self-harm training and suicide course and only 64% of staff had completed the ligature rescue training on Saltwood ward which were below the provider's target of 90%. Only 29% of staff had received up to date training on safeguarding individuals at risk (intermediate) virtual classroom training and only 36% of eligible staff had completed the safeguarding programme training.
- Staff did not ensure that patients' medicines were managed safely. Staff did not ensure that

# Summary of findings

medicines were safely administered and recorded. Staff did not ensure that physical health of patients who were administered rapid tranquilisation were sufficiently monitored to mitigate against or reduce the risk of harm. For example, patients were administered overdose of rapid tranquilisation medicines above the recommended limits. They did not ensure that the physical health of patients who were administered rapid tranquilisation was adequately monitored to reduce harm. Staff did not ensure that controlled drugs were appropriately signed for.

- Not all patients had a care plan that met their holistic needs, and care plans were not always written to reflect patients' views. For example, one patient who had been prescribed medicines for substance misuse disorder did not have a specific substance misuse management plan in place. Some patients told us they had refused their care plans because they did not reflect their views or assessed needs. One patient was discharged from their section following a tribunal, but staff did not have aftercare plans in place. Although the service responded appropriate to arrange transport for them so they could get their depot medicine next day.
- Some patients told us there were not always enough meaningful activities on the ward which upskilled them for independent living. Patients told us that planned activities were sometimes cancelled. Some patients reported that their section 17 leave were often cancelled.
- Staff did not always treat patients with kindness and compassion. Four out of six patients we spoke with on Saltwood ward told us that night staff did not always care for them well or treated them kindly. Patients said that staff did not always listen to them or respected their wishes. Two patients on Saltwood ward reported that staff did not respect their dignity or privacy and often walked in on them in the shower.

# Summary of findings

- The service had blanket restrictions in place without clear rationale. For example, patients reported that staff kept the quiet room locked without a clear explanation or rationale. Although staff reported that this was because of a high risk patient on the ward. There was a hot and cold water urn, patients who needed to make hot drinks were dependent on staff, as the water was tepid.
- Governance processes around quality assurance and audits were not robust enough to mitigate or reduce risks. We saw that there were concerns in prescription charts and care records which had previously been identified in the pharmacy audit but had not been acted upon. When lessons were learnt following an incident, the provider did not ensure that the actions were embedded to reduce such risks. For example, there were two battery swallowing incidents within a 48 period in February 2023. Although the provider took some action, we saw that another battery swallowing incident occurred again in May 2023. The provider did not ensure that actions from previous Mental Health Act (MHA) 1983 monitoring visits were completed and improvements were fully embedded.

However,

- The ward environments were clean and generally well maintained. The wards had enough nurses and doctors. Staff assessed and managed risk well. They minimised the use of restrictive practices and followed good practice with respect to safeguarding.
- Staff provided a range of treatments suitable to the needs of the patients and in line with national guidance about best practice.
- The ward teams included or had access to the full range of specialists required to meet the needs of patients on the wards. Managers ensured that these staff received training, supervision and appraisal. The ward staff worked well together as a multidisciplinary team and with those outside the ward who would have a role in providing aftercare.

# Summary of findings

- Staff understood and discharged their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005.
- On most occasions, staff planned and managed discharges well and liaised with services to ensure that discharges were successful. Managers monitored delayed discharges to ensure that patients did not stay in hospital longer than they needed to.
- Leaders had a clear vision of what they wanted to achieve. Staff were very positive about their leaders and the culture. Staff said leaders were very kind and supportive.

# Summary of findings

## Contents

# Summary of this inspection

## Background to Cygnet Hospital Maidstone

Cygnet Hospital Maidstone is a purpose built, 65-bed mental health facility for adults. The hospital has four wards:

**Roseacre** ward is a 16-bed specialised personality disorder ward for women. The aim of the service is to support service users manage their mental health, develop coping strategies, reinforce daily living skills, and prepare for a return to independent living. Roseacre Ward provides a care pathway for service users who are preparing to step down to community living and uses a recovery focused model. The ward supports individuals with primary diagnoses of personality disorder, schizophrenia, schizoaffective disorder, bipolar affective disorder, and depression.

**Bearsted ward** is a 15-bed male psychiatric intensive care unit (PICU) service at Cygnet Hospital Maidstone and accepts emergency and crisis admissions. Referrals are accepted from all areas, including acute and prison services. The ward provides support for individuals experiencing difficulties that present a risk to the well-being of themselves or others that cannot be treated in an open environment.

**Kingswood ward** is a 16-bed service providing acute and high dependency rehabilitation services for adult men with complex mental health needs. The service outlined their high dependency rehabilitation service as a recovery focused service delivering high quality care, balancing risk management with therapeutic optimism and encourages men to build upon skills needed to move towards the least restrictive care option or return to the community. The National Institute for Health and Care Excellence (NICE) defines high dependency rehabilitation units as "Inpatient rehabilitation units for people with complex psychosis whose symptoms have not yet been stabilised and whose associated risks and challenging behaviours remain problematic. These units aim to maximise benefits of medication, address physical health comorbidities, reduce challenging behaviours, re-engage families and facilitate access to the community." The primary diagnoses of the patients referred to the high dependency rehabilitation unit was a mental health condition which may include complex co-morbidities, substance misuse, treatment resistance and behaviours that challenge.

**Saltwood Ward** is a 16 bed low secure service for men with enduring mental illness, including those with a personality disorder. The service is provided in a joint working arrangement with Kent and Medway Partnership NHS Foundation Trust and promotes shared understanding and practice. The NHS Trust undertakes case management and until May 2023 they employed social workers who worked at the hospital. Cygnet Health Care provides psychiatry, nursing, therapy, social workers and ancillary staff, and they operate the service. This allows for opportunities of shared learning and shared excellence.

The multidisciplinary team is integrated and work as one, sharing expertise. The Trust also has extensive community links which can be particularly helpful for service users moving towards discharge, thus helping to keep lengths of stay to a minimum.

Cygnet Hospital Maidstone was registered with the Care Quality Commission (CQC) on 5 October 2018 to provide:

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

The hospital has been inspected twice since registering with the CQC. We first carried out a comprehensive inspection of this hospital on 19 and 20 March 2019. Following that inspection, we rated the provider good overall and requires

improvement for safe. On that inspection we issued the provider with requirement notice for the breach of Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment because risk assessments were not always completed and did not identify and mitigate all risks. Appropriate action was not always taken in response to incidents to remedy the situation and prevent future reoccurrence. We told the provider that it must make the following improvements:

- The provider must ensure that when incidents take place, appropriate action is always taken to remedy the situation and prevent future reoccurrence.

The most recent inspection was conducted on 2 and 3 December 2019 where we carried a focussed inspection of the Safe, effective and well led domain. We did not rerate the service following this inspection. However, we issued the provider with a requirement notice under Regulation 12 HSCA (RA) Regulations 2014 Safe Care and Treatment. We told the provider it must make the following improvements:

- The provider must ensure they improve information recorded in patients' risk assessments, risk management and care plans. Risk assessments and risk management plans should be updated following a change in risk and reflective of all risks identified.

At the time of the inspection, the hospital had a registered manager in post.

**What people who use the service say.**

**Forensic inpatient or secure wards**

We spoke with six patients whilst on site and the feedback we received was mixed. Patients reported that while the day staff cared for them well with kindness and compassion, they did not always receive the same level of support and care from the night staff. Two patients reported that staff did not always respect their dignity and privacy and they often entered their bedrooms without permission. Some patients felt staff did not always listen to them or respected their wishes. Some patients told us they had refused their care plans because they did not always reflect their assessed needs. However, patients told us they generally felt safe on the ward and the food was of good quality. Patients told us they knew how to make a complaint or raise a concern when they needed to.

**Acute wards for adults of working age and psychiatric intensive care unit**

During this inspection, we spoke with a total of 11 patients. Feedback we received from the patients was mixed. Patients told us night staff did not always treat them with compassion and kindness. Staff especially at night did not always respect their privacy and dignity. Patients told us that staff did not always understand their individual needs and did not always support them to understand and manage their care, treatment or condition.

Four patients told us night staff used unprofessional language such as 'patients kicking off' and 'jabbing' patients.

Patients gave mixed feedback about the quality of food. Six out of 11 patients we spoke with were satisfied with the food. However, five patients were not happy with either the portion sizes, the quality, and lack of vegan food.

Feedback we received about the day staff was more positive. Patients described the day staff as approachable, polite, kind, and respectful.

# Summary of this inspection

Feedback we received from carers was overall positive. Three out of four carers told us they felt their relatives were safe and were very happy with the care their relatives received. However, one carer told us their complaint was poorly dealt with and not in a timely manner. They did not receive feedback following the complaint. The staff did not give them enough information, and the initial communication they had received from the ward staff was poor.

**Long stay or rehabilitation mental health wards for working age adults.**

At the time of the inspection there were 15 patients on the high dependency rehabilitation unit, out of a total capacity of 16. All patients were detained under the Mental Health Act. We spoke with three patients whilst on site and we spoke with three patients via telephone. All patients told us that they felt safe and were happy with the care they received. They told us that the ward was clean and comfortable, and that staff treated them with kindness and respect. They told us that they felt involved in their care, although, one patient told us that they were ready to leave but were still waiting for an assessment on a flat and two patients were not aware of their discharge plans. Some patients told us that smoking breaks were activities for them and that the available activities were not always focused on what they liked to do, although they told us that there were lots of therapies available and four patients told us how they had found these helpful. One patient told us they did not go to therapies as they were not awake to go to them.

We spoke with five relatives of people using the service. All relatives told us that the service helped them to keep in touch with their loved one. Most relatives told us that they were kept informed with their loved one's care. They all told us how their loved ones felt safe. Most relatives told us that they knew how to raise a concern and were also able to provide feedback for the service verbally and through a survey. However, four of the five relatives raised concerns about the activity provision both on and off the wards. One told us that their loved one did not have a lot going on all day. Another told us that their loved one was not inspired to get up and do anything. Another relative told us how their loved one had started smoking again since being there as something to do. Two of the five relatives told us that they were not aware of discharge plans for their loved one, and one told us that they had not seen any plans for their care and treatment progress. Other relatives told us that they had not been involved in discharge planning but felt that as the follow-on plans had not been put in place, they preferred that their loved one was not being discharged.

## How we carried out this inspection

The team that inspected the hospital comprised of four CQC inspectors, three specialist advisors with mental health nursing background, three experts by experience and a medicines inspector.

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

During the inspection visit, we completed the following activity:

- undertook a tour to look at the quality of the ward environment
- observed how patients were being cared for by staff both informally and through direct observations of care using the Short Observational Framework for inspection (SOFi). SOFi is an observational tool used to help us collect evidence about the experience of people who use services, especially where people may not be able to fully describe this themselves because of cognitive or other problems. It enables inspectors to observe people's care or treatment looking particularly at staff interactions
- spoke with 23 patients across the hospital
- spoke with nine relatives by telephone

# Summary of this inspection

- spoke with 37 members of staff including the hospital manager, the medical director, ward managers, two ward consultants, ward doctors, the visiting pharmacist, psychologists and psychology assistants, a psychotherapist, occupational therapists and occupational therapy assistants, nursing staff, support staff and an advocate
- observed the hospital daily flash meeting
- observed Multidisciplinary Team (MDT) handover and ward round on three wards
- reviewed 24 patient care records and risk assessments
- reviewed 31 prescription charts
- inspected the clinic rooms on all wards
- reviewed incidents, complaints and compliments records
- reviewed a range of policies, procedures and other documents relating to the running of the wards.

You can find information about how we carry out our inspections on our website: https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

## Areas for improvement

Action the service MUST take is necessary to comply with its legal obligations. Action a trust SHOULD take is because it was not doing something required by a regulation, but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

**Action the service MUST take to improve**:

**Forensic inpatient or secure wards**

- The provider must take action to review all ligature risks across the ward and ensure there are clear plans in place to remove or mitigate against such risks (Regulation 12 (1) (2)(d)(e): Safe Care and treatment)
- The provider must ensure that there is a robust ligature audit programme in place, and all staff completing the ligature risk audit have the right training, skill and experience (Regulation 12 (1)(2)(c)(d)(e): Safe Care and Treatment).
- The provider must take action to ensure that the seclusion rooms are robustly monitored, and clear actions are implemented to remove or mitigate against ligature risks. (Regulations 12 (1)(2)(b): Safe care and treatment)
- The provider must ensure there is a robust governance process in place to ensure the safety and effective use of medicines. The provider must ensure that peoples medicines are administered safely as prescribed. (Regulation 12(2)(g): Safe Care and treatment).
- The provider must ensure they follow their own policy and national best practice for the use of rapid tranquilisation. The provider must ensure that the physical health of patients who are administered rapid tranquilisation are robustly monitored. (Regulation 12(2)(g): Safe Care and treatment).
- The provider must ensure they follow national guidance when recording controlled drugs use. (Regulation 12(2)(g): Safe Care and treatment).
- The provider must ensure records are accurate and provide appropriate information to support review of the use of as required 'Pro Re Neta' (PRN) medicines. (Regulation 12(2)(g): Safe Care and treatment).
- The provider must ensure appropriate physical health monitoring is completed and recorded, especially when administering high dose antipsychotic therapies. (Regulation 12(1)(2)(a)(b)(g): Safe Care and treatment).
- The provider must ensure that staff kept up to date with their mandatory training. (Regulation 18(2)(a): Staffing).
- The provider must take action to ensure that staff provide care that is kind, compassionate, and monitor this to ensure that compassionate care is consistent across all shifts. The provider must ensure that patients are treated with dignity and respect at all times. (Regulation 10(1)(2)(a): Dignity and respect).

# Summary of this inspection

- The provider must ensure that patients are involved in their care and care planning and ensure all care plans are up to date and meets the patient's individual needs, reflective their preferences and it appropriate. (Regulation 9(1)(a)(b)(c)(3)(a)(b)(c)(d)(e)(f): Person-centred care)
- The provider must take action to improve on its governance processes to ensure that care is delivered in a safe and person centred way. The provider must take action to ensure that there is consistent learning from incident and monitor this to ensure it is fully embedded. (Regulation 17 (1): Good governance)
- The provider must ensure that actions following the Mental Health Act 1983 (MHA) monitoring visits are completed and improvements are fully embedded. (Regulation 17: Good governance)

**Long stay or rehabilitation mental health wards for working age adults.**

- The service must ensure that the emergency bag check list is kept up to date and includes the full contents requiring checking. (Regulation 12 (2)(e)(f): Safe care and treatment)
- The service must ensure that the emergency bag seal is one that can be broken with ease to enable timely access to the bag. (Regulation 12 (2)(e): Safe care and treatment)
- The service must ensure adequate record keeping and thorough checks on medicines including the completion of index pages in medication check books and stock lists. (Regulation 12 (2)(g): Safe care and treatment)
- The service must ensure that there are cleaning records available which are audited to ensure staff maintain and clean clinic room equipment. (Regulation 12 (2)(e)(h): Safe care and treatment)
- The service must ensure that the ligature risk assessment audits are completed appropriately to identify the accurate risk and ensure suitable mitigations are in place. (Regulation 12 (2)(a)(b): Safe care and treatment)
- The service must ensure that all staff complete their ligature rescue training, and that there is always a member of staff with this completed training on shift. (Regulation 12 (2)(c): Safe care and treatment)
- The service must ensure that the provision of meaningful activities is suitable for a long stay rehabilitation service and meet the needs of the patient group. (Regulation 9 (1) Person-centred care)
- The service must ensure that the ligature risk assessment audits are understood by managers and staff to ensure appropriate understanding and oversight. (Regulation 17: Good governance)
- The service must ensure that restrictive interventions are appropriately identified and recorded to ensure accurate oversight. (Regulation 17: Good governance)
- The service must ensure that leaders have appropriate oversight of the recovery-orientated activities suitable to patients' care and treatment on this ward and that appropriate action is taken to address shortfalls with this. (Regulation 17: Good governance)

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

- The service must ensure the proper and safe management of medicines. The provider must ensure that controlled drugs are safely managed in line with national guidelines (Regulation 12 (g): Safe Care and Treatment)
- The provider must ensure ligature risks are safely assessed and managed and that ligature risk assessments are developed by a suitably trained person. (Regulation 12(2)(d): Safe Care and Treatment)
- The provider ensure that the premises (seclusion room) used by the service provider is safe to use for its intended purpose and are used in a safe way. (Regulation 12 (2)(d): Safe Care and Treatment)
- The provider must ensure service users are treated with dignity and respect. (Regulation 10(1): Dignity and Respect).

**Action the service SHOULD take to improve:**

**Forensic inpatient or secure wards**

- The service should ensure that there are enough activities for patients which are meaningful and meets their needs. The provider should work towards improving patient and staff engagement on the ward.

# Summary of this inspection

- The service should ensure they review all blanket restrictions so that people's needs are met consistently.
- The provider should ensure that standards of cleanliness are maintained 24 hours of the day, seven day a week.

**Long stay or rehabilitation mental health wards for working age adults:**

- The service should enable best practice in treatment and care by facilitating a recovery-orientated approach in line with national best practice.
- The service should ensure that team meetings take place regularly to ensure appropriate and consistent information sharing.
- The service should ensure all patients have a clear plan for discharge and that they, and where possible, their relatives, are involved and kept informed of recovery progress.
- The service should improve the recorded involvement of people within care plans, including where a patient has signed their care plan, been given a copy or refused.
- The service should ensure that the correct weekly food menu is displayed clearly for patients.
- The service should ensure that updates are always provided where actions are raised during community meetings/ patient feedback.
- The service should ensure that restrictive interventions are appropriately identified and recorded to ensure accurate oversight.

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

- The provider should ensure the patients have access to enough therapeutic activities during the weekend.
- The provider should ensure that the patients have access to quality food and patient should have a variety of food to choose from. The provider should ensure the kitchen provide food to meet the dietary needs of patients.

# Our findings

## 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 | Requires Improvement | Good | Requires Improvement | Good | Requires Improvement | Requires Improvement |
| Long stay or rehabilitation mental health wards for working age adults | Requires Improvement | Requires Improvement | Good | Good | Requires Improvement | Requires Improvement |
| Forensic inpatient or secure wards | Requires Improvement | Requires Improvement | Requires Improvement | Good | Requires Improvement | Requires Improvement |
| Overall | Requires Improvement | Requires Improvement | Requires Improvement | Good | Requires Improvement | Requires Improvement |

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

Requires Improvement

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

## Is the service effective?

Good

Our rating of effective stayed the same. We rated it as good.

### Assessment of needs and planning of care

**Staff assessed the physical and mental health of all patients on admission. They developed individual care plans which were reviewed regularly through multidisciplinary discussion and updated as needed. Care plans reflected patients' assessed needs, and were personalised, holistic and recovery-oriented.**

Staff assessed the physical and mental health of all patients on admission. They developed care plans which were reviewed and updated regularly through multidisciplinary team discussion and updated as needed.

All patients had care plans in place which included short and long-term strategies for how to manage their needs and were completed within 72 hours of the patient being admitted to the ward. Care plans were reviewed every four weeks and discussed during ward rounds. Care plans were informative, up-to-date, personalised, and included the views of the patient, where possible in line with the National Institute for Health and Care Excellence (NICE) guidance.

On most occasions, staff assessed patients' physical health soon after admission and regularly reviewed during their time on the ward. However, staff did not ensure that there were clear baseline physical health observations for patients prescribed high dose antipsychotic medication.

Staff developed a comprehensive care plan for each patient that met their mental health needs. Each person had an informative, up to date individualised care plans. Care plans were personalised, holistic and recovery-orientated with four sections covering 'keeping safe,' 'keeping healthy,' 'keeping connected, and 'keeping well.' These were recorded on the provider's electronic records system with paper records for physical health and fluid charts.

Staff told us that they regularly reviewed and updated care plans when patients' needs changed, and this was confirmed in the 10 patient records we looked at on both Roseacre and Bearsted wards.

### Best practice in treatment and care

**Staff provided a range of treatment and care for patients based on national guidance and best practice. They ensured that patients had good access to physical healthcare and supported them to live healthier lives.**

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

Requires Improvement

Patients had access to psychological and other therapies recommended by the National Institute for Health and Care Excellence (NICE).

The psychology team conducted psychology assessments with patients to identify a psychology treatment pathway specific to their individual needs. They delivered psychological therapies such as dialectical behaviour therapy (DBT) and cognitive behaviour therapy. DBT is a proactive behavioural therapy specifically designed for patients with a diagnosis of personality disorder who require active engagement. It is designed to support individuals to manage distress, regulate emotion and develop adaptive coping skills. Interventions were based on individual need and assessment and delivered on a one-to-one basis or in a group. The psychology team monitored and measured patient outcomes.

Both wards had a weekly activity timetable which included psychological therapies and activities led by the occupational therapy or psychology team. The occupational therapist or ward psychologist led activities during the weekdays. Healthcare assistants led activities on weekends. Both patients and staff could initiate activities over the weekend. For example, staff sometimes initiated movie and karaoke nights for patients and patients engaged in activities such as arts and crafts, and board games. Patient had access to the outdoor space for games such as ball games and sports as well as a sensory garden which had a beach area with sand and landscaping.

Each patient had their own individual timetable which could be updated as required during morning planning meetings. Patients on Roseacre ward told us their time was always occupied. Each ward had an ADL kitchen. The occupational therapist supported patients to make their own food as part of developing their independent living skills.

However, some patients on Bearsted ward said there was not enough activity over the weekend, and they often felt bored.

All staff on Roseacre ward were trained or in the process of being trained in DBT. Patients on Roseacre ward were each offered four hours of DBT each week, spread over two days. The psychiatrist informed us DBT was added to all ward routine and values which focused on DBT skills. One patient told us staff previously used restraint and segregation to manage patients who were distressed. However, the introduction of DBT had helped patients to learn new skills and be able to manage difficult emotions. Another patient said their condition had improved and they became an informal patient due to DBT skill they gained with support from staff. Staff told us patients had the option to engage or not to engage with the treatment and the therapy only started when a patient was willing to engage with it. Staff told us not all patients responded well to DBT.

On Bearsted ward, the multidisciplinary team held complex case reviews in response to challenging patients with a focus on engaging and reducing the use of restraint.

Staff followed best practice guidance in the delivery of care and treatment. The occupational therapists completed assessments and outcomes monitoring with patients using the model of human occupation screening tool (HoNOS). They worked with patients to develop life and independent living skills. Occupational therapists worked with patients on one-to-one and group basis, depending on individual need. For example, the OT held a cultural cooking group where patients were encouraged to cook meals from their own cultures.

Staff reported that the introduction of the Springbank model of care had improved outcomes for patients. Springbank is a model used by specialist mental health wards dedicated to supporting people with borderline personality disorder. The model involved offering a range of therapeutic activities and fun outings to build up skills to help individuals struggling with the demands of independent community living.

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

Requires Improvement

The Springbank Model was co-produced with the University of Hertfordshire in partnership with patients to build trust, willingness, responsibility, communication, teamwork and respect. Staff reported that the model had helped improve patient engagement and reduced the number and severity of incidents on the wards.

All policies and procedures used by staff referenced current guidance such as the Mental Health Act Code of Practice. The management of physical intervention was delivered in line with guidance on short-term management of violence and aggression (2015) issued by the National Institute for Health and Care Excellence.

Staff identified patients' physical health needs and recorded them in their care plans. Staff kept records of patients' physical health and monitored patient's vital signs regularly using National Early Warning Score charts (NEWS2).

Staff ensured that patients had access to physical healthcare. Patients received a physical health examination on admission and their physical health was reviewed at least weekly depending on individual's circumstances. A general practitioner visited the hospital and each of the wards once a week. Patients were able to other specialist services such as opticians and podiatry.

The hospital had a gym that patients could use for exercises. Patients also had access to personal gym trainers and a yoga instructor and regular activity groups sessions in the community. However, one carer told us they were not happy with how staff approached the physical health needs of a patient.

Staff met patients' dietary needs and assessed those needing specialist care for nutrition and hydration. Patients had access to a dietician, patients were served with healthy food by the kitchen.

Staff encouraged patients to live healthier lives by supporting them to take part in programmes or giving advice. Staff offered patients the opportunity to see a smoking cessation specialist, and they were offered nicotine replacement therapy (NRT).

Staff used recognised rating scales to assess and record severity and outcomes. Staff used Health of the Nation Outcome Scale (HoNOS) to record and review a patient's progress. Staff also provided examples of using physical health rating scales with patients, including the modified early warning score (MEWS)

The service carried out regular audits to check if outcomes for patients were positive. Managers used results from audits to make improvements.

### Skilled staff to deliver care.

The ward teams included or had access to the full range of specialists required to meet the needs of patients on both wards. These included, qualified nurses, nursing assistants, a consultant psychiatrist, Clinical psychologist, speciality doctor, an occupational therapist, DBT therapist, and a dietician.

Managers ensured staff had the range of skills and experience needed to provide high quality care to meet the needs of the patients. They supported staff with appraisals, supervision, and opportunities to update and further develop their skills. Managers provided an induction programme for new staff.

At the previous inspection, we told the provider to ensure they further developed staff skills to support them in working in a psychiatric intensive care environment. During this inspection, we saw that managers ensured staff had the right

skills, qualifications, and experience to meet the needs of the patients in their care. For example, staff working in areas identified as being high risk of restraint and restrictive interventions were supported to attend RAID training in addition to being trained in the use of the Prevention and Management of Violence and Aggression (PMVA). Staff told us the PMVA had helped them increase their confidence in responding incidents.

All staff received an appropriate local and corporate induction. Induction packages were available for clinical staff, non-clinical staff, bank staff, students, and agency staff. Induction provided staff with information on organisational policies and procedures and provided the opportunity to work supernumerary to ward staffing numbers. Staff also completed a ward specific orientation and induction. For example, staff told us the induction they received prepared them for their role, and they were guided through the induction process by experienced staff who acted as their mentors.

Managers supported staff through regular, constructive appraisals of their work and monthly one to one supervision sessions. We looked at supervision records of four staff and found that staff had an opportunity to raise any concerns during these sessions. The manager had regular supervision with the regular bank and agency staff that worked in the service.

Managers supported staff with supervision, reflective practice sessions and opportunities to update and further develop their skills. Staff received supervision once a month as per the providers policy. Managerial supervision took place alongside clinical supervision. The provider had a clinical supervision target of 90%. Although records showed that supervision rates were 87% on both wards. Staff we spoke with confirmed they had regular supervision and felt it was supportive and beneficial for their needs and development. A psychologist from another ward facilitated reflective practice sessions once a month which staff were encouraged to attend.

Managers made sure staff attended regular team meetings. Team meetings followed an agenda, were recorded and a copy of the meeting was sent to all staff including those who could not attend the meeting. Minutes of recent team meetings indicated that topics discussed included ward audits, governance, incidents, lessons learnt, training and positive comments and complaints. Staff spoke positively about team work on both wards and support provided by their line managers. Managers monitored the number of hours staff worked to ensure they had they had breaks and utilised their annual leave.

Managers identified any training needs of their staff and gave them the time and opportunity to develop their skills and knowledge. For example, most staff had completed dialectical behaviour therapy (DBT) skills training and new starters received two days training in DBT and monthly skills workshop led by experienced staff. Most staff had completed their Oliver McGowan training, which is a specialist training on working with autistic people or people who have a learning disability. The management team on Bearsted ward had also introduced a new training for staff on how to screen patients using the inclusion and exclusion criteria. Screening training provided staff with skills on how to screen referrals using the admissions processes.

Managers recognised poor performance, could identify the reasons for poor performance and dealt with these. Managers told us they had access to human resources support for dealing with poor staff performance. At the time of our inspection, there were no performance issues reported on either ward.

### Multi-disciplinary and interagency teamwork

**Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care. The ward team(s) had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation.**

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

Requires Improvement

The multi-disciplinary team consisted of registered nurses, consultant psychiatrist, a specialist doctor, a clinical psychologist, an occupational therapist (OT) and full-time social worker. Each MDT member contributed to the delivery of care and treatment to patients.

There were regular face-to-face multidisciplinary meetings, with external professionals, patients and families invited to attend or contribute before the meeting. In addition to one-to-one work with the patients, the psychology team supported patients and staff with reflective practice sessions and de-brief sessions following incidents. All staff we spoke to told us staff engaged in reflective practice once every month.

The hospital had a dedicated social worker who supported patients with any social care issues including benefits and contact with families. They attended ward rounds and patients care programme approach (CPA) meetings. The ward also had good links with care co-ordinators who were invited to attend ward rounds and CPA meetings.

The managers for both wards told us the hospital worked well to maintain relationships with professionals outside of the service. This included the visiting GP, commissioners, case managers and local authority safeguarding team. For example, the managers told us they maintained good relationship with integrated care boards and funders and had good collaborative work with Kent County council.

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

**Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice and discharged these well. Managers made sure that staff could explain patients' rights to them.**

All staff received and were kept up to date with training on the Mental Health Act and the Mental Health Act Code of Practice and could describe the Code of Practice guiding principles. Staff told us that they had access to support and advice on implementing the Mental Health Act and the Code of Practice. Staff told us that they had access to support and advice on implementing the Mental Health Act and the Code of Practice.

The service had clear, accessible, relevant, and up-to-date policies and procedures that reflected all relevant legislation and the Mental Health Act Code of Practice. Staff requested an opinion from a Second Opinion Appointed Doctor (SOAD) when they needed to.

Patients had easy access to information about independent mental health advocacy and patients who lacked capacity were automatically referred to the service. Information about the advocacy service was posted on the notice board in the communal room on the ward and how to contact them. During this inspection, we saw an advocate who was speaking to a patient.

Staff explained to each patient their rights under the Mental Health Act in a way that they could understand, repeated as necessary and recorded it clearly in the patient's notes each time. There were documents which gave evidence of informed consent which was signed by patients. The documents had treatment plans.

Staff made sure patients could take section 17 leave (permission to leave the hospital) when this was agreed with the Responsible Clinician. We reviewed patients records of leave from the ward into the community, granted by the consultant psychiatrist. The conditions of leave were clearly documented. For example, we saw that the location of leave, time and duration and the numbers of staff required to support the patient was clearly recorded. Staff organised trips out in minibuses for those who had section 17 leave to go out to the community to places such as the goat sanctuary.

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

Requires Improvement

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

Mental Health Act documentation for detained patients was in place and completed correctly.

Informal patients knew that they could leave the ward freely and the service displayed posters to tell them this.

Managers and staff made sure the service applied the Mental Health Act correctly by completing audits with the findings made available to all staff.

Staff at the service were fully supported by a Mental Health Act administration team. They provided support and advice when needed and oversaw the renewals of detention under the MHA, consent to treatment and appeals against detention. For example, we saw that MHA paperwork contained evidence of informed consent, treatment plans and required paperwork for detained and informal patients.

The MHA team completed regular audits to ensure records and practice was in line with current legislation.

### Good practice in applying the Mental Capacity Act

**Staff supported patients to make decisions on their care for themselves. They understood the trust policy on the Mental Capacity Act 2005 and assessed and recorded capacity clearly for patients who might have impaired mental capacity.**

Staff received and kept up to date with training in the Mental Capacity Act and staff we spoke with had a good understanding of the five principles.

There was a clear policy on Mental Capacity Act which staff knew how to access, and they also knew where to get accurate advice on the Mental Capacity Act within the provider organisation. Staff we spoke with were aware of the policy and how to access it. Staff we spoke with demonstrated a good understanding of the MCA.

Staff gave patients all possible support to make specific decisions for themselves before deciding a patient did not have the capacity to do so. We observed capacity assessments recorded for patients where there was doubt about their ability to consent to treatment. Staff gave an example of when MCA was used appropriately to treat a patient.

Staff assessed and recorded capacity to consent clearly each time a patient needed to make an important decision. For example, staff told us MCA was recorded and regularly reviewed by the psychiatrist for informal patients.

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

No patients were subject to Deprivation of Liberty Safeguards (DoLS) at the time of our inspection.

## Is the service caring?

Requires Improvement

Our rating of caring went down. We rated it as requires improvement.

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

Requires Improvement

## Kindness, privacy, dignity, respect, compassion, and support

**Staff did not always treat patients with compassion and kindness. They did not always respect patients' privacy and dignity. They did not always understand the individual needs of patients and did not always support patients to understand and manage their care, treatment, or condition**.

We spoke with 11 patients on Roseacre and Bearsted wards and feedback was mixed. The feedback we received about the night staff was mainly negative. Four patients said the night staff were disrespectful, not caring and did not respect their privacy and dignity. Patients described the night staff as unapproachable, impolite, unkind and not helpful. Patients told us some staff always communicated in a foreign language.

One patient said the night staff rushed them to go to bed. However, feedback we received about the day staff was largely positive. Patients described the day staff as approachable, polite, kind, and respectful. We observed that staff greeted patients in a friendly manner and were respectful during conversations, appeared engaged and responded appropriately.

All patients we spoke with told us they were kept up to date with changes to their medicines, treatment, and discharge plans.

Staff directed patients to other services and supported them to access those services if they needed help. For example, staff supported patients to attend GP appointments.

Staff felt that they could raise concerns about disrespectful, discriminatory, or abusive behaviour or attitudes towards patients.

Staff followed policy to keep patient information confidential and arranged to speak with patients in one of the ward's private rooms when needed.

### Involvement in care

**Staff involved patients in care planning and risk assessment and actively sought their feedback on the quality of care provided. They ensured that patients had easy access to independent advocates.**

### Involvement of patients

Staff introduced patients to the ward and the services as part of their admission. There was a 'Meet our nurses,' board with photographs of permanent staff on the ward displayed near the ward's reception. All patients received a welcome pack on admission. This included the ward's commitment to support patients to make their own choices, work towards independence, and feel good and proud. It had information on what to expect on the ward, including staff roles, mealtimes; smoking, phone and internet use, medication times, activities, therapies, visiting times, how to access fresh air, leave, contraband items and details of the different meetings that took place. The pack also contained information about how to make a complaint or give feedback.

Staff involved patients and gave them access to their care plans and risk assessments. Care plans were generally detailed and holistic, indicating some patients' involvement and views, although these were sometimes quite minimal. However, two patients told us they were not involved in their care plans, and they had not seen copies of their care plans.

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

Requires Improvement

Staff made sure patients understood their care and treatment and found ways to communicate with patients who had communication difficulties. For example, one patient on Bearsted ward who had communication difficulties was supported to have an interpreter. Staff printed document using the patient's preferred language which made it easier for the patient to understand their care and treatment.

Staff involved patients in decisions about the service, when appropriate. Patients could give feedback on the service and their treatment and staff supported them to do this. There was a board posted in the patient's lounge with information on 'You said, we did,' feedback on requests made by patients.

Patients and relatives we spoke with told us that staff listened to feedback and tried to make changes to the ward accordingly. For example, staff arranged trips away from the ward for following feedback from patients.

Staff made sure patients could access general advocacy services, with contact information made available to them as appropriate. All patients we spoke with were aware of the advocacy service and the support they offered.

**Involvement of families and carers**

**Staff informed and involved families and carers appropriately.**

Staff supported, informed, and involved families or carers and encouraged families to give feedback on the service. Most patients we spoke with told us their family were involved in their care. Most care plans we reviewed demonstrated family views and involvement. However, not all patients wanted their families involved in their care. Staff sought patient consent to share information with relatives before doing so. For example, at the point of admission, staff enquired from patients if they wanted their families involved in their care.

We saw evidence that home leave had been facilitated with the input of family members visiting the service. Family members were invited to attend ward rounds and other key meetings and were able to give feedback. Staff told us some carers chose to join ward rounds by phone, and others preferred a video call. We spoke with one family member who spoke positively about their involvement in their relative's care, and inclusion in ward meetings using video-conferencing facilities.

The service had carers lead across all wards. Carers were invited to attend events across the hospital sites and ward social worker liaised with patients' families. The service sent carers newsletter to all carers regarding upcoming hospital events. Carers were able to give feedback about the service via a carer survey form which was readily available online.

Staff gave carers information on how to find the carer's assessment. Managers told us that information regarding carers assessments were sent out to the patients next of kin, on admission.

## Is the service responsive?

Good

Our rating of responsive stayed the same. We rated it as good.

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

Requires Improvement

## Access and discharge

**Staff managed beds well. A bed was available when needed. Patients did not have to stay in hospital when they were well enough to leave. Discharge was rarely delayed for patients other than clinical reasons.**

On Bearsted ward, all admitted patients were detained under the Mental Health Act. Referrals came from NHS trust, private providers, prison services or via the criminal justice system. Bearsted ward admitted patients from across the country. Referrals that came through directly to the wards were triaged and assessed by the ward staff, ward managers, or a medical doctor.

Referrals received out of hours were screened by the hospital coordinator or the on-call duty manager. The ward doctor told us, all referrals were reviewed quickly within one hour, and decisions communicated back to the referrer to ensure patients had timely access to care and treatment. However, one staff on Roseacre ward told us that some referrals were sometimes unsuitable for the wards because they sometimes received limited information about the patient at the point of admission.

Roseacre ward accepted referrals from a range of sources including the NHS and private providers across the country. Patients were offered a meeting with the MDT and a visit to the service before they were admitted to the service.

At the time of the inspection, both wards were running at full capacity. The average length of stay was 14 days.

### Bed management

Managers regularly reviewed length of stay for patients to ensure they did not stay longer than they needed to.

Managers and staff worked to make sure they did not discharge patients before they were ready.

Staff did not move or discharge patients at night or very early in the morning. All admissions were planned and coordinated with the local mental health NHS trust who block booked the beds. Staff told us all admissions were planned and carefully assessed by the MDT who had the power to refuse inappropriate referrals.

Patients' beds remained open for as long as they were admitted on the ward, and they could access the bed at any time.

The psychiatric intensive care unit always had a bed available if a patient needed more intensive care and this was not far away from the patient's family and friends.

### Discharge and transfers of care

Discharges were planned, managed and well-established including supporting patients with self-medication. We saw documented evidence that consultants and the MDT appropriately reviewed patients prior to discharge and found that comprehensive admissions and discharge checklists were in place for staff to follow.

The wards planned discharge well. Social workers discussed discharge plan with patients as soon as they were admitted onto the wards. Managers held regular meetings with the commissioners and funders to plan discharge, and transition.

As part of discharge planning, patients were given increased periods of home leave and staff supported them to plan overnight visits home to the new placement. For example, one patient told us the staff facilitated home leave to prepare them for discharge.

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

Requires Improvement

Most patients were discharged back to their home area or to a supported living accommodation. Patients we spoke with told us about the plans for their discharge which had been discussed at the multidisciplinary team meetings.

At the time of the inspection, there were no delayed discharges on Roseacre ward. All the patients were in hospital because they needed inpatient care and treatment. Discharges on Bearsted ward was sometimes delayed due to bed shortages and lack of appropriate accommodation. The manager informed us the home teams were occasionally involved in ward rounds during discharge.

**Facilities that promote comfort, dignity, and privacy**

The design, layout, and furnishings of the ward supported patients' treatment, privacy, and dignity. Each patient had their own bedroom with an ensuite bathroom and could keep their personal belongings safe. There were quiet areas for privacy. Both wards were welcoming, with names of staff on shift clearly displayed, as well as the activities for the day.

Each patient had their own bedroom, which they could personalise. Patients could keep their personal belongings safe. The service had quiet areas and rooms where patient could meet with visitors in private and an outside space that patients could access easily. Patients could make phone calls in private.

The wards were spacious with access to open space and rooms. The wards had a quiet room which patients could access for privacy, a multifaith room and large communal room with access to a television, comfortable chairs and sofas, and a dining area. There were private rooms used for one-to-one sessions and meetings. A laundry room was also available on each ward.

The hospital had a gym room, which was well equipped, and patients could use the facility following an induction, physical assessment by the doctor and with staff supervision. On Bearsted ward, there was a boxing punch bag available for patients to use for exercise and stress relief.

The wards also had a dedicated family room. The room was very well furnished and decorated. It was welcoming for both adults and children, with plenty of seating, toys, and access to a designated outside space which had additional seating and outside games.

Patients could make hot and cold drinks in the communal area on both wards. However, on Bearsted ward, whilst hot water and tea/ coffee were readily available for patients, they had to request cups from staff which were stored in the locked kitchen. Snacks were available on request.

Patients that were risk assessed to have access to their own cups always had access to their own cups to make hot drinks. However, patients we spoke with on both wards reported that some night staff prevented them from making hot drinks.

The hospital offered a choice of food to meet dietary requirements of religious and ethnic groups. The OT told us the ward held a cultural cooking group session where patients were encouraged to cook from their various cultures.

While most patients thought the hospital's food was good, two patients said they were not always happy with the vegetarian options available, and the food was not always great. Two patients reported they were not very happy with the portion sizes.

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

Requires Improvement

The hospital had a designated family room. The room was well furnished and decorated. It was welcoming for both adults and children, with good seating, toys, and access to a designated outside space which had additional seating. Both wards had their separate secure garden space with astroturf flooring, picnic tables, punch bag, table tennis, space for field games and furniture to relax on. The wards also had a new beach area with sand and landscaping. Part of the garden area was sheltered by a roof so could be used by patients in all weather.

Both wards had separate rooms for patients to make phone calls in private, they had rooms that offered quiet space for patients and had a computer room. Furnishings and fittings on both wards were in good condition. There were paintings and pictures on the walls within the communal areas to make the place welcoming and personalise the environment for the patients.

**Patients' engagement with the wider community**

**Staff supported patients with activities outside the service, such as work, education, and family relationships.**

Staff made sure patients had access to opportunities for education and work, and supported patients. Patients accessed the providers recovery college and had access to educational and vocational courses. The recovery college offered educational courses designed to provide increased understanding of mental health and support people through their recovery, promoting hope, opportunity, and aspirations for the future. They worked with individuals on their personal recovery journey.

The hospital had developed some vocational roles across the hospital which patients could engage in. These included gardening, maintenance, cleaning and running the patients' shop which patients could volunteer to work in on a rota basis, dependent on assessment.

Staff told us on the weekends, staff organised trips on minibuses for patients who had section 17 leave to visit the animal sanctuary, beach and patients utilised their leave from the wards, to engage in one-to-one time, relax, and socialise or participate activities such as arts and crafts.

The ward had a co-production with patients as part of a therapeutic programme to give patients the opportunity to take control of their own care. For example, patients who were on self-catering programme received a budget and went out to purchase their own ingredients which they used to cook a meal for themselves.

Staff helped patients to stay in contact with families and carers.

Staff encouraged patients to develop and maintain relationships both in the service and the wider community such at local gymnasium, library, and shops.

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

**The service met the needs of all patients – including those with a protected characteristic. Staff helped patients with communication, advocacy, and cultural and spiritual support.**

A lift was available in the service to ensure that people who could not use the stairs could access both wards and other areas of the hospital. The corridors and doorways were wide for disability access. The bathroom on both wards was adapted to support people with disabilities and was equipped with a mobile hoist.

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

Requires Improvement

During the inspection, we saw that numerous posters and noticeboards were on the walls informing patients of advocacy, the Mental Health Act, how to complain, safeguarding and activities. Although all information were written in English, staff told us that information could be provided to patients in other languages if needed.

The hospital had a locally contracted interpreting and translation service. Staff were familiar with and knew how to access these services. We saw that staff were providing regular interpreter services for a patient who required this to participate in planning his care and treatment.

The hospital offered a choice of food to meet dietary requirements of religious and ethnic groups. Patients we spoke with reported mixed feelings about the quality of food they received.

Patients had access to spiritual, religious, and cultural support with a multifaith room available for their use on the ward. Staff told us how they had supported patients to observe religious festivals and a Muslim patient was supported to see an Imam. Staff told us they could facilitate church visits for those who wished to attend.

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

**The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team and wider service.**

Patients, relatives, and carers knew how to complain or raise concerns. The service displayed information about how to raise a concern on the ward and in the brochure for patients and carers.

The service clearly displayed information about how to raise a concern in patient areas. We observed information boards and leaflets on all wards stating how patients and carers could complain.

Staff understood the policy on complaints and knew how to handle them. They acknowledged complaints and patients received feedback from managers after the investigation into their complaint.

Managers investigated complaints and identified themes.

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

Managers shared feedback from complaints with staff and learning was used to improve the service. However, one carer told us they did not receive feedback after they complained to the staff and the initial communication with the staff was poor.

The service also used compliments to learn, celebrate success and improve the quality of care on the ward.

## Is the service well-led?

Requires Improvement

Our rating of well-led went down. We rated it as requires improvement.

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

Requires Improvement

**Leadership**

**Leaders had the skills, knowledge, and experience to perform their roles. They had a good understanding of the services they managed and were visible in the service and approachable for patients and staff.**

At the previous inspection in 2019, we told the provider to ensure the manager and leadership team on Bearsted ward received the support to develop the skills so they could manage the ward with confidence. At this inspection, the manager of Bearsted ward told us they received great mentorship from the leaders and the leaders focussed on developing the managers.

The provider had enrolled the manager on leadership training course. The leadership team provided peer support for all the other managers. The service offered leadership training to some nurses.

Ward managers on both Roseacre and Bearsted wards had a good understanding of the services they managed, were visible and accessible to staff and patients. Staff said their managers were very supportive and managers said they felt supported by senior leadership team. The leadership team were experienced, had the knowledge and skills to undertake their roles and had a good understanding of the services and their challenges. Leaders empowered staff to develop ideas to improve the care of patients.

**Vision and strategy**

**Staff knew and understood the provider's vision and values and how they applied to the work of their team.**

Staff explained that the vision of the wards was to provide high quality, sustainable specialist services that ensured patients felt safe and supported.

Staff on both wards felt that these were reflected by their team and the service they provided. Managers on both wards ensured team objectives reflected those of the organisation through team meetings, supervision, and appraisals.

Managers had regular team development days to discuss ward models which fed into the vision and strategy. The vision was communicated to staff through emails and through posters around the hospital.

**Culture**

**Staff felt respected, supported, and valued. They said the trust promoted equality and diversity in daily work and provided opportunities for development and career progression. They could raise any concerns without fear.**

Staff on both Bearsted and Roseacre wards said they felt motivated, were passionate about the development of the service and found the hospital to be a good place to work. Staff spoke positively about the service, described the atmosphere on the wards as friendly and patient centred. Staff also said their team worked well together. New staff including staff from overseas said they felt welcomed to the ward by the multidisciplinary team.

All staff we spoke to felt comfortable raising issues directly with senior colleagues and were confident these would be addressed.

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

Requires Improvement

Staff at all levels told us they felt valued, had input into the service, and were consulted and involved in service quality improvement.

Staff we spoke with talked positively about their roles and were passionate about their services. Staff felt able to raise concerns without fear of victimisation and spoke positively about the organisation. Staff members at all levels told us they felt valued, had input into the service, and were consulted and involved in service quality development.

At the time of the inspection, managers told us no grievance procedures were being pursued within the wards and there were no allegations of bullying or harassment.

Staff were aware of the provider's whistleblowing policy and knew how to use the whistleblowing process. Staff said they could raise concerns directly with senior management and they described the culture as being very open and honest. They felt confident that their concerns would be acted upon without recourse to the whistleblowing procedure.

**Governance**

**Governance processes around the management of patient safety risks needed improvement. Risk assessments and audits around ligatures and medicines management were not robust. However, leaders had the skills and experience to manage the service.**

The provider did not ensure that ward managers and the maintenance team had the right training and experience to undertake a detailed and comprehensive ligature risk assessment. We saw that the ligature risk audits were nearly identical across all wards. Ligature audits were completed at random for each about four bedrooms per ward annually, which meant that potential risks on all other bedrooms were not assessed and there were no mitigations in place to remove the risks. Staff and managers agreed that more needed to be done to make the ligature risk assessment more robust following feedback. The provider was developing an action plan to address concerns we raised.

The provider did not ensure that all staff including new starters had a robust induction around managing ligature risks. Staff did not know how to use the ligature risk assessment tool, while some staff had not even seen the tool, even though they were required to sign to say they had understood the policy and procedures.

The provider had not responded to previous concerns raised by the pharmacy audit around medicines administration and recording of controlled drugs use. We saw on both wards a number of medication errors and poor recording which had not been addressed via a clear action plan.

Hospital clinical governance meetings reviewed a wide range of quality and safety information, including ward community meeting minutes, infection control audits, incident reports and complaints. The minutes of the clinical governance meetings were stored on the staff intranet so that all staff could access and read them.

The service used a performance dashboard to monitor key aspects of care of treatment. The dashboard was used to rate key aspects of performance including the amount of therapeutic activity, key documentation, numbers of restraints and seclusions, admissions and discharges and staffing across the wards. Ward managers were familiar with the dashboard and said they used the findings to improve the quality of care on their respective wards.

**Management of risk, issues, and performance**

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

Requires Improvement

**Teams had access to the information they needed to provide safe and effective care and used that information to good effect.**

The provider had a risk register to capture, monitor, and address all risks at the hospital. Staff maintained and had access to the risk register at hospital level. The risk register acted as a formal mechanism for the managers, senior managers, and board of directors to assess and manage risks. Ward managers could escalate concerns when required. Managers told us the risks listed on the register were discussed at the clinical governance meeting. However, risks we found during this inspection were for example around poor medicines management were not recorded on the risk register.

The provider learnt from complaints and patient feedback was identified and actions were planned to improve the service. Staff and patients were involved in post incident de-briefs and review processes. However, the provider did not always ensure that learning from incidents were embedded.

**Information management**

Staff had access to sufficient equipment and information technology to do their work. There was a secure record keeping system that was easily available to staff to update patient care records and to review when needed. Managers had systems and dashboards in place to support them in their role. This included information on staffing, supervision and appraisals, training, and service performance data.

The provider ensured that patient' data were managed safely. Stored had received confidentiality training and there were practical measures in place such as staff training, files stored in locked cupboards and rooms to ensure the safety of information. Information was only shared with other professionals and agencies when appropriate.

**Engagement**

The service prioritised engagement with the patients to give patients the opportunity to give feedback about the services they received. Each ward had a weekly community meeting where patients could raise any concerns or suggest areas for improvement. These were then communicated through 'you said, we did' boards which were on each ward so patients could see what actions had been taken.

Service leaders invited patients to attend the monthly information governance meetings, so they could contribute to quality monitoring and improvement. The service had also set up a 'people's council' whose aim was to ensure the people's views were represented across the service.

The service had a newly established carer's group and monthly newsletter. Each ward had an identified carer's lead.

Service leaders made efforts to engage with the wider community.

**Learning, continuous improvement and innovation**

The hospital management team were committed to continuous improvement of the service.

The hospital had introduced Springbank model for Roseacre ward. Springbank derived its name from a specialist mental health ward called Springbank which is dedicated to supporting women with borderline personality disorder.

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

Requires Improvement

The Springbank model offers a range of therapeutic activities and fun outings to build up skills to help individuals struggling with the demands of independent community living. We were informed the Springbank model worked well with informal patients and it gave them shared responsibility for keeping themselves safe and avoiding restrictions of the MHA 1983.

The provider was in process of applying for the Quality Network for Psychiatric Intensive Care Units (QNPICU) accreditation for Bearsted ward. The QNPICU adopts a multi-disciplinary approach to quality improvement, with a key component of their work being the sharing of best practice through the facilitation of peer-review visits.

The provider had introduced a new initiative called Oak therapy, which was a nature and animal-based therapy service for patients and staff. They offered unique and creative approaches to therapy within the tranquillity of a non-clinical setting. They helped people grow and flourish while supporting caregivers with the aim of to create a safe and nurturing space where everyone could find the help, they needed to live their best lives.

The team on Roseacre ward is exploring the possibility to develop a dialectical behavioural therapy (DBT) outpatient service. DBT is a proactive behavioural therapy specifically designed for patients with a diagnosis of personality disorder who required active engagement. It was designed to support individuals to manage distress, regulate emotions and develop adaptive coping skills. Interventions were based on individual needs and assessment and delivered on a one-to-one basis or in a group.

The service had a recovery college to ensure that patients and staff could have access to a range of mental health related education and personal development. The recovery college offered educational courses designed to provide increased understanding of mental health and support people through their recovery, promoting hope, opportunity, and aspirations for the future. They worked with individuals on their personal recovery journey.

The provider was in the process of introducing Safewards to the hospital. The aim of Safeward was to minimise conflicts between healthcare workers and patients that could lead to the use of restrictive interventions.

# Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

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

## Is the service safe?

Requires Improvement

Our rating of safe went down. We rated it as requires improvement.

### Safe and clean care environments

**All wards were clean well equipped, well furnished, well maintained and fit for purpose. However, the risks within the environment were not always assessed and mitigated appropriately.**

### Safety of the ward layout

Managers completed a ligature risk assessment audit of the ward. This was kept in the nursing station, along with a footprint map which showed staff where the ligature equipment and emergency equipment were located on the ward. However, the ligature risk assessment audit was not always clear about all potential ligature anchor points and had generic mitigations to keep patients safe. For example, some individual ligature points in patient bedrooms were not mitigated against, some of the ligature risks identified were described as “anti-ligature features” and some of the ligature assessments were generalised as “see bedroom 1”. Some mitigations were not always specific to each ligature risk, for example, they only included general observations or individual risk assessments for bedroom risks. We fed this back at the time of the inspection and leaders were open in recognising the lack of confidence and need for improved oversight and understanding by managers of ligature risk assessment audits. Due to the nature of the concern, the provider was given a warning notice immediately post-inspection to address this concern. Both managers and staff did advise us that at the time of the inspection all patients on the ward were assessed as low risk of self-harm and/or suicidality. Managers told us that in the event of the risk increasing, appropriate enhanced observations would be put in place.

The provider informed us following the inspection that there had been no ligature incidents on the ward in the last 12 months.

Staff could observe patients in all communal areas and staff followed procedures to minimise risks where they could not easily observe patients, such as patient bedrooms. The nursing station for the ward was central to the communal areas of the ward and had clear visibility into the main lounge and dining areas, as well as the bedroom doors. Convex mirrors

also aided visibility down the bedroom corridor. The ward had closed circuit television (CCTV) which was reviewed regularly for audit purposes and when incidents occurred to identify learning. Staff ensured that all patients had at least hourly observations, although this was increased if the presenting risk required this. It was clear which staff members were allocated this responsibility and we saw that these observations were happening as prescribed.

The ward complied with national guidance and there was no mixed sex accommodation.

Staff had easy access to alarms and patients had easy access to nurse call systems. The service carried out monthly health and safety audits.

### Maintenance, cleanliness and infection control

Ward areas were clean, well maintained, well-furnished and fit for purpose. Patients told us that the ward was cleaned daily and that there was a weekly rota for the cleaning of their bedrooms. We observed housekeeping staff on the ward during our inspection. Cleaning records were in place and up to date.

Staff followed infection control policy, including handwashing. There was an infection control notice board within the main ward area and infection control concerns were discussed as part of the senior management team daily meeting. The service had 100% compliance in a recent hand hygiene audit and infection, prevention and control audits were carried out quarterly.

### Clinic room and equipment

Clinic rooms were fully equipped, with accessible resuscitation equipment and emergency drugs that staff checked regularly. The clinic rooms were spacious and tidy and there was a separate room for the medication administration.

However, we did find that the emergency bag checklist template on Kingswood ward did not include the entire contents that required checking. This meant that staff responsible for checking were having to write down the additional items and we saw instances when there were items missing from the document. Nurses were responsible for auditing the checks of these items. This increased potential of items being missed or not checked as appropriate. Additionally, the emergency bag seal itself required cutting with scissors to access the contents. This was not standard whereby it could be ripped off. This meant tools required to cut open the seal may not always be readily available and could impact the timeliness of responding to a patient in an emergency.

We did not find any cleaning rotas or cleaning audits for the clinic room. We could therefore not be assured that staff always fully maintained and cleaned equipment, or that any actions identified from audits were followed up.

### Safe staffing

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

Nursing staff

The service had enough nursing and support staff to keep patients safe. Staff told us that the service was rarely short staffed and that this usually only happened in the event of sickness. They also told us that they were able to cover these shifts through overtime, agency, or bank staff. However, concerns were expressed in a team meeting in March 2023 whereby staff felt that there was a lack of staff leading to the ward being quite challenging and overwhelming. For

example, staff identified that they were not able to take regular breaks. Senior members of the multidisciplinary team recognised that there were specific challenges from certain patients at this time and plans were being made to move them to a more appropriate setting. At the time of inspection, managers told us these moves had happened and that this had a positive impact on the ward which was more settled. We observed it to be calm during our time on the ward.

At the time of the inspection, the service had low vacancy rates. Managers told us there was currently only one vacancy for a qualified nurse which was yet to be advertised with one nurse recruited and currently going through the process of onboarding.

The service had low and reducing rates of bank and agency nurses and support staff. The service provided us with data for the entire hospital which showed they currently used 22% agency nursing and care staff, which was a reducing figure. This figure included an equivalent of two full time nurses and 30 full time support staff. There were 11 full time equivalent bank staff used across the hospital.

Managers limited their use of bank and agency staff and requested staff familiar with the service. We spoke with both agency and bank staff during our inspection who told us they had previously worked on the ward and were familiar with the patients.

Managers made sure all bank and agency staff had a full induction and understood the service before starting their shift. The service gave ward-specific inductions to bank and agency staff who were not familiar with the ward. This included necessary information for working on the ward. The ward had handovers at the start of both day and night shifts to ensure that necessary information about patients was shared.

The service had low turnover rates. The data provided for the hospital showed a staff turnover rate of 7%.

Managers supported staff who needed time off for ill health. The service provided a 2022 staff survey for the entire hospital which identified that 85% of staff agreed their manager took an interest in their health and wellbeing. Although, 58% of staff had identified in the 3 months prior, they had gone into work despite not feeling well enough and 18% had felt pressure from their manager to come to work.

Levels of sickness were reducing. The data for the overall hospital showed sickness levels were reducing. The provider gave data for the hospital site which showed that for the sickness hours for February were 946, March 926 and April 746.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants for each shift. The service had a staffing matrix which they used to calculate the numbers of each grade required for a shift dependent upon patient numbers. The ward manager told us that they could adjust staffing levels according to the needs of the patients.

Patients rarely had their escorted leave or activities cancelled, even when the service was short staffed. All patients told us their leave was only cancelled due to behavioural or risk concerns. We saw each patient had their care team details noted on a board in the main communal area, so they knew which staff were caring for them.

### Medical staff

The service had enough daytime and nighttime medical cover and a doctor available to go to the ward quickly in an emergency. Managers made sure all locum staff had a full induction and understood the service before starting their shift.

The ward had an acting consultant psychiatrist, whereby this senior staff member was temporarily assuming the responsibilities of this position whilst awaiting accreditation, and a speciality doctor. The doctor and consultant provided out of hours duty cover to respond to emergencies. We were told that they attended the site within 15-20 minutes in an emergency.

### Mandatory training

Most staff had completed and kept up to date with their mandatory training. The ward was currently 91% compliant with the provider's mandatory training list. However, there were some courses lower in their completion including ligature rescue training, whereby only 65% of staff had up to date training. The remaining 35% of staff were identified as awaiting initial assignment. Given the concerns in relation to the ligature risk assessments on the ward, this impacted our assurances as to the service's ability to safely care for patients in respect of ligature risk. Other courses lower in completion included Fire warden e-learning at 75% and Safeguarding Individuals at Risk (intermediate) (virtual classroom) and the Safeguarding programme which were at 61.5% completion rate.

The mandatory training programme was comprehensive and met most of the needs of patients and staff. The provider offered training on the Prevention Management of Violence and Aggression (PMVA) to staff who worked with patients. This training assists staff working with violent and aggressive behaviour to effectively approach and manage these situations, in a way that prioritises the safety of both staff and those in their care.

Managers monitored mandatory training and alerted staff when they needed to update their training. Managers told us that they received alerts each month as to any outstanding and overdue training of staff in their team so they could remind staff. We saw evidence in team meeting minutes that managers reminded staff to check their training accounts for upcoming training.

### Assessing and managing risk to patients and staff

**Staff followed best practice in anticipating, de-escalating and managing challenging behaviour. As a result, they used restraint and seclusion only after attempts at de-escalation had failed. The ward staff participated in the provider's restrictive interventions reduction programme. Although, the provider did not have a mandatory training course to assist staff in preventing and managing incidents of conflict and aggression safely.**

### Assessment of patient risk

Staff completed risk assessments for each patient on admission, using a recognised tool, and reviewed this regularly, including after any incident. Staff used a short-term assessment of risk and treatability (START) risk assessment. Risk assessments were updated every three months unless there was an identified change in risk. All patients risk assessments were thorough and appropriately care planned where relevant.

Patients also had individual risk assessments in place for example, for the use of the kitchen on the wards, to have their own bedroom keys and access to mobile phones. Managers told us that they tried to enable as much independence as possible, where safe to do so.

### Management of patient risk

Staff knew about any risks to each patient and acted to prevent or reduce risks. For example, one patient on the ward was at risk of low sodium due to excess fluid intake and we saw appropriate risk management plans in place to help staff manage this. There was also a multidisciplinary team (MDT) approach to this, and we observed this during a ward round. There was also MDT input into the assessment of referrals. This enabled more holistic screening of the presenting risks, and whether these could be safely managed on the ward.

Staff identified and responded to any changes in risks to or posed by patients. Managers held daily meetings for the entire hospital to discuss a range of information which included any emerging risks or incidents.

Staff followed trust policies and procedures when they needed to search patients or their bedrooms to keep them safe from harm. The ward had a secure room where contraband items such as cigarettes and lighters were kept, and given to patients upon leaving the ward. This enabled staff to keep record of these items. Staff told us they did not carry out a full search of everyone upon return from leave as this was deemed restrictive and they opted for positive risk management. This was in line with the operational policy for the ward. Managers told us full body searches and room searches were done if concerns were present and gave an example of this taking place for a patient who was suspected of bringing contraband onto the ward.

Staff shared key information to keep patients safe when handing over their care to others. A daily handover took place every morning and every evening to ensure that staff on different shifts were aware of any updates within the past 24 hours to patient presentation, Section 17 leave, compliance with treatment, risk concerns and medicine changes. We observed a morning handover meeting and saw that this was attended by the multidisciplinary team and all patients were discussed comprehensively. Any significant concerns were taken forward to the hospital wide meeting. The service held a monthly Clinical Information Governance (CIG) meeting for the ward whereby the MDT reviewed incidents, safeguarding and any other risk concerns for the ward and fed this into the wider clinical governance for the hospital.

### Use of restrictive interventions

Staff participated in the provider's restrictive interventions reduction programme. They held monthly positive and safe meetings which senior leadership and ward managers attended. Staff told us that within these meetings feedback from community meetings around any restrictions is reviewed to see whether a new approach could balance safety and risk more appropriately for patients. They also reviewed the blanket restrictions six monthly. The service had the blanket restrictions for the ward visible within the communal area and invited patients to feedback any concerns around these to staff. These included limited access to the kitchen (which was risk assessed), regular and random searches for contraband, set smoking times and control over portion sizes.

Levels of restrictive interventions were low. Staff told us that they made every attempt to avoid using restraint by using de-escalation techniques and restrained patients only when these failed and when necessary to keep the patient or others safe.

The specific data provided to us by the service for restraints showed there had been no recorded restraints for Kingswood ward over the past 12 months. However, separate data provided on incidents showed that restraint had been used five times in the last three months. Staff told us that the use of restraint was rare on the ward. Although the specific data drawn on restraints and rapid tranquilisation and provided to us by the provider did not accurately reflect the information recorded within the incidents, the provider has since informed that there had been an error in the data shared at the time of the inspection. They advised that all incidents of rapid tranquilisation and restraints were recorded at their daily flash meeting.

On occasions they had to restrain people's movement to guide them to their bedrooms or the de-escalation room by the way of arm/wrist holds which we saw was recorded within the incidents. The data provided by the service to specifically show the figures of rapid tranquilisation used on the ward showed its last use in August 2022. However, incident record data showed there was at least one incident recorded in March 2023 where rapid tranquilisation medication was given. Given that the specific data drawn on restraints and rapid tranquilisation and provided to us by the provider did not accurately reflect the information recorded within the incidents, we did not have assurance that all forms of restrictive interventions were always identified from incidents and recorded for accurate oversight.

# Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

The ward had a de-escalation room with comfortable furniture, access to toileting facilities and an outside space. This space afforded patient privacy and dignity in a space away from the communal area where they could calm down if they were feeling agitated.

## Safeguarding

**Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.**

Staff received training on how to recognise and report abuse, appropriate for their role. Some staff kept up to date with their training. There was a Safeguarding Individuals at Risk (intermediate) E learning which had been completed by 92% of staff and a Safeguarding Individuals at Risk (intermediate) introduction which had been completed by 100% of staff. Although, Safeguarding Individuals at Risk (intermediate) (virtual classroom) and the Safeguarding programme were both at 61.5% completion rate. There was a system to alert managers when staff needed to complete or refresh their training.

Staff knew how to recognise adults and children at risk of or suffering harm and worked with other agencies to protect them. The hospital worked closely with the local authority and external agencies to ensure that it worked with others to action, report and seek advice. The service kept a log of referrals to monitor ongoing investigations and actions.

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

Staff knew how to make a safeguarding referral and who to inform if they had concerns. All staff were able to make referrals. The ward had recently employed a full-time social worker who was based on the ward.

## Staff access to essential information

**Staff had easy access to clinical information, and it was easy for them to maintain high quality clinical records – whether paper-based or electronic.**

Patient notes were comprehensive, and all staff could access them easily. Staff completed patient progress notes using the service's electronic record system which also contained risk assessments and care plans. The care plans included assessment and plans for personal needs, communication and social needs, mental health needs, rehabilitation needs, potential risks, physical health and arranged leave.

Records were stored securely. All records were stored on the electronic computer systems which required password access.

## Medicines Management

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

Staff followed systems and processes to prescribe and administer medicines safely. Staff completed medicines records accurately and kept them up to date. The service used an external pharmacy service to provide oversight of medication and documentation. The pharmacist visited weekly and told us that they carried out medication audits monthly, and comprehensive ones quarterly.

# Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

Staff reviewed each patient's medicines regularly and provided advice to patients about their medicines. We saw evidence of regular reviews. The ward doctor reviews patients' medication on a regular basis during ward rounds or as required if there was a change in the patient's presentation. We saw that one patient was on self-administration, with a plan in place to progress to the next stage.

All prescribing documentation was stored in the clinic room which was kept locked. The service did not have any controlled drugs, but they had "drugs that are liable to misuse". We checked these and saw that these were managed in line with national guidance. However, the index page of the book to check these was not completed. This increased the potential risk of human error and a wider impact of potential stock levels not being correctly identified.

Medication was in date and not overstocked. We saw the stock medication was well arranged and there was no evidence of excess stock. Although, there was no stock list available. Staff told us that nurses carried out checks of expiry on stock, yet there was no evidence to support this.

Staff followed national practice to check patients had the correct medicines when they were admitted, or they moved between services. Staff reviewed patients' medicines and clinical records when they were admitted making sure they had the correct medicines.

Staff learned from safety alerts and incidents to improve practice. There was an incident which happened in April whereby a patient was administered another patients' intramuscular medication that was not prescribed to them. To prevent this happening again, the lessons learnt from the provider identified that best practice protocols were reminded to staff responsible for administering medication, including asking the patient for their name and date of birth, instead of relaying these details for confirmation. In addition, medication cards were to have clear photographs of the patient on.

The service ensured people's behaviour was not controlled by excessive and inappropriate use of medicines. We saw that five patients were prescribed more than one antipsychotic but were assured that this was well managed.

Staff reviewed the effects of each patient's medicines on their physical health according to NICE guidance. Staff told us that physical health observations were carried out daily on admission and weekly thereafter. We saw that monitoring was done to the recommended standard for patients prescribed Lithium and Clozapine.

### Track record on safety

The service had a good track record on safety.

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

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

Staff knew what incidents to report and how to report them. Incidents were discussed at MDT handovers, hospital daily flash meetings, and ward rounds.

Staff reported serious incidents clearly and in line with trust policy. The service recorded all incidents using an electronic incident management system. For example, we reviewed the incident management system and saw that two incidents which had been discussed at the daily meeting had been recorded on the system at the time these had taken

place. The incident reports were thorough and recorded the relevant information. The service had 69 incidents recorded from March to May 2023. The main themes seen in the incident data provided and within the incident records reviewed onsite included contraband (drugs), absence without official leave (AWOL), verbal threats, security, violence and aggression.

Staff made appropriate notifications to external agencies such as the CQC and the local authority when required. Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation when things went wrong.

Managers debriefed and supported staff after any serious incident. Managers and staff told us debriefs happened after serious incidents. They also engaged in reflective practice with the support of psychology staff to reflect and discuss any serious incidents.

We saw evidence that lessons learned, including those from other Cygnet locations, were shared in weekly staff briefings, as well as ward-based staff team meetings which were minuted. However, team meetings were not always consistently held.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations. Staff received feedback from investigation of incidents, both internal and external to the service. For example, we saw that as a result of an incident which took place on the ward where a patient's oxygen levels went down to 85% and who was not placed on oxygen until advised by the on call manager, all nursing staff had been told that if a patient has low saturation levels, they must be given oxygen. The service also discussed with nurses to ensure their confidence in administering oxygen and to identify any additional training needs.

## Is the service effective?

Requires Improvement

Our rating of effective went down. We rated it as requires improvement.

### Assessment of needs and planning of care

**Staff assessed the physical and mental health of all patients on admission. They developed individual care plans which were reviewed regularly through multidisciplinary discussion and updated as needed. Care plans reflected patients' assessed needs, and were personalised, holistic and recovery-oriented.**

Staff completed a comprehensive mental health assessment of each patient either on admission or soon after. Staff told us they completed thorough assessments to identify their needs. Staff developed comprehensive care plans for each patient that met their mental and physical health needs.

Patients had their physical health assessed soon after admission and regularly reviewed during their time on the ward. Staff told us that when patients were admitted they had a physical health examination. We reviewed eight care plans and saw evidence of regular physical health reviews within patients care plans. These included blood tests and electrocardiograms (ECG).

# Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

Staff regularly reviewed and updated care plans when patients' needs changed. Managers told us care plans were reviewed and updated each month unless any significant changes required this to be done sooner. We saw good evidence of previous reviews.

Care plans were personalised, holistic and recovery-orientated. We saw good evidence of multidisciplinary team input into care plans to make them holistic and recovery orientated. We also saw that these were personalised, and that patients' views were clear in most, although there were two where this was not so evident. However, all patients we spoke with told us they were involved in their care, and we saw patients' involvement and knowledge of their treatment plans in the ward rounds that we attended.

### Best practice in treatment and care

**Staff did not always provide a range of treatment and care for patients based on national guidance and best practice. Patients were engaged in therapies; however, patients were not always actively engaged in meaningful activities and the recorded activity and engagement was not appropriate for a rehabilitation ward. Staff supported patients with their physical health and encouraged them to live healthier lives. Staff used recognised rating scales to assess and record severity and outcomes. They also participated in clinical audit, benchmarking and quality improvement initiatives.**

Patients we spoke with told us that there were lots of therapies available and four patients told us how they had found these helpful. We saw a provision of therapy focused programmes available on the ward including coping skills, social skills, art therapy, community clinics, psychology and occupational therapy clinics. There was a therapy dog that visited the hospital once a week which helped to offer comfort and affection to people who were dealing with physical and emotional problems. Leaders also told us about their links with a local outdoor therapy centre which provided equine therapy and eco sensory therapy. Staff told us the therapy timetable was reviewed quarterly and they sought feedback from patients on what they did or did not enjoy. For those with access to Section 17 leave, we saw that arrangements were made for patients to go shopping, on grounds walks and visits to the local restaurant/shopping centre as well as visits with relatives. There were also monthly community social activities such as a trip to the beach and a theme park.

However, there appeared to be a lack of meaningful activity provision which upskilled patients ready for their discharge back into the community. There was an activity cupboard on the ward which identified board games, puzzles, and arts and crafts and there was also a pool table, table tennis table, games console and books. Patients had access to an IT room and TVs in their bedrooms and lounge. There was also an Activities of Daily Living kitchen which patients, where risk assessed, could use as part of activity or for two hours a day for self-catering, although we did not see this in use during our onsite visit. A daily planning meeting was scheduled to take place every morning where patients could attend and plan their activities for the day. We did not see all patients attend this.

During evenings and weekends there was a focus on self-directed and ward based activities which relied on support and nursing staff to organise delivery of, whilst managing the other ward tasks. Some staff told us that they did not often observe any activity taking place on the ward. NICE guidelines state that "patients in hospital for mental health care should be able to access meaningful and culturally appropriate activities 7 days a week, not restricted to 9am to 5pm". Some patients told us that smoking breaks were activities for them and that the available activities were not what they liked to do. Four of the five relatives we spoke with raised concerns about the activity provision both on and off the wards. One told us their loved one did not have a lot going on all day and another told us their loved one was not inspired to get up and do anything. A further relative told us how their loved one had started smoking again since being there.

# Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

We saw some care plans lacked identification of recovery focus and life skill improving activities suitable for a rehabilitation service and ward round discussions also lacked evidence of patients being offered individual areas of interest activities, except for generic group ones. The provider has since provided evidence for one patient that showed occupational therapy inputs of meaningful activity recorded on care plans. They told us that occupational therapy met with patients twice a month to review care plans, including within ward rounds.

In recent clinical governance meeting minutes where oversight of meaningful activity was reviewed, it was noted the percentage of patients achieving 25 hours of meaningful activity per week had decreased on the ward in both March and April 2023 yet there was no action taken forward from this information. Team meeting minutes we reviewed, there was no discussion around the activities on the ward, and in May's minutes the agenda item "community trips/activities on the ward" was blank. Leaders, managers and staff all identified that engagement and motivation from patients was an issue, although some staff felt that the ward would benefit from an activity coordinator to assist with improving this. Leaders told us they were exploring budgets for a bespoke role to enable better provisions of activity on the ward.

Staff identified patients' physical health needs and recorded them in their care plans. Staff made sure patients had access to physical health care, including specialists where needed. They were registered with a local GP service.

Staff met patients' dietary needs and assessed those needing specialist care for nutrition and hydration. One patient had a specific care plan and risk assessment for fluid intake due to excess fluid intake and low sodium levels. This patient was on a fluid monitoring chart.

Staff helped patients live healthier lives by supporting them to take part in programmes or giving advice. The service had a dietician and patients were encouraged to eat healthily with a range of information available in communal areas and guidance on menu choices. They had a blanket restriction on there not being any control over portion sizes to support patients with health promotion. The service also had a gym which patients could access every day. Smoking cessation support was also available, and patients had access to nicotine replacement therapy.

Staff used recognised rating scales to assess and record the severity of patients' conditions and care and treatment outcomes. For example, the Health of the Nation Outcome Scales, Model of Human Occupation Scale and Daily Living Skills Observation Scale (DLSOS). DLSOS tracks functionality and the ability to successfully live an independent life in the community. In clinical governance meeting minutes from April, where DLSOS was reviewed as part of effectiveness, we saw a discharge from Kingswood ward had shown an improvement in their DLSOS.

Staff took part in clinical audits, benchmarking and quality improvement initiatives. The service had a clinical audit schedule and also carried out quality walk arounds. Managers used results from audits to make improvements.

### Skilled staff to deliver care

**The ward team included or had access to the full range of specialists required to meet the needs of patients on the ward. Managers made sure they had staff with the range of skills needed to provide high quality care. They supported staff with appraisals, supervision and opportunities to update and further develop their skills. Managers provided an induction programme for new staff. Although, team meetings were not always held regularly.**

The service had a full range of specialists to meet the needs of the patients on the ward. The service had nursing and care staff, psychology staff, occupational therapy staff, a dietician, a social worker, a consultant and a specialist doctor. Managers and staff told us that patients had access to additional specialists where required and that these could be accessed externally.

Managers did not always ensure staff had the right skills, qualifications and experience to meet the needs of the patients in their care, including bank and agency staff. Although most staff were up to date with their mandatory training courses, only 65% of staff had completed their ligature rescue training.

Managers gave each new member of staff a full induction to the service before they started work. Managers told us that permanent and bank staff received a two-week induction of training and ward introduction prior to starting. Agency staff received a ward induction at the start of their shift.

Managers supported staff through regular, constructive appraisals of their work. The data provided by the service for the hospital showed a current appraisal compliance of 90%. Staff told us that they received their yearly appraisals.

Managers supported staff through regular, constructive clinical supervision of their work. The data provided by the service for the hospital showed managerial supervision at 94% compliance and clinical supervision at 97% compliance. All staff we spoke with told us they received supervision. This was a hierarchical process, therefore nurses provided supervision to senior support staff and senior support staff provided supervision to support staff.

Managers did not always make sure staff attended regular team meetings. Staff told us they did not have team meetings regularly. We received data from the service which showed the minutes of team meetings from 8th March 2023 and 25th May 2023. In the March minutes it was noted that the last meeting was held in November 2022. Although, there was a Nursing meeting held on 4th May 2023 which recorded that attendance had been poor and managers were taking action to review staff's attendance. The service also provided supplementary information acknowledging the lack of consistency of the meetings and additionally, how these did not contain key information from the hospital's governance meetings. They provided a schedule of monthly team meeting dates for the ward for the remainder of the year, which were also reflected in the recent team meeting minutes.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Staff told us that they were supported to complete additional training to upskill themselves. Managers told us that they accessed specific leadership training. They also employed two staff members on the nursing pathway and another staff member was supported in completing a successful application for a non-medical prescribing course.

Managers made sure staff had access to specialist training for their role. There were several other specialist training courses on offer to staff, such as Dialectical Behavioural Therapy (DBT) awareness and complex trauma training, as well as others which were attended by multidisciplinary leaders.

### Multi-disciplinary and interagency teamwork

**Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care. They had effective working relationships with staff from services providing care following a patient's discharge.**

Staff held regular multidisciplinary meetings to discuss patients and improve their care. Staff made sure they shared clear information about patients and any changes in their care, including during handover meetings. A daily handover meeting took place every morning and was attended by members of the multidisciplinary team. The service also carried out fortnightly ward rounds for each patient which were attended by the multidisciplinary team.

Ward teams had effective working relationships with other teams in the organisation. Staff spoke positively about the support of the multidisciplinary team in bringing about the best outcomes for patients and staff. For example, some staff gave the example of how psychology staff would assist in spending time to de-escalate and support a patient who

may be agitated or distressed, to enable nursing and care staff to focus on the needs of other patients. We saw evidence of multidisciplinary involvement in daily entries on patient notes and staff accessing multidisciplinary teams for support and advice. We also saw good liaison between the hospital advocate and the nursing and care teams with regards to safeguarding concerns.

Ward teams had effective working relationships with external teams and organisations. Staff told us they maintained contact with patient's care coordinators, who were invited to attend ward round meetings. They also had effective working relationships with the local authority safeguarding team and local police who attend monthly safeguarding meetings at the hospital.

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

**Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice and discharged these well. Managers made sure that staff could explain patients' rights to them.**

Staff received and kept up to date with training on the Mental Health Act and the Mental Health Act Code of Practice and could describe the Code of Practice guiding principles. The service was at 100% compliance with the Mental Health Act awareness mandatory training.

Staff had access to support and advice on implementing the Mental Health Act and its Code of Practice. Staff knew who their Mental Health Act administrators were and when to ask them for support.

Patients had easy access to information about mental health advocacy and patients who lacked capacity were automatically referred to the service. An advocate visited the wards twice a week. There were also posters within the communal areas of the wards with details on how to contact an advocate. Although, these advocates were commissioned by the service and were therefore not deemed independent. Leaders told us the service could still refer to local authority independent advocates if needed.

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

Staff made sure patients could take section 17 leave (permission to leave the hospital) when this was agreed with the Responsible Clinician and/or with the Ministry of Justice. Section 17 leave was discussed at ward rounds. Patients had section 17 care plans in place. Patients told us they could access section 17 leave, and this was not cancelled due to staff shortages. We observed this taking place during our inspection.

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

Informal patients knew they could leave the ward freely and the service displayed posters to tell them this. We saw these posters within the communal areas of the ward, although at the time of inspection, no patients were informal.

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

# Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

### Good practice in applying the Mental Capacity Act

Staff supported patients to make decisions on their care for themselves. They understood the trust policy on the Mental Capacity Act 2005 and assessed and recorded capacity clearly for patients who might have impaired mental capacity.

Staff received and kept up to date with training in the Mental Capacity Act and had a good understanding of at least the five principles. The service was at 95.7% compliance with the Mental Capacity Act & Deprivation of Liberty in principle and practice mandatory training.

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

Staff gave patients all possible support to make specific decisions for themselves before deciding a patient did not have the capacity to do so. Staff assessed and recorded capacity to consent clearly each time a patient needed to make an important decision. When staff assessed patients as not having capacity, they made decisions in the best interest of patients and considered the patient's wishes, feelings, culture and history.

Staff audited how they applied the Mental Capacity Act every quarter and identified and acted when they needed to make changes to improve.

## Is the service caring?

Good

Our rating of caring stayed the same. We rated it as good.

### Kindness, privacy, dignity, respect, compassion and support

**Staff treated patients with compassion and kindness. They respected patients' privacy and dignity. They understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition.**

Staff were discreet, respectful, and responsive when caring for patients. Through our observations we saw genuine and friendly care being given by staff towards patients. We saw staff knocking on patients' doors before entering and we observed staff taking the time to respond appropriately to patients when they made requests of them. Patients told us staff treated them well, behaved kindly and treated them with respect. In the recent people's council minutes, we saw that the patient from Kingswood ward had fed back that the ward was "friendly but with boundaries" and the "care was very attentive".

Staff gave patients help, emotional support and advice when they needed it. They understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition.

Staff directed patients to other services and supported them to access those services if they needed help. A relative told us the service was supporting their loved one to get dentures after years of problems with their teeth.

# Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

Staff felt that they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards patients. All staff we spoke with were certain in their ability to report any concerns relating to the treatment of patients if they were to witness this and described to us the processes they would follow if this was to happen.

Staff followed policy to keep patient information confidential. All staff followed the provider's information governance policy and ensured patient information was kept secure and confidential. The system was accessed by secure individual passwords and the nursing station was always locked.

## Involvement in care

**Staff involved patients in care planning and risk assessment and actively sought their feedback on the quality of care provided. They ensured that patients had easy access to independent advocates.**

## Involvement of patients

Staff introduced patients to the ward and the services as part of their admission. All patients received a welcome booklet and ward orientation when admitted onto the ward.

Staff involved patients and gave them access to their care planning and risk assessments. All patients we spoke with told us they were involved in their care planning and risk assessments. Although, their involvement was not always explicitly recorded in all care records. In addition, we did not see any evidence in any of the records we reviewed of patients signing or being given a copy of their care plans. Managers told us they documented when a patient refused to sign or receive a copy, so this was clear, although we did not see this. The service's Overarching Local Action Plan (OLAP) also identified that the evidence of patient's involvement in care plans needed improvement.

Staff made sure patients understood their care and treatment (and found ways to communicate with patients who had communication difficulties). For example, we observed a ward round and saw that staff ensured patients understood their care and treatment decisions and they were fully involved and supported to do this. One patient told us specifically how they had choices in their care.

Patients could give feedback on the service and their treatment and staff supported them to do this. We observed people give feedback during their ward rounds. The service held a people's council where patient representatives from the wards could feedback on the service and make suggestions for improvements. We saw a patient from Kingswood ward had attended a recent meeting and provided some feedback that had also been discussed in the ward based community meetings. The ward also held community meetings which took place every two weeks. Managers told us that previously, the attendance had been poor, so they rearranged the meetings prior to lunchtime when they knew more patients would be on the ward. They told us attendance had improved since doing this. Within the recent minutes we saw of these, the topics of discussion and actions were recorded, although there was no deadline or update on the actions at the following meeting. For example, on the meeting for 3rd May there had been an action for a visit to the local park and beach to be arranged. However, on the minutes for the following meeting held on 17th May, the actions were listed with no update recorded as to whether these had been completed and a further action was set for a beach trip. The ward also had "you said, we did" boards within the communal area which were not completed.

Staff made sure patients could access advocacy services. Patients had easy access to information and contact details of the advocacy services which were displayed clearly on posters in the main communal areas of the ward. The service commissioned an advocacy service that visited the wards twice weekly. Managers also told us that they referred out to independent advocacy. There were details on the ward on how to contact a solicitor.

# Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

### Involvement of families and carers

**Staff informed and involved most families and carers appropriately.**

Staff supported, informed and involved families or carers. The service had a carers lead. All relatives told us that the service helped them to keep in touch with their loved one. One relative told us that staff were very polite and helpful. One told us that a volunteer driver took them to and from the hospital every two weeks to facilitate visits due to their distance. Another relative told us that due to a disability they were not able to travel, so staff regularly enabled calls. Most relatives told us they were kept informed with their loved one's care. Although, one relative told us they had not received feedback on their loved one's progress or plans for them to leave. We saw that relatives were invited to ward rounds (including virtual attendance).

Staff helped families to give feedback on the service. Most relatives told us that they knew how to raise a concern and were also able to provide feedback for the service verbally and through a survey. One relative told us how the service was proactive in seeking feedback every time staff spoke with them, and another told us they were invited to a meeting with senior leadership to discuss any concerns. The service provided a booklet for relatives upon the admission of their loved one.

Staff gave relatives information on how to find the carer's assessment. For those for which this was relevant, relatives told us they had been supported with this. Most relatives told us they were satisfied with the care their loved ones received and told us that their loved one felt safe. Most gave positive praise for their involvement and communication with staff from the service.

## Is the service responsive?

Good

Our rating of responsive stayed the same. We rated it as good.

### Access and discharge

**Staff planned and managed some patient discharges well. They worked well with services providing aftercare and managed patients' move out of hospital. As a result, patients did not have to stay in hospital when they were well enough to leave.**

The service had six admissions in the last six months. The service had seven out-of-area placements and eight placements from the local authority area. This meant that for some patients, they could maintain contact easily with family and friends and were also local to the communities in which they would be discharged back to. However, all patients and relatives told us that staff enabled their contact whether this was through regular visits, or telephone calls.

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

Managers and staff worked to make sure they did not discharge patients before they were ready. Staff told us that discharge was carefully considered as a team and that patients remained on the wards until it was felt that discharge was safe and suitable for that individual. We saw discharge planning was discussed within the ward rounds we observed. However, one patient told us they were ready to leave, but due to waiting for an assessment on a flat they already had, they were not able to. Two patients also told us that they did not know their plans for discharge. Two of the

five relatives told us that they were not aware of discharge plans, and one patient told us that they had not seen any plan for their loved one's care and treatment progress. Other relatives told us they too had not been involved in any discharge planning but felt the follow on plans had not been put in place and therefore preferred that their loved one was still on the ward.

### Discharge and transfers of care

Managers monitored the number of patients whose discharge was delayed, knew which wards had the most delays, and took action to reduce them. Managers told us there was one delayed discharge for the ward and this delay was due to finding the appropriate supported living placement for patients to move on to. One patient had been at the service over three and a half years. Another relative had told us their loved one had been there two years. Local leadership on the ward told us there was no set time for people to be on the ward, however other senior leaders and staff told us the aim was for people to stay between nine to twelve months.

When discharge did happen, staff worked with care managers and coordinators to make sure discharge went well. The service worked closely with community-based care coordinators, social workers, commissioners, and specialist teams including the Learning Disability Forensic Outreach Liaison Service (LDFOLS) team and Multiagency Public Protection Arrangements (MAPPA) in organising the discharge pathway for patients and planning onwards care.

Staff supported patients when they were referred or transferred between services. Staff explained that when patients were discharged or transferred to community placements, they supported patients to visit placements, and even stay overnight, before being discharged to them.

### Facilities that promote comfort, dignity and privacy

**The design, layout, and furnishings of the ward supported patients' treatment, privacy and dignity. Each patient had their own bedroom with an ensuite bathroom and could keep their personal belongings safe. There were quiet areas for privacy. The food was of good quality and patients could make hot drinks and snacks at any time. When clinically appropriate, staff supported patients to self-cater.**

Each patient had their own bedroom, which they could personalise. One patient showed us their bedroom which was personalised with posters and a TV, they also had their own personalised boards outside to identify their own bedrooms.

Patients had a secure place to store personal possessions. Each bedroom had lockable storage and patients had their own key access to their bedrooms (based upon individual risk assessments).

Staff used a full range of rooms and equipment to support treatment and care. There was an activity room with computers, a games console and books. There was also a large communal space with sofas, chairs, tables, TV, pool table, table tennis and a locked activities cupboard. There was a separate Activities of Daily Living kitchen. The service had a room where patients could meet with visitors in private. The ward had two quiet rooms with soft furnishings where patients could go for therapy interventions, private conversations, and private telephone calls. There was also a de-escalation room with soft furnishings, which had its own access to outside space and bathroom facilities.

The service had an outside space that patients could access easily. There was an outdoor space directly accessible from the ward and this was open 24/7 for patients to access fresh air. This had astroturf, seating and was decorated with murals.

Patients could make their own hot drinks and snacks and were not dependent on staff. We saw that patients had access to an area within the communal space which included a fridge, hot and cold drinking facilities and snacks. Patients told us they could access drinks and snacks.

The service offered a variety of good quality food. We saw a four week menu rota on display in the communal area which showed a few choices for each meal. Patients were positive about the food at the service and told us they chose their meals a week in advance. If they did not want their meal choice on the day, there were other options that could be explored. Although, the service displayed the menus, it was not clear which week was the present one. This was an action set from a Mental Health Act review in August 2022. We saw a separate locked display box showing one of the menu's however this displayed the wrong week. Leaders told us that the action to show the menu of the week had been put in place but had not been embedded. The service also provided a shop where people could purchase their own snacks, and some patients also sought purchases via staff if for any reason they were not able to access leave to go shopping themselves.

### Patients' engagement with the wider community

**Staff supported patients with activities outside the service, such as work, education and family relationships.**

Staff made sure patients had access to opportunities for education and work, and supported patients. The service had good links with a local college and provided paid vocational roles onsite within the shop and gardening roles. There were also two patients from the ward who were volunteering at a local healthy living centre. They told us that this gave them a sense of worth and helped to prepare them for future work opportunities.

Staff encouraged patients to develop and maintain relationships both in the service and the wider community. Patients were encouraged to build relationships on the ward and within the hospital through group therapies. We saw some positive engagement between patients during our time on the ward. Patients also told us that they regularly went into the community for leave to spend time with family, to go for a walk or to go shopping. We also saw a calendar of monthly community trips which every patient on the ward, if able, could attend. Although there were visiting hours, staff told us that they were flexible with visits from patient's relatives. There was a visitor's room on the hospital site which could be used for visits. Patients also had access to their own mobile phones (where risk assessed) to maintain contact with loved ones. For those who did not, the ward enabled use of a ward phone.

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

**The service met the needs of all patients – including those with a protected characteristic. Staff helped patients with communication, advocacy and cultural and spiritual support.**

The service could support and make adjustments for disabled people and those with communication needs or other specific needs. Patient's care plans detailed how they wanted to be supported to meet all their needs including communication, cultural and spiritual needs. We saw evidence that the service had considered movement of bedrooms so that a new admission who experienced mobility issues was able to be in a bedroom nearest to the nursing station and communal areas. Although the service was located on one level, it was on an upper floor. There was lift access for those with mobility concerns and this was appropriately planned for with regards to emergency evacuations where they had access to evacuation chairs. The ward was a smoke-free environment. Patients were however able to use e-cigarettes in their bedrooms and in outside area.

Staff made sure patients could access information on treatment, local services, their rights and how to complain. There was information within the communal areas on local services, including bus times/routes, how to complain and patients' rights. Patients told us that they knew how to complain and were aware of their rights and access to advocacy

and solicitors. The blanket restrictions for the ward were visible and were also discussed within community meetings where patients were invited to feedback and discuss these. There were also information boards identifying staff that were on duty each day and this also identified patients' keyworkers for that day. The keyworkers were not on the board on the first day onsite but were identified on the board on the second day.

The service had information leaflets available in languages spoken by the patients and local community, as well as easy read versions of some documents. The patients we spoke with all told us that the information they received was accessible to them. The service had a display board which identified different languages so that patients could identify with their native language. Managers made sure staff and patients could get help from interpreters or signers when needed. Staff told us about a patient on the ward who spoke Polish and how a staff member, who also spoke Polish, supported with communication and in their absence, they also used interpreters via the telephone.

The service provided a variety of food to meet the dietary and cultural needs of individual patients. The service also provided cultural food days, for example recently they had an Africa day where food served was African.

Patients had access to spiritual, religious and cultural support. There was a multi-faith room on the ward which contained articles of faith such as a Quran and the bible. The service also had access to a visiting chaplain. Where appropriate, people were supported to visit external places of worship.

### Listening to and learning from concerns and complaints

**The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team and wider service.**

Patients and most relatives knew how to complain or raise concerns. All the patients we spoke with told us that they were aware of how to complain, although none of them had done this. Most relatives were aware of how to make a complaint, although one had said that they were not aware of the process.

Staff understood the policy on complaints and knew how to handle them. Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint. All staff identified to us that they were aware of the process involved with complaints and would always pass these on to the local management on the ward to investigate.

Managers investigated complaints and identified themes. Managers shared feedback from complaints with staff and learning was used to improve the service. The service had received one complaint in the last four months which was investigated. This complaint was from a patient and was in relation to an allegation of abuse, isolation and bullying by staff. Through the investigation it was identified that the patient had felt that staff were not visible on the ward and spent too long in the office, not being present for their needs promptly. This was partially upheld, and an action was taken from this for the member of staff carrying out the general observations to base themselves within the communal areas of the ward where possible.

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

The service used compliments to learn, celebrate success and improve the quality of care. The service provided evidence of seven compliments received into the service between in the last three months. These compliments related to staff supporting each other, staff's care and support of patients and record keeping. Staff also received compliments in team meeting minutes and a hospital wide weekly briefing.

# Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

## Is the service well-led?

Requires Improvement

Our rating of well-led went down. We rated it as requires improvement.

### Leadership

Leaders had the skills, knowledge and experience to perform their roles. They had a good understanding of the services they managed and were visible in the service and approachable for patients and staff.

All staff told us the ward manager and senior leadership team were all very approachable. The ward manager felt supported by her direct line manager and was being supported to undertake a specific leadership course. Leaders told us that there was an ongoing plan to build up the confidence of managers within the service.

Managers and staff told us how leaders were both proactive when things needed to be actioned. Leaders told us that the regional Cygnet support was positive.

### Vision and strategy

Staff knew and understood the provider's vision and values and how they applied to the work of their team.

The model of care for the high dependency rehabilitation service showed clear stages to move patients onto their recovery and discharge, with each stage identifying the role of medical, nursing, psychology, occupational therapy and the multidisciplinary team within these. Managers and staff told us that admissions were reviewed holistically and as such, other members of the team were part of assessing whether an individual was suitable based on understanding of the service model.

Managers told us how they were reviewing the future for the ward and how they wanted to redefine what rehabilitation looked like on the ward. Due to the model of rehabilitation on the ward, some staff told us that patients admitted to the ward were not always clear on the expectations and restrictions that were in place due to the level of acuity, compared to other rehabilitation services. Managers told us that they wanted to become more recovery and community discharge focused. Given that recovery focused activities and discharge planning was not always seen as a focus in the care and treatment of patients on the ward, and managers were not specific about the expected timeline for patients within the service, there was a need for this to be fully embedded.

Leaders also told us that whilst aspects of the overall hospital strategy had already been put in place, including recruitment and audit processes, they felt the strategy for the service was still in its early stages and was ongoing, with a focus on stabilising and developing the nursing workforce.

### Culture

All staff told us they felt respected, supported and valued as members of the team. They said the provider promoted equality and diversity in daily work and provided opportunities for development and career progression. They could raise any concerns without fear.

# Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

Staff spoke positively of the collaborative support and contributions each team member was able to add to patient care. We observed a supportive and cohesive team working and the atmosphere appeared relaxed and encouraging. The recent staff survey showed the majority of staff agreed that their manager valued, respected and supported them in their job.

The service recognised compliments given to staff, both in team meetings and in the wider weekly staff bulletins. We saw a number of compliments which recognised the culture of team working on the ward with one describing how "inclusive and supportive" the team were.

All staff felt able to raise concerns without repercussions and were aware of the whistleblowing policy. The service had internal employees who were allocated as freedom to speak up ambassadors that staff could speak to for advice and support. Staff also told us they would feel comfortable approaching managers and senior leaders if they had any concerns one staff member gave an example of when they had done this and had their concerns addressed.

Leaders shared lessons learnt when something went wrong and told staff about any actions taken to prevent the same happening again. They described a supportive approach, rather than a blame culture when things went wrong, and they wanted staff to be open and transparent with mistakes.

In the recent staff survey, 20% of staff identified experiences of racial abuse from service users, their relatives, or other members of the public. Managers told us about the work being done to support staff experiencing racism at work. Staff who had experienced this told us they felt supported and were able to report this directly to the police. The police liaison officer also attended the hospital when needed. The service had a multicultural staff forum facilitated by a member of the senior leadership team. This forum supported the staff team to address any concerns around discrimination.

To assist with wellness and retention of staff, the service had put in place a wellbeing calendar marking memorable dates/weeks and events such as team building days. They also provided staff wellbeing sessions including beauty treatments at a local college and half a day at a local outdoor therapy centre engaging in equine therapy and eco sensory therapy. This centre was also used for patients too.

### Governance

Our findings from other key questions demonstrated that governance processes did not always operate effectively at team level and performance and risk were not always managed well. For example, there was not always accurate and adequate oversight of restrictive practices and meaningful activity. In addition, there were concerns around the ligature risk audits and clinic room cleaning rotas and audits.

The senior management team worked closely together, and we saw evidence of risk issues being discussed at daily flash meetings and monthly clinical governance meetings. Information for escalation from handover meetings was cascaded to the daily flash meetings, and clinical governance meetings were thorough. Clinical governance meetings took place monthly and covered a wide range of information, including incidents, enhanced observations, safeguarding, compliance, training, feedback from patients, relatives and advocates, recruitment and retention and lessons learnt. In addition, leaders told us that they held monthly workshops to review items such as incidents, gaps in service, and any improvements or training that was needed.

However, given that the specific data on restraints and rapid tranquilisation from the provider did not accurately reflect the information recorded within the incidents on the ward, we were not assured that restrictive interventions, such as restraints and rapid tranquilisation, were always accurately identified and recorded from incidents to enable the adequate oversight and action to be taken.

In addition, although clinical governance meeting minutes showed meaningful activity was reviewed, it acknowledged a decrease on Kingswood ward in March and April 2023, yet there were no actions set from this meeting to address this. Separately, managers did identify that recently they had requested a record of what activity had been done for the past month with patients. They acknowledged that with therapy, a record was kept of what patients were engaging with, however they stated more needed to be done to understand the engagement in meaningful activity, and what could be done to ensure patients were engaged in activities to upskill them for discharge.

### Management of risk, issues and performance

Team meetings were not held consistently and regularly to ensure information was always relayed to staff where necessary. Leaders also acknowledged the minutes of the recent team meetings did not contain key information from the hospital's governance meetings. Therefore, teams did not always have access to the information they needed to provide safe and effective care. Although, some information was distributed in daily handovers and weekly staff briefs.

There was a clinical governance structure in place to ensure information and risk was escalated and managed in a timely manner. Senior leaders confirmed that organisational policies and procedures from the wider provider were applied to the operational running of the hospital and

that these were clear and regularly reviewed. The service had an Overarching Local Action Plan (OLAP) which incorporated feedback from audits, quality visits, complaints, and community meetings.

The service had an overall risk register which covered high risk areas of the hospital. Leaders told us this was reviewed and updated every month. Although ward managers could escalate local concerns to the risk register, this function was overseen by the compliance team. The risk register did not identify the concerns we found on inspection.

During the inspection, leaders discussed the concerns we raised relating to the ligature risk assessments and the recognised gap in knowledge and confidence with the audits surrounding these. Leaders recognised there was a need for better oversight of the assessments and audits, as well as increased training and confidence building of managers to understand them. They told us these shortfalls were escalated within the internal governance structures at the time of inspection.

### Information management

Staff collected and analysed data about outcomes and performance and engaged actively in local and national quality improvement activities. Leaders told us they were part of quality networks and carried out peer reviews.

Staff had access to the equipment and information technology (IT) needed to do their work. The electronic system containing patient information worked well and all staff could access the system. Staff had their own individual computer log in to access patient records to ensure confidentiality.

Staff had access to an online incident reporting tool which prompted staff to consider if notifications to external bodies was appropriate.

# Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

## Engagement

Managers engaged actively with other local health and social care providers to ensure that an integrated health and care system was commissioned and provided to meet the needs of the local population. Managers from the service participated actively in the work of the local transforming care partnership.

The service held meetings monthly with various stakeholders including local NHS trusts, commissioners, safeguarding teams and the local police.

The service had resources available to engage staff in providing feedback about the service. This included a yearly staff survey and more local supervision processes.

Patient feedback was captured regularly at the ward community meetings, people's council and through ward rounds. At discharge, staff offered patients a feedback survey.

Staff actively sought the views of carers via carers leads and a friends and family survey. Leaders recently held a carers event where members of the staff team met with carers to talk generically about the service, the responsibilities, and the pathways.

## Learning, continuous improvement and innovation

The provider was in the early stages of introducing a quality improvement initiative on "safe wards". This was an initiative to improve the ward environment, reduce incidents of aggression and improve safety for both patients and staff. They were hoping that by giving staff more skills, this will help with the de-escalation and management of conflict on the ward, which in turn will improve staff retention and incident reduction. At ward level, managers told us that they had recently proposed to explore some quality improvement initiatives to undertake.

Leaders encouraged continuous improvement with quality walks where checks were carried out of the wards. Any identified areas for improvement would be fed into their overarching local action plan.

The service carried out "resident of the day" where staff members would go onto a ward to gain perspective of what it would be like a patient on that ward. They also carried out role swaps where staff members from different areas of the service would shadow different roles within the hospital for a day so that staff could learn about and understand different roles. For example, kitchen staff would shadow a ward manager for the day.

The service was hoping to renew their accreditation through Accreditation for Inpatient Mental Health Services (AIMS) which recognised high standards of organisation and care. Leaders told us that this was currently on hold due to a requirement to have a clinical psychologist within the ward quota, where the service currently had a qualified psychotherapist. They felt that the provision in place was suitable for the ward and the patients and should not preclude them from achieving this accreditation.

Requires Improvement

# Forensic inpatient or secure wards

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

## Is the service safe?

Requires Improvement

Our rating of safe stayed the same. We rated it as requires improvement.

### Safe and clean care environments

**The provider did not manage ligature risks well. There were multiple ligature points across the wards which were not sufficiently mitigated. However, the wards were well furnished.**

### Safety of the ward layout

Staff did not ensure that a thorough risk assessment were completed on the ward in order to reduce or remove all ligature risks. There were multiple ligature points across the wards including in patients' bedrooms, that were not covered in the ligature risk assessment. The information Communication and technology (ICT) room contained fixed ligature points such as cupboards, tables and cables that my pose a risk to patients, and it was required to be kept lock when not in use. Staff told us that patients using the ICT room were risk assessed and they should be supervised at all times. However, during this inspection, we saw that ICT was left open and patients using the room were not being supervised.

Ward managers and the maintenance manager were required to complete a six monthly ligature risk assessment audit of the ward environments. Managers and staff told us that the ligature risk assessment tool was complicated, and the audit involved random checks of around three or four rooms. Staff and managers informed us they had not received any training on how to complete a thorough ligature risk assessment. Staff also reported that they had not received any training on how to use a ligature cutter safely.

The provider's ligature risk assessment tool was to be used alongside the ward ligature heat maps to identify hight risk points for ligatures. Two out of four members of nursing staff we spoke with did not know about the ligature risk assessment. All staff were required to complete and sign the ligature policy when read and understood but during this inspection we saw that these signature forms were partially completed. There was no requirement for staff to read or understand the ligature risk assessment and how the tool would be utilised.

Saltwood ward was a male only unit. However, patients from other wards including the female ward used the seclusion facilities on Saltwood ward.

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

### Maintenance, cleanliness and infection control

Ward areas were generally clean and well furnished, and staff kept cleaning records up to date. There were cleaners allocated to each ward. Patients we spoke with said the cleaners kept the environment clean in the day. However, patients said that there were no cleaners at night, and the wards were not always cleaned thoroughly by the night staff. Patients also told us that the wards were not always properly cleaned on weekends.

While staff informed us that maintenance issues were escalated and responded to promptly, we saw that there was a very bright emergency light flashing at the end of the corridor. Staff reported that this was the emergency light from the adjacent ward, and it had been broken and reported for weeks but was still not resolved. We were concerned that the flashing light were disorientating for patients and staff especially at night. We raised this with the hospital manager following our inspection who assured us it will be resolved immediately.

Staff followed infection control policy, including handwashing and use of personal protective equipment (PPE).

### Seclusion room

The seclusion room had an ensuite facility. It had a two-way communication and a clock. Patients in seclusion could be observed using a CCTV camera and parabolic mirrors. However, we saw that staff did not always have continuous line of sight for a patient in the seclusion shower room, and this was not mitigated by a CCTV or parabolic mirror. We raised this with the provider following the inspection and they informed us that there was no CCTV in the shower room based on the decision to preserve the dignity of the patient in these circumstances.

There was a mattress on the floor which appeared thin, and this could be uncomfortable for heavier patients. Staff told us there had not been any complaints from patients about the mattress.

There was a red lighting strip stuck to the ceiling. The provider informed us that the lighting was designed to be a sensory light. However, we were concerned that the lighting strip was a very long piece of material which could pose a risk to a patient in seclusion if they accessed it, and it was not clear if this had been thoroughly risk assessed.

### Clinic room and equipment

Clinic rooms were fully equipped, with a range of equipment to monitor patients' physical health as well as accessible resuscitation equipment and emergency drugs that staff checked regularly.

The service had a separate physical health assessment room next to the clinic which included an examination couch with a screen to maintain patients` dignity and privacy.

Staff checked, maintained, and cleaned equipment. Medicines fridge was locked, and temperature checks completed daily. The ward had a defibrillator which was checked weekly. There was oxygen in bag which was full and in date. Although there were no stickers to indicate when the equipment was last cleaned.

There was a medicines disposal box in a locked cupboard with opening date and location details entered. There was a clinical waste bin attached to the wall. However, there was no date of opening of location on the box.

### Safe staffing

**The service had enough nursing and medical staff who knew the patients well.**

Requires Improvement

# Forensic inpatient or secure wards

## Nursing staff

The service had enough nursing and support staff to keep patients safe. The service was reporting a vacancy of two registered nurses and one healthcare support worker. There was ongoing recruitment for two registered mental health nurses and two healthcare support workers. The service was recruiting a physical health support worker and interviews were scheduled for 12 June 2023.

The service's agency staff usage reduced between March to April from 17.2% to 16.7%. However, the agency staff percentage usage rose to 22.4% in May 2023. Staff told us they had to increase the staffing numbers to compensate for patients on enhanced monitoring.

Managers informed us they used bank and agency staff who were familiar with the service and knew the patients well when possible. Managers made sure all bank and agency staff had a full induction and understood the service before starting their shift.

The service had an increasing turnover rate of about 7% in the last three months.

Managers supported staff who needed time off for ill health. Levels of sickness had been stable over the last 12 months. However, there was an increase in sickness rate from 4.2% to 6.4% in the last month.

Managers accurately calculated and reviewed the number and grade of nurses and health care support workers for each shift. The ward manager could adjust staffing levels according to the needs of the patients. The usual staffing levels was 6.5 staff per shift and an additional staff member for enhanced observations.

Patients reported they had one to one session with their named nurse, but this was not regular.

Patients told us that their escorted leave or activities had been cancelled on some occasions due to staff shortage.

The service had enough staff on each shift to carry out any physical interventions safely.

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

## Medical staff

The service had enough daytime medical cover and a doctor was available to go to the ward quickly in an emergency. The service had a full-time doctor and a consultant psychiatrist who worked from 9am to 5pm Mondays to Fridays.

The service did not have a doctor on site at night. However, the medical director and hospital manager informed us that there was an on-call doctor system in place and where required, for example in case of an emergency, the on call doctor would attend site and was usually available within 20 minutes. Doctors were able to provide support to night-time nursing and support staff over the telephone.

## Mandatory training

Staff were not up to date with their mandatory training. For example, only 34% of staff had completed the awareness of self-harm and suicide course and only 64% of staff had completed the ligature rescue training which was below the providers target of 85%. This meant that staff might not always have the necessary skills to manage ligature risks well. However, we saw some staff who had not completed their mandatory training such as face to face training had booked them. The provider informed us following the inspection it had assigned the awareness of self-harm and suicide training to all clinical staff to be completed by end of September 2023.

Requires Improvement

# Forensic inpatient or secure wards

While managers monitored the training compliance and reminded staff to complete their mandatory training, we were concerned about the effectiveness and oversight of the mandatory training programme. For example, 83.3% of staff had completed the medication competency for nursing services module. However, we saw consistently poor medicines practices across all wards during this inspection.

## Assessing and managing risk to patients and staff

**Staff assessed and managed risks to patients and themselves well.**

**They achieved the right balance between maintaining safety and providing the least restrictive environment possible to support patients' recovery. Staff had the skills to develop and implement good positive behaviour support plans and followed best practice in anticipating, de-escalating, and managing challenging behaviour. As a result, they used restraint and seclusion only after attempts at de-escalation had failed. The ward staff participated in the provider's restrictive interventions reduction programme.**

### Assessment of patient risk

Staff completed risk assessments for each patient on admission using a recognised tool. Staff completed the short-term assessment of risk and treatability (START) which is a clinical tool used to evaluate a patients' level of risk of aggression and how well they would respond to treatment. Staff also assessed patients for violence using historical clinical and risk management 20 (HCR 20). However, we saw that one patient HCR-20 had been completed but not updated since March 2023 following several incidents and was therefore not up to date with current risks.

### Management of patient risk

Staff identified and responded to any changes in risks to, or posed by, patients. We saw that a patient was placed on two to one arms-length observation for their own safety and the safety of other patients.

Staff followed procedures to minimise risks where they could not easily observe patients. There were closed circuit television (CCTV) and parabolic mirrors across the wards which managers used to review incidents or any safeguarding concerns.

Staff followed the provider's policies and procedures when they needed to search patients or their bedrooms to keep them safe from harm. However, the ward did not have a dedicated search wand. Staff told us they borrowed from the adjacent Bearsted ward when a search was required.

There was a storage room where individual items that could pose risks were stored, as well as contraband items.

### Use of restrictive interventions

The provider monitored the use of restrictive practices which was reviewed at clinical governance meetings. The levels of restrictive interventions were reducing between February and April 2023. For example, the provider reported a reduction in the numbers of prone restraints in April 2023 and an increase in post incident debriefs.

Staff understood the Mental Capacity Act definition of restraint and worked within it. Staff made every attempt to avoid using restraint by using de-escalation techniques and restrained patients only when these failed and when necessary to keep the patient or others safe.

When a patient was placed in seclusion, staff kept clear records and followed best practice guidelines. Staff secluded patients only when they could not be safely deescalated, and their behavioural disturbance was likely to cause harm to others. The provider reported in April 2023 that there was an overall decrease in the number of seclusions.

Requires Improvement

# Forensic inpatient or secure wards

Staff participated in the provider's restrictive interventions reduction programme, which met best practice standards.

Staff followed best practice, including guidance in the Mental Health Act Code of Practice, if a patient was put in long-term segregation. No patients were placed in long term segregation in April 2023.

## Safeguarding

**Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. However, staff did not keep up to date with their safeguarding training.**

All staff we spoke with understood how to protect people from abuse. Staff knew how to make a safeguarding referral and who to inform if they had concerns.

Staff ensured that appropriate safeguarding referrals were made when there were concerns. Managers fully investigated incidents of abuse and discussed outcomes with staff. However, at the time of our inspection, only 29% of staff on Saltwood ward had received up to date training on safeguarding individuals at risk (intermediate) virtual classroom training and only 36% of eligible staff had completed the safeguarding programme.

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

Staff knew how to recognise adults at risk of or suffering harm and worked with other agencies to protect them.

Staff followed clear procedures to keep children visiting patients safe. The hospital had a family room away from the ward which was private and secure.

## Staff access to essential information

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

The service uses an electronic patient record system. Staff made sure patient notes were comprehensive and all staff could access them easily.

When patients transferred to a new team, there were no delays in staff accessing their records.

All patient records including mental health records and prescriptions were stored securely.

## Medicines management

**Staff did not ensure that patients' medicines were managed well. Staff did not ensure that medicines were safely administered and recorded. Staff did not ensure that physical health of patients who were administered rapid tranquilisation were sufficiently monitored to mitigate against or reduce the risk of harm.**

Staff did not always follow the provider's systems and processes to safely administer and record medicines. For example, one patient`s record showed that there was an overdose administration of the rapid tranquilisation medicine which was above the recommended limit. Another patient was administered medicines longer than the prescriber had intended. The prescriber's instruction required staff to stop the medicine administration after two weeks, but staff had continued administering the medicine beyond the prescribed time. This meant that patients were at risk of avoidable harm.

Requires Improvement

# Forensic inpatient or secure wards

Staff stored controlled drugs (medicines with heightened security and record keeping requirements) safely and securely. However, records had only single signatures for stock checks or administrations. Staff were not following best practice and provider policy on recording controlled drug use. We counted over 30 occasions in the last two months where a controlled drug (Methadone) was administered but not countersigned. On one occasion Methadone was administered and was not signed for at all, which was not in line with the national best practice and the provider's policy on recording and the management of controlled drug use.

Staff did not ensure that records for “when required” (PRN - 'pro re nata,' the administration of medication is not scheduled but taken as needed) for the management of agitation and aggression were used safely by the service were consistent between administration and care records. Entries did not always match between these care documents, and we could not be assured that every use of a PRN medicine was being appropriately recorded.

When PRN medicines were a variable dose, staff usually administered the highest available dose without a clear rationale in relevant care records.

The service did not ensure people’s behaviour was not controlled by excessive and inappropriate use of medicines. Staff did not record on the specific paperwork the baseline physical health monitoring that had been completed prior to and during the HDAT treatment, when patients were prescribed high dose antipsychotic therapies (HDAT – where antipsychotic medicines are prescribed alone or in combination above recommended limits),

When a medicine was used as a rapid tranquilisation (intramuscular injections for the management of severe agitation and aggression) these were used as a last resort. However, staff were failing to complete any of the required post dose monitoring of patients following administration. When speaking to staff they did not always appear clear on what was required of them if they did administer a rapid tranquilisation medicine. Failure to monitor a patient’s physical health after administration of a rapid tranquilisation medicine puts them at increased risk of harm.

Staff stored and managed all medicines and prescribing documents safely. Staff stored medicines safely and securely. They monitored ambient room and fridge temperatures daily.

## Track record on safety

**The service had a good track record on safety.**

## Reporting incidents and learning from when things go wrong

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

Staff knew what incidents to report and how to report them. Staff discussed incidents in daily ward rounds and escalated to the senior leaders via the daily flash meetings.

Staff raised concerns and reported incidents and near misses in line with provider policy. Staff reported 78 incidents on Saltwood ward between March and May 2023. Most of the incidents were related to violence and aggression by patients. On most occasions, managers investigated incidents and learnt lessons.

The service had no serious incidents ward in the last three months.

Requires Improvement

# Forensic inpatient or secure wards

The service had no never events on any wards.

Staff understood the duty of candour. Staff told us it was about being open and transparent and giving patients and their families a full explanation if and when things went wrong. We saw examples of where the provider given an apology and provided explanation following an incident.

## Is the service effective?

Requires Improvement

Our rating of effective went down. We rated it as requires improvement.

### Assessment of needs and planning of care

**Staff assessed the physical and mental health of all patients on admission. However, not all patients had a comprehensive care plan in place that met their specific needs.**

Staff completed a comprehensive mental health assessment of each patient either on admission or soon after. The service had an admission checklist including reviewing patients risks, medication reconciliation, physical health checks and care planning.

Staff developed individual care plans which were reviewed through multidisciplinary discussion. However, care plans were not always updated following an incident. For example, following a safeguarding incident where a patient spat on the face of another patient, the incident was reviewed by the multidisciplinary team (MDT) but no clear plans for how this type of incident will be managed to keep the patient and others safe.

Not all patients had specific care plans in place that met their needs. For example, one patient who were prescribed methadone for opioid misuse disorder did not have a specific substance misuse management care plan in place.

Staff ensured that patients were offered copies of their care plans. However, some patients told us they had refused copies of their care plans because they were not current or reflected their views or assessed needs. Three out of six patients we spoke with said their care plans were not up to date or personalised. We also saw that care plans were not always dated.

Patient records showed that patients physical health was assessed on admission.

### Best practice in treatment and care

**Staff provided a range of treatment and care for patients based on national guidance and best practice. However, patients felt there was not enough activities on the ward.**

Staff ensured that patients had good access to physical healthcare and supported them to live healthier lives. Patients' physical health checks were completed weekly by the ward doctor. Although the service did not have a physical health nurse, the hospital manager informed us they were actively recruiting to post for a physical health lead worker. The hospital had a service level agreement with a local GP surgery who provided additional support when required and operated weekly clinics for patients.

Requires Improvement

# Forensic inpatient or secure wards

Staff used recognised rating scales to assess and record the severity of patients' conditions and care and treatment outcomes such as the Model of Human Occupation Screening Tool (MOHOST), Health of the Nation Outcome (HoNOs) Scale.

Staff recorded patient treatment outcomes using rating scales such as Daily Living Skills Observation Scale (DLSOS) which tracks functionality and the ability to successfully live an independent life in the community. However, patient reported they did not always have enough meaningful activities on the wards which upskilled them for independent living. Patients told us ward activities were very limited and were often cancelled. During our two day inspection, we observed very little interaction between patients and staff.

The ward had a range or equipment to keep patients entertained including a pool table, a television in the communal area, games, and books. Some patients when risk assessed could utilise the information and communication technology (ICT) room which had computers and internet. The local papers were delivered daily which allowed patients to keep up to date with world events.

Staff met patients' dietary needs and assessed those needing specialist care for nutrition and hydration.

Staff helped patients live healthier lives by supporting them to take part in programmes or giving advice. The service had a no smoking policy and actively participated in smoking cessation programmes. Staff encouraged patients to quit smoking by offering them nicotine replacement therapies and vapes, which they could use on the ward. Staff encouraged patients to eat healthily, although one patient record showed they were ordering a high number of takeaway meals.

Staff used technology to support patients. The service had an electronic patient record system and an electronic system for medicine's prescription.

Staff took part in clinical audits, benchmarking, and quality improvement initiatives. For example, the have introduced a programme to reduce self-harm through the use of sensory therapies. The service had a schedule of audits which included a quarterly physical health audit and a six-monthly blanket rules audit.

Managers used results from audits to make improvements.

### Skilled staff to deliver care

**The ward team included or had access to the full range of specialists required to meet the needs of patients on the ward.**

**Managers made sure they had staff with the range of skills needed to provide high quality care. They supported staff with appraisals, supervision, and opportunities to update and further develop their skills. Managers provided an induction programme for new staff. However, team meetings were not always regular.**

The service had a full range of specialists to meet the needs of the patients on the ward. The ward staff included ward managers, registered nurses and healthcare support workers, occupational therapists, psychologists, a ward doctor, and a consultant psychiatrist.

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

Managers supported staff through regular, constructive appraisals of their work. Records showed that 90% of staff across all wards have had an appraisal in the last 12 months.

Managers supported medical staff through regular, constructive clinical supervision of their work. Supervision Records showed that 91% of staff have had a clinical supervision on Saltwood ward in the last month.

Staff told us that team meetings were held once a month. However, team meetings were not always held regularly. We reviewed the last three team meetings and we saw that they were detailed and comprehensive. It included staffing and leave cover arrangements, admissions, ward risks, training, supervision, and team building. Managers made sure staff attended team meetings or gave information from those they could not attend.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Staff told us there were protected times for training. Staff were paid to attend training on their days off.

Managers made sure staff received any specialist training for their role. There was a range of training available to staff including substance misuse, phlebotomy, root cause analysis (RCA) training for managers and dialectical behaviour training (DBT) awareness and essentials.

Managers recognised poor performance, could identify the reasons, and dealt with these. For example, we reviewed a medication incident where a staff had administered a medication to the wrong patient. The staff member was dismissed following the investigation and lessons were learnt.

### Multi-disciplinary and interagency teamwork

**Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care. The ward team had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation.**

Staff held regular multidisciplinary meetings to discuss patients and improve their care. There was a daily ward round/ handover meeting that fed into the daily flash meeting (Sit Rep) which was attended by senior leaders at the hospital to review any concerns over the previous 24 hours or weekend.

Staff made sure they shared clear information about patients and any changes in their care, including during handover meetings.

Ward teams had effective working relationships with other teams in the organisation. Staff supported other wards when there was an incident or an emergency and vice versa.

Ward teams had effective working relationships with external teams and organisations such as the general advocates, local authority safeguarding and the police.

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

**Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice and discharged these well. Managers made sure that staff could explain patients' rights to them. However, some patients reported that they were not always able to utilise their escorted section 17.**

Staff received, and kept up to date, with training on the Mental Health Act (MHA) and the Mental Health Act Code of Practice with a training compliance rate of about 91%. Staff could describe the MHA Code of Practice guiding principles.

Staff had access to support and advice on implementing the Mental Health Act and its Code of Practice. They knew who their Mental Health Act administrators were and when to ask them for support. The service had a Mental Health Act administrators regularly reviewed detained patients and ensured that all legal documents and detentions papers were stored correctly and up to date. They also reminded staff of when a patient's section was about to expire.

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

Patients had easy access to information about general advocacy that was commissioned by Cygnet Health Care Limited. Patient who lacked capacity were automatically referred. However, not all patients and staff knew who the local authority commissioned independent mental health advocacy service was.

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

Patients reported that their section 17 leave (permission to leave the hospital) was often cancelled due to poor organisation or lack of staff. Five out of six patients we spoke with told us that leave often get cancelled and staff and it was sometimes difficult to rearrange. One patient told us that they were frustrated because they had arranged to meet up with friends, but their section 17 leave was cancelled.

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

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

### Good practice in applying the Mental Capacity Act

**Staff supported patients to make decisions on their care for themselves. They understood the trust policy on the Mental Capacity Act 2005 and assessed and recorded capacity clearly for patients who might have impaired mental capacity.**

Staff received, and were consistently up to date, with training in the Mental Capacity Act and had a good understanding of at least the five principles. Ninety one percent of staff on Saltwood ward had completed their Mental Capacity Act training which was above the provider's target.

The service had not made any deprivation of liberty safeguards application in the last 12 months.

There was a clear policy on Mental Capacity Act and deprivation of liberty safeguards, which staff could describe and knew how to access.

Staff knew where to get accurate advice on the Mental Capacity Act and deprivation of liberty safeguards.

On most occasions staff gave patients all possible support to make specific decisions for themselves before deciding a patient did not have the capacity to do so. However, one patient reported that because they were under the influence of an illicit substance during a ward round, staff deemed them as lacking capacity to treatment. The patient felt they were being punished and staff had refused to review their treatment.

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

Requires Improvement

# Forensic inpatient or secure wards

Staff told us that when they assessed a patient as not having capacity, they made decisions in the best interest of the patient and considered the patient's wishes, feelings, culture and history.

The service monitored how well it followed the Mental Capacity Act and made changes to practice when necessary. Staff audited how they applied the Mental Capacity Act and identified and acted when they needed to make changes to improve.

## Is the service caring?

Requires Improvement

Our rating of caring went down. We rated it as requires improvement.

### Kindness, privacy, dignity, respect, compassion and support

**Staff did not always treat patients with kindness and compassion.**

We spoke with six patients on Saltwood ward during this inspection, and the feedback was mixed. Some patients reported that they received kind and compassionate care from some staff members mostly in the day. However, four out of six patients reported that night staff did not always care for them well or treated them kindly. One patient reported that night staff sometimes made them feel like they were bothering them when they asked for their night-time "when required" (PRN) medicines. Another patient reported that staff were often reluctant to provide them with assistance, and on some occasion, staff were very slow to provide support.

Patients felt staff did not always listen to them or respected their wishes. For example, one patient told us they were not always involved in decisions about their care and treatment because staff felt they lacked capacity. The patient felt they had capacity to make the decision about their care and treatment, but staff were not listening to their concerns. Another patient reported that they informed staff they would like to be taken off their methadone due to the stigma, but staff had not considered their concerns. Three other patients reported when they were not happy about the treatment they were receiving because they did not feel listened to.

Some patients told us that staff respected their dignity and privacy. However, two patients told us staff did not knock on their doors before entering their rooms and often walked in on them in the shower. One patient said they made a complaint about this but nothing had changed.

Staff felt that they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards patients.

Staff followed policy to keep patient information confidential.

### Involvement in care

**Staff involved patients in care planning and risk assessment and actively sought their feedback on the quality of care provided. They ensured that patients had easy access to independent advocates.**

Requires Improvement

# Forensic inpatient or secure wards

## Involvement of patients

Staff introduced patients to the ward and the services as part of their admission. They gave patients an admission pack when they first arrived on the ward including information about the service, their treatment, their rights and information about advocacy.

While patient records showed that care plans were written from patients' views, three out of six patients said they refused copies of their care plans because it was not always current and did not always reflect their wishes or what they wanted to achieve. For example, one patient reported that their care plan was not up to date and did not reflect current changes therefore they had refused it.

Staff involved patients in decisions about the service, when appropriate. There was a bi-weekly community meeting where patients could feedback about the service. There was also a People's Council meeting that took place every month was attended by staff and patient representative from each ward. Minutes from the meetings showed good patient engagement and staff ensured that concerns raised from these meeting were monitored and actioned.

Staff made sure patients could access general advocacy services. The provider had commissioned a third party general advocate provider who provided advocacy support to patients. Although there was a local authority commissioned independent mental health advocacy support, under Section 130A of the Mental Health Act (MHA) 1983, patients and staff we spoke with were not aware of this.

## Involvement of families and carers

**Staff informed and involved families and carers appropriately.**

Staff supported, informed and involved families or carers in patients' care where appropriate.

Staff helped families to give feedback on the service. The service carried out regular surveys where carers can give feedback.

Staff gave carers information on how to find the carer's assessment.

## Is the service responsive?

Good

Our rating of responsive stayed the same. We rated it as good.

## Access and discharge

**Staff worked well with services providing aftercare and managed patients' moves to another inpatient service or to prison.**

## Bed management

The service had a clear admission and inclusion criteria which included patients who were detained under the Mental Health Act (MHA) 1983, a primary diagnosis of mental illness and forensic history and involvement with the criminal justice system. The service accepted referrals all over the country. Saltwood ward was reporting a low out of area placement at the time of this inspection.

Requires Improvement

# Forensic inpatient or secure wards

Managers told us they monitored the length of stay for patients to ensure patients did not stay longer than they needed to. Managers and staff worked to make sure they did not discharge patients before they were ready.

When patients went on leave there was always a bed available when they returned. A bed had been kept for one patient who had was on extended section 17 leave.

Patients were moved between wards only when there were clear clinical reasons or it was in the best interest of the patient.

Staff did not move or discharge patients at night or very early in the morning.

## Discharge and transfers of care

Managers monitored the number of patients whose discharge was delayed, and worked towards discharging patients who were ready for discharge. The service was reporting two delayed discharges. One patient had been with the service since March 2021.

Staff told us that they worked to ensure that patients did not have to stay in hospital when they were well enough to leave. Although sometimes other factors such as social care needs, lack after care support and care coordinators could cause delayed discharge.

Staff told us that patient discharges were carefully planned, and they worked with care managers and coordinators to make sure this went well. However, during this inspection, we saw that a patient was taken off their section following a tribunal without a clear discharge plan in place. The patient decided to discharge themselves as they became informal. The patient had no fixed abode. Staff told us they had not anticipated the outcome of the tribunal because and they felt the patient was not well enough to be discharged. Staff responded appropriately by arranging free taxi for the patient next day to receive their depot injection (a slow release from of medicine that has a longer lasting effect). The provider also informed us following the inspection that a section 117 aftercare was then put in place on the day post discharge.

Staff supported patients when they were referred or transferred between services. The service followed national standards for transfer.

The hospital manager informed us that they also measured outcome based on the numbers of successful discharges as part of their key performance indicator sent to the commissioners.

## Facilities that promote comfort, dignity and privacy

**The design, layout, and furnishings of the ward supported patients' treatment, privacy and dignity. Each patient had their own bedroom with an ensuite bathroom and could keep their personal belongings safe. The food was of good quality and patients could make hot drinks and snacks at any time. However, patients reported that the quiet room was always locked.**

Each patient had their own bedroom, which they could personalise. There were locked cabinets in each patient's room where they could store personal possessions. Other contraband items or items that may pose risks were stored securely in a storage room.

Requires Improvement

# Forensic inpatient or secure wards

The service had a full range of rooms and equipment to support treatment and care. Staff and patients could access the rooms. The ward had an information communications and technology (ICT) room with computers and patients could use the internet. The ward was bright and airy with large spaces, a pool table and private rooms, including music room. However, some patients told us that they were frustrated because the quiet room was always locked. Staff told us that they needed to lock the quiet room because of a high risk patient. Patients felt this was a blanket restriction.

Visitors were not allowed on the wards. The hospital had a dedicated visitors room away from the ward where patients could meet with their visitors in private which was well lit and well furnished.

Patients were allowed their own mobile phones when risk assessed, and staff felt it was safe to do so. Patients who were not allowed their mobile phones had access to ward phones and could make calls in private.

The service had an outside space that patients could access easily. The ward had a large courtyard. There was a garden area and patients reported they had been doing some gardening and planted some flowers. Managers informed us they were planning to make the garden area bigger so patients could grow more crops.

Patients could make their own hot drinks and snacks and were not dependent on staff. The was a cold and hot water urn. Staff told us that the water urn was temperature controlled to reduce the risk of scalding. However, patients did not have access to hot water to make drinks from a designated boiler, if they needed a hot drink, they would have to ask staff for assistance to make one.

The service offered a variety of good quality food. The hospital had recently revised the menu and patients gave very positive feedback about the food. Staff ensured there were enough healthy food options as well as fruits and drinks.

## Patients' engagement with the wider community

**Staff supported patients with activities outside the service, such as work, education and family relationships.**

While some patients reported that they were able to access opportunities for education and work, some felt they had not been offered the same opportunities, and that staff were not always supportive.

Staff helped patients to stay in contact with families and carers when appropriate. One patient reported that their parents was always invited to their ward rounds and Care Programme Approach (CPA) meetings.

Staff told us they encouraged patients to develop and maintain relationships both in the service and the wider community. However, some patients felt there is very little to do in the area and the shops were quite far away. Some patients reported they have a very short section 17 leave time, and this allowed only them to get out to the grounds and back.

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

**The service met the needs of all patients – including those with a protected characteristic. Staff helped patients with communication, advocacy and cultural and spiritual support.**

The service could support and make adjustments for disabled people and those with communication needs or other specific needs. The wards supported disabled patients. The ward was on the second floor and there were elevators to assist patients with mobility problems.

Requires Improvement

# Forensic inpatient or secure wards

Staff made sure patients could access information on treatment, local service, their rights and how to complain. The was a notice board on the ward to inform patients on how they could get extra support.

Managers made sure staff and patients could get help from interpreters or signers when needed via a third party organisation.

The service provided a variety of food to meet the dietary and cultural needs of individual patients. For example, there were dairy free options available for patients who were lactose intolerant and halal options for Muslims.

The hospital had a multifaith room. Patients could access spiritual, religious and cultural support when required. Managers told us they were working towards getting a vicar. However, two patients reported they did not know about the multifaith room another patient reported that the multifaith room was designed for a particular faith and not inclusive. One patient reported they would like to attend church on Sundays.

### Listening to and learning from concerns and complaints

**The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team and wider service.**

Patients, relatives and carers knew how to complain or raise concerns. The service clearly displayed information about how to raise a concern in patient areas.

Staff understood the policy on complaints and knew how to handle them. Managers reminded staff to ensure formal complaints at ward level including complaints which had an action were added to the Overarching local action plan (OLAP). Staff were to ensure that there was a care plan for patients who made regular complaints. The service had a template for informal complaints, and staff were required to send out a letter to ensure that the correct people were informed.

The provider planned to have a complaint handling training for all staff in future.

Managers investigated complaints and identified themes. Although the provider had not reported any specific complaints on Saltwood, we saw examples of complaint investigations from other wards and lessons learnt. However, one patient reported they had complained previously about staff coming into their shower room to check on them without permission, which affected their dignity and privacy, and this was an ongoing concern.

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

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint.

Managers shared feedback from complaints with staff and learning was used to improve the service.

The service used compliments to learn, celebrate success and improve the quality of care.

## Is the service well-led?

Requires Improvement

# Forensic inpatient or secure wards

Requires Improvement

Our rating of well-led went down. We rated it as requires improvement.

## Leadership

Leaders had the skills, knowledge and experience to perform their roles. They had a good understanding of the services they managed and were visible in the service and approachable for patients and staff.

Staff spoke very highly of the ward managers and the senior leadership team. Staff said the hospital director knew the staff and patients by name and they spent time on the wards.

## Vision and strategy

Staff knew and understood the provider's vision and values and how they applied to the work of their team. The provider's vision was to provide high quality, specialist services that ensure service users feel safe and supported and staff are proud of.

Managers told us that the service was focussed improving the quality of care for patients and reducing restrictions.

## Culture

Staff felt respected, supported and valued. They said the service promoted equality and diversity in daily work and provided opportunities for development and career progression. Staff felt they could share their concerns with the ward manager, and they were very supportive both professionally and personally.

Staff could raise any concerns without fear of retribution or victimisation.

## Governance

**Governance processes around medicines and ligature risk management needed improvement.**

The records of quality assurance audits and checks; audit programme around the management of patient safety risks such as ligature risks, and medicines were not robust enough to mitigate against such risks. We saw that here were concerns in prescription charts and care records which had previously been identified in the pharmacy audit but had not been acted upon. For example, the medication live view report for Saltwood ward for May 2023 showed that 36% of queries/ interventions were not acknowledged and errors to controlled drugs were not amended appropriately. During this inspection we found that controlled drugs were still not managed well, and the provider had not taken timely action to remedy this.

While we saw that the teams discussed incidents in daily leadership meetings, weekly head of department meetings and monthly clinical governance meetings, the provider did not ensure that action plans following review of incidents were always robust and embedded. For example, we reviewed an incident which occurred on 18 March 2023 when a swallowed a battery. Another incident occurred on 19 March 2023 of another patient reporting they had swallowed batteries.

Requires Improvement

# Forensic inpatient or secure wards

The provider told us lessons learned were shared around managing battery swallowing incidents with staff during March 2023 team meeting, and the plan of action included gluing remote control battery covers to prevent patients accessing the batteries. However, the provider reported another incident on 9 May 2023 where a patient reported they had swallowed a battery, and they were subsequently admitted to the accident and emergency department (A&E).

Leaders and staff discussed risks and patient feedback at daily flash meetings, weekly Head of Department Meetings, and monthly clinical governance meetings. Clinical governance meetings were well documented and included research and quality improvement initiatives aimed at improving the overall patient experience.

## Management of risk, issues and performance

**While the teams had access to the information, they needed to provide safe and effective care, the provider did not no ensure that risk issues and performance were managed well.**

The provider had a risk register which contained hospital wide risks. Managers told us they could escalate risks to the risk register via the daily flash meeting (sit rep) which was overseen by the compliance team and reviewed monthly. However, provider did not ensure that risks were being monitored appropriately and that there was a systematic review and updating of the risk register. We saw that high risk concerns we found during this inspection were not being escalated to the risk register.

The provider had not ensured it acted on previous CQC feedback. For example, following CQC's Mental Health Act 1983 (MHA) Reviewer monitoring visits to Saltwood ward in February 2022, we raised concerns around lack of air conditioning across sites and patients' bedrooms being uncomfortably warm in the summer months. The provider submitted an action plan to complete the works by March 2023. However, during this inspection we saw that the work had still not been completed. The provider had since submitted a new action plan for installing air conditioning units on the ward.

## Information management

**Staff collected analysed data about outcomes and performance and engaged actively in local and national quality improvement activities.**

Teams had access to the information they needed to provide safe and effective care and used that information to good effect. Staff collected and analysed data about outcomes and performance and engaged actively in local and national quality improvement activities. For example, the service was had introduced Trauma Informed Practice on Saltwood ward. Staff reviewing new cases each month with a focus on complex cases to better understand how trauma exposure could impact an individual's neurological, biological, psychological and social development.

## Engagement

**Managers engaged actively other local health and social care providers to ensure that an integrated health and care system was commissioned and provided to meet the needs of the local population. Managers from the service participated actively in the work of the local transforming care partnership.**

The service was part of the Kent, Surrey and Sussex provider collaborative. The provider held regular meetings with various stakeholders including local NHS trusts, commissioners, safeguarding teams and the local police.

Staff could give feedback about the service through the annual staff survey. Staff could also feedback about the service during their supervision and one to one with their line managers. On the most recent staff survey conducted in March 2022, 86% of staff across all wards said they were proud to work for Cygnet. Ninety one percent of staff felt service users was Cygnets top priority and 83% of the respondents said they would be happy to recommend Cygnet Hospital Maidstone to relatives and friends if they needed care and treatment.

Patients and their carers could give feedback through patient satisfaction surveys and carer surveys. There was a monthly patient council meeting that was attended by patient representatives from each ward and staff from the various hospital departments including housekeeping, maintenance, dietician, chef, therapies and quality assurance and compliance administrator. Patient feedback was captured regularly at these meetings. Other ways for patient to feedback about the service included at ward rounds, ward community meetings and via the compliments, complaints and concerns process.

The service carried out a discharge survey which they reported to the commissioners.

### Learning, continuous improvement and innovation

**The provider was committed to continually improving service via structured quality improvement initiatives, research and learning.**

The service had a therapy dog that was trained to offer support and comfort to patients at the service. The dog visited the hospital weekly, and patients booked slots to spend time with the dog.

Staff across site are working together to book in meetings and workshops to talk about structure, boundaries and empowerment for teams and patients.

The hospital manager told us about the strategy for the last year which was to improve on staff general wellbeing. The hospital had invested in providing a nice and comfortable staff room, free sanitary products and beauty treatment for staff at the local college. Staff now have a wellbeing calendar and discussions around staff general health and wellbeing was a standing agenda at supervisions and one to one session with their line manager or supervisor.

Staff had worked to develop patients essential living skills via the Oak Therapies. Oak therapies involved an equine therapy, where patients are given opportunity to groom, observe and learn about their chosen horse and forming a connection and also the occupational therapy where patients are supported to develop essential living skills including learning new strategies to cope with challenges.

Managers informed us they were working towards reducing self-harm through the use of sensory therapies, which uses play activities to change the way in which the brain reacts to different stimulations.

Other initiatives developed by the service included the introduction of varying catering themes throughout the year to promote equality and diversity, and staff from different departments were encouraged to get involved. The service had introduced a team development day, that encouraged staff to work together in different settings as part of team building.

Managers informed us they were trialling a new quality improvement project called Safewards. The Safewards model is an evidence-based model that provides effective nursing interventions to create safer therapeutic ward environments.

Requires Improvement

# Forensic inpatient or secure wards

The provider had also introduced new programme such as ‘resident of the day’ and ‘back to floor’ day, which allowed staff to gain an understanding of the different departments in the hospital and how all teams worked together. Resident of the day provided staff with a greater understanding on what it was like to be a patient on the wards which also identified areas of concerns and how staff could create a better environment for patients.

This section is primarily information for the provider

# Requirement notices

## Action we have told the provider to take

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

| Regulated activity | Regulation |
|---|---|
| Assessment or medical treatment for persons detained under the Mental Health Act 1983<br><br>Treatment of disease, disorder or injury | Regulation 17 HSCA (RA) Regulations 2014 Good governance<br><br>• The provider did not ensure that its governance processes were robust enough to ensure that care is delivered in a safe and person centred way.<br>• The provider did not ensure that there was consistent learning from incident and it monitored actions from learning to ensure they were fully embedded.<br>• The provider did not ensure that the ligature risk assessment audits were understood by managers and staff to ensure appropriate understanding and oversight.<br>• The provider did not ensure that restrictive interventions were appropriately identified and recorded to ensure accurate oversight.<br>• The provider did not ensure that leaders had appropriate oversight of the recovery-orientated activities suitable to patients' care and treatment on this ward and that appropriate actions were taken to address shortfalls with this.<br>• The provider did not ensure that actions following previous Mental Health Act (MHA) 1983 monitoring visits were completed and improvements fully embedded. |

| Regulated activity | Regulation |
|---|---|
| Assessment or medical treatment for persons detained under the Mental Health Act 1983<br><br>Treatment of disease, disorder or injury | Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect<br><br>• The provider did not ensure that staff provided care that is kind, compassionate, and monitored this to ensure that compassionate care is consistent across all shifts.<br>• The provider did not ensue that patients are treated with dignity and respect at all times. |

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<br><br>Treatment of disease, disorder or injury | Regulation 18 HSCA (RA) Regulations 2014 Staffing<br><br>The provider did not ensure that staff kept to date with the mandatory and statutory training. |

| Regulated activity | Regulation |
| --- | --- |
| Assessment or medical treatment for persons detained under the Mental Health Act 1983<br><br>Treatment of disease, disorder or injury | Regulation 9 HSCA (RA) Regulations 2014 Person-centred care<br><br>• The provider did not ensure that all patients had a care plan that met their holistic needs, and care plans were not always written to reflect patients' views.<br>• The provider did not ensure that all patients had a clear plan for discharge and and that relatives were involved and kept informed of recovery progress and discharge planning.<br>• The provider did not ensure that there were clear records to show when a patient had signed or been given a copy of their care plan. The provider did not ensure that, recording of patient involvement was clear in all care plans.<br>• The provider did not always ensure the provision of meaningful activities suitable for the rehabilitative needs of the patient group.<br>• The provider did not ensure that there was a focus on recovery- orientated activities within care planning, ward rounds or team meetings.<br>• The provider did not ensure that when meaningful activity engagement was recorded as below 25 hours per week on the ward, there were clear actions in place actions to address this. |

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<br><br>Treatment of disease, disorder or injury | Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment<br><br>• The provider did not ensure that all ligature risks were managed well across the wards and that there were clear plans in place to remove or mitigate against such risks<br>• The provider did not ensure that there is a robust ligature audit programme in place, and all staff completing the ligature risk audit have the right training, skill and experience.<br>• The provider did not ensure that the seclusion rooms were robustly monitored, and clear actions were implemented to remove or mitigate against ligature risks.<br>• The provider did not ensure there was a robust governance process in place to ensure the safety and effective use of medicines.<br>• The provider did not ensure that peoples medicines were administered safely as prescribed.<br>• The provider did not ensure it followed its own policy and national best practice for the use of rapid tranquilisation.<br>• The provider did not ensure that the physical health of patients who were administered rapid tranquilisation were robustly monitored.<br>• The provider did not ensure that it followed national guidance when recording controlled drugs use.<br>• The provider did not ensure records were accurate and provide appropriate information to support review of the use of as required 'Pro Re Neta' (PRN) medicines.<br>• The provider did not ensure appropriate physical health monitoring was completed and recorded, for patients who were administered high dose antipsychotic therapies. |