Cygnet Hospital Derby

Quality Report

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Date of inspection visit: 5th and 6th April 2018
Date of publication: 04/06/2018

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

Ratings

Overall rating for this location	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive?	Good
Are services well-led?	Good

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

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

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

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

Summary of findings

Overall summary

We rated this service as Good because:

- The hospital provided a good standard of accommodation to patients. The hospital was clean and records demonstrated this. There were adjustments in place for people requiring disabled access, support of patients' spiritual needs and an extra care facility for patients needing seclusion or long-term segregation.
- The hospital was staffed safely and all shifts occurring from staff sickness, absence and vacancies were filled. Each ward had a multi-disciplinary team. Employment records demonstrated that staff were qualified and experienced for the positions they held, and all staff received an induction and mandatory training.
- Information needed to deliver care was stored securely and was available to staff when they needed it. Risk assessments and care plans were present and up to date in patients' records. Care plans were recovery focussed and demonstrated that staff shared copies with patients. The Recovery Star provided a visual record of a patients' recovery progress.
- Patients said that staff were caring, respectful and polite, and we saw evidence of this in interactions. Patients felt involved in their care and had the opportunity to make decisions about how they would like to be treated if they were unable to make that decision in the future. The hospital had initiatives in place to involve patients in making decisions about the service.
- The hospital had an established recovery college, offering educational and recovery focussed courses that were co-produced and facilitated by staff and patients. Outcome measures demonstrated the effectiveness of the college and patients described the college's activities as meaningful.
- The hospital had a strategy and delivery plan for reducing restrictive practice. Following a risk assessment from staff, where safe to do so, patients could have a key to their bedroom and their own mobile phones. Figures demonstrated that occurrences of restrictive practice including restraint, rapid tranquilisation, seclusion and long-term segregation, were low.
- The hospital used key performance indicators to gauge the performance of ward teams and had effective governance systems to monitor performance. There was an overarching local action plan that brought together all the actions from risk assessments, incidents, the Peoples Council, peer review assessments, and staff, patient, and carer surveys.

However:

- Staff had not always completed medicine charts to confirm administration of medicine or record a reason why the medicine had been omitted. Staff had not always kept records of high dose antipsychotic monitoring updated with the correct dates and outcomes of physical health checks.
- Staff did not routinely record return details on leave risk assessment forms. This meant that a record of the outcome of Section 17 leave was not maintained to inform future decision-making.

Summary of findings

Contents

Good

Location name here

Services we looked at

Forensic inpatient/secure wards; Long stay/rehabilitation mental health wards for working-age adults;

Summary of this inspection

Background to Cygnet Hospital Derby

Cygnet Hospital Derby is a purpose built facility run by Cygnet Health Care Limited. It provides services to adults aged over 18 years of age across three wards. It registered with the CQC in 2010 and provides the following regulated activities:

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

Alvaston ward is a 16 bed low secure ward for females with a primary diagnosis of emotionally unstable personality disorder or mental illness.

Litchurch ward is a 15 bed low secure ward for males with mental illness, sometimes with dual or multiple diagnoses.

Wyvern ward is 16 bed locked rehabilitation ward for males who no longer require care in a low secure environment. Attached to the ward are an additional three beds in a self-contained apartment for male patients nearing discharge. This area is called Wyvern Court.

On the day we visited, Alvaston ward had 16 patients, Litchurch ward had 14 patients and Wyvern ward had 18 patients. All patients were detained under the Mental Health Act.

Cygnet Hospital Derby has had four inspections since registering with CQC. It was last inspected in July 2015, where all five inspection domains were rated as good and an overall good rating was awarded.

Between March 2017 and March 2018, one Mental Health Act monitoring visit had occurred on Alvaston ward. The provider had developed an action plan in response to the concerns identified from this visit.

Our inspection team

The team that inspected the service comprised three CQC inspectors, two specialist advisors, and one expert by experience. The specialist advisors included a psychologist and a mental health nurse. An expert by experience is a person who has personal experience of using, or supporting someone using, mental health services.

Why we carried out this inspection

We inspected this service as part of our ongoing comprehensive mental health inspection programme.

How we carried out this inspection

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

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

During the inspection visit, the inspection team:

- visited all three wards at the hospital, looked at the quality of the ward environment and observed how staff were caring for patients
- spoke with seven patients who were using the service
- spoke with the registered manager and managers for each of the three wards

Summary of this inspection

- spoke with 19 other staff members including doctors, nurses, support workers, and a social worker
- spoke with an independent advocate
- attended and observed two hand-over meetings, and one multidisciplinary ward review
- looked at 17 care and treatment records of patients
- reviewed 28 prescription charts
- looked at a range of policies, procedures and other documents relating to the running of the service
- checked two employment records of staff employed by the hospital
- received feedback about the service from one commissioner
- collected feedback from four staff and patients using comment cards
- spoke with two family members of patients being cared for at the hospital
- returned to the hospital on 27th April 2018 to inspect the extra care facility.

What people who use the service say

Patients told us staff were caring, respectful and polite, and took interest in them as individuals. They described how staff practices protected their privacy and dignity. Patients felt involved in decisions about their care and reported that staff shared copies of care plans with them. One patient described how they had been involved in the recruitment of staff and had received a small financial reward for their participation. Most patients were satisfied with the choice and quality of food available to them.

The experiences of family members or carers of patients receiving care at the hospital varied. One responded very positively, believing that staff did a good job and they felt confident about the care provided. The other responded negatively, describing strict ward rules and a failure to meet the individual needs of their family member.

One commissioning manager believed the hospital to be patient-centred and well run.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Good

We rated safe as good because:

- Cleaning records were up to date and demonstrated that the hospital was cleaned regularly. All ward areas appeared clean and ward furnishing appeared comfortable and in good order. Staff adhered to infection control principles including using hand gel dispensers as they moved around the hospital.
- The hospital used an electronic staffing tool to calculate the numbers of qualified nurses and nursing assistants needed for each shift. The hospital filled all shifts occurring from staff sickness, absence and vacancies, and staff reported that wards were rarely short staffed.
- The hospital had a strategy and delivery plan for reducing restrictive practice. Staff reported and figures demonstrated that occurrences of restrictive practice including restraint, rapid tranquilisation, seclusion and long-term segregation, were low. Staff had introduced zonal observations in one ward area in response to reducing restrictive practices.
- The hospital had one extra care facility that was used when patients required seclusion or long-term segregation. Records demonstrated that staff had completed the necessary reviews of a patient in long-term segregation, in accordance with the Mental Health Act Code of Practice.
- Staff received training in safeguarding adults and children. Staff knew what to report and how to report it. The hospital kept a completed record of all safeguarding concerns raised and held monthly safeguarding meetings.
- Staff used recognised risk assessment tools. Records demonstrated that staff completed a risk assessment of every patient on admission and updated them regularly.
- Staff knew what events to report as an incident and how to report them. We saw evidence of change made because of learning from the outcomes of incident investigations.

However:

- Clinic cleaning records did not prompt staff to complete and record cleaning of portable examination equipment.
- In our review of medicine charts, two charts did not demonstrate that staff had signed to confirm administration of medicine or recorded a reason why the medicine had been omitted.

Summary of this inspection

- In two of the records we reviewed, staff had not kept up to date with the correct dates and outcomes of physical health checks required for the monitoring of high dose antipsychotic.

Are services effective?

Good

We rated effective as good because:

- Care plans were present in all patient records. Plans were recovery focussed, demonstrating patients' strengths and goals. Records demonstrated that staff shared copies of care plans with patients.
- There was good access to physical healthcare. Ward doctors led on physical healthcare and nursing staff made monthly checks of patients' physical health observations. All patients were registered with a local general practitioner surgery and a doctor from the surgery attended the hospital once a week.
- In addition to qualified nurses and nursing assistants, each ward had a multi-disciplinary team. Employment records demonstrated that staff were qualified and experienced for the positions they held, and all staff received an induction.
- Staff held regular and effective handovers at changes of shift. Staff recorded patient information on an electronic record to handover information.Senior and multidisciplinary team staff attended daily morning meetings to discuss staffing levels, incidents, patient risk levels, patient observation levels, and patient community leave.
- Staff received training in the Mental Health Act. Staff adhered to consent to treatment and capacity requirements, and explained to patients' their rights under the Mental Health Act. Patients had access to information about independent Mental Health Act advocacy services.
- Staff received training in the Mental Capacity Act. Staff we spoke with demonstrated an understanding of the Mental Capacity Act and its guiding principles. Staff knew how to access the hospital's policy on the Mental Capacity Act that included Deprivation of Liberty Safeguards.

However:

- Staff did not routinely record return details on the leave risk assessment form. This meant that a record of the outcome of Section 17 leave was not maintained to inform future decision-making.

Are services caring?

Good

We rated caring as good because:

Summary of this inspection

- Patients believed that staff were caring, respectful and polite. They described ways that staff took care to protect privacy and dignity when delivering care. We saw staff interacting warmly and respectfully with patients, offering help and support.
- Patients felt involved in their care and reported that staff shared copies of their care plans with them. Patients had the opportunity to make advance statements that detailed how they would like to be treated if they were unable to make that decision in the future.
- Patients could get involved in making decisions about the service. This included a People's Council, governance meetings, staff recruitment, surveys and audits.
- The hospital had initiatives to involve family and carers. This included a carer's forum and quarterly carer's survey.

Are services responsive?

Good

We rated responsive as good because:

- Wards had guidance around admission and discharge criteria, identifying the client group, admission criteria, specific exclusions and discharge criteria. The hospital manager identified the importance of prioritising patient safety over full bed occupancy on wards.
- All patients had a single bedroom with shower and toilet. Following a risk assessment from staff, where safe to do so, patients could have a key to their bedroom and their own mobile phones.
- Patients had access to activities, including at weekends. There was also a recovery college at the hospital, offering educational and recovery focussed courses that were co-produced and facilitated by staff and patients.
- The hospital had made adjustments for people requiring disabled access and supported patients' spiritual needs. There was a choice of food to meet dietary requirements of religious and ethnic groups.
- Patients knew how to make a complaint and felt confident to do so. Staff knew how to respond to concerns raised with them and received feedback on the outcomes of complaints investigations. The hospital displayed information on how to make a complaint.

Are services well-led?

Good

We rated well-led as good because:

Summary of this inspection

- Staff knew and agreed with the hospital's values. The hospital's objectives reflected the organisation's values and objectives.
- The hospital manager and clinical manager were visible and accessible to staff and patients.
- The hospital used key performance indicators to gauge the performance of ward teams and had effective governance systems to monitor performance. There was an overarching local action plan that brought together all the actions from risk assessments, incidents, the Peoples Council, peer review assessments, and staff, patient, and carer surveys.
- Staff spoke positively about working at the hospital, including morale and job satisfaction. They felt confident to raise concerns without fear of victimisation and knew how to use the hospital's whistleblowing process.

Detailed findings from this inspection

Mental Health Act responsibilities

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

The hospital provided staff with Mental Health Act and Code of Practice training as part of mandatory training requirements. Staff we spoke with demonstrated an understanding of the Mental Health Act, Code of Practice and its guiding principles.

The hospital employed three staff, one for each ward, in the role of Mental Health Act administrator, medical secretary and Care Programme Approach administrator. Staff knew who their Mental Health Act administrators were and how to contact them. Administrators carried out regular audits to ensure that the Mental Health Act was being applied correctly and staff met to discuss the outcome of audits at integrated governance and clinical audit meetings.

The service kept clear records of leave granted to patients, provided information to patents in line with section 132 of the Mental Health Act, and staff adhered to consent to treatment and capacity requirements.

Patients had access to information about independent Mental Health Act advocacy services and posters were on display at the wards we visited.

Mental Capacity Act and Deprivation of Liberty Safeguards

The hospital provided staff with Mental Capacity Act training as part of mandatory training requirements. Staff demonstrated an understanding of the Mental Capacity Act and its five statutory principles.

The hospital had a policy on the Mental Capacity Act that included Deprivation of Liberty Safeguards. Staff were aware of the policy and knew how to access it.

Staff described how they provided patients with assistance to make specific decisions for themselves before they assumed the patient lacked the mental capacity to make it. When patients lacked capacity, staff described how they would make decisions in a patient's best interests, recognising the importance of the person's wishes, feelings, culture and history.

Adherence to the Mental Capacity Act was ensured by the Mental Health Act administrators. This included regular audits that staff shared and discussed at integrated governance and clinical audit meetings.

Between September 2017 and February 2018, the hospital had made no Deprivation of Liberty Safeguard applications.

Good

Forensic inpatient/secure wards

Safe	Good
Effective	Good
Caring	Good
Responsive	Good
Well-led	Good

Are forensic inpatient/secure wards safe?

Good

Safe and clean environment

- All wards were locked and accessed through air-lock doors. Air-lock doors consist of a small chamber between two locked doors, the locked doors cannot be opened at the same time. Wyvern ward had fewer security measures than the low secure wards. For example, patients had unsupervised access to the ward kitchen and courtyard.
- Ward staff allocated a daily-designated security person to monitor and carry out security procedures. These included checking windows, locks, keys, sharps and utensils. Security handovers took place between shifts. The hospital provided new staff with a security induction.
- Staff obtained and signed for hospital keys from reception at the start and finish of shifts. We saw that staff kept keys firmly attached to them at all times using belts and pouches.
- The hospital had security policies and procedures in place to guide staff practice. Staff were aware of these and knew how to access them.
- The hospital had closed circuit television installed in communal areas, ward clinics and courtyard areas. Staff used closed circuit television recordings as audit data to ensure prescribed observations were completed correctly and that staff presence in communal areas of the wards was maintained.
- The layout of wards did not allow staff to observe all areas from a central location. Staff positioning, prescribed observations, closed circuit television and convex mirrors helped staff to manage risks.
- The hospital completed ligature risk audits every six months. Ligature points are fixtures to which people intent on self-harm might tie something to strangle them self. Where ligature risks were identified, we saw resulting actions to manage the risk. This included fitting ligature proof taps in bathroom areas and changes to bedroom and ensuite doors on Alvaston ward. Staff assessed patients' risk of ligature individually. Resulting management plans and prescribed observations allowed staff to manage any identified risk. Staff were aware of potential ligature points on wards and described how they used observations to manage risks. Staff kept ward areas of greater ligature risk locked and supervised patients when they accessed these areas. For example, within the courtyard areas. Records from integrated governance and clinical audit meetings demonstrated that senior staff met to discuss the outcomes of ligature audits, resulting action plans and learning from ligature incidents.
- Wards had anti-barricade doors. Staff received training on anti-barricade mechanisms at induction and anti-barricade bolts were present on wards. In an emergency, staff could quickly open anti-barricade doors outwards.
- Each ward provided same sex accommodation in accordance with national guidance on eliminating mixed sex accommodation.
- Patients and staff reported they felt safe on wards.

Good

Forensic inpatient/secure wards

- All ward clinic rooms were visibly clean, tidy and well ordered. Clinic cleaning records showed that staff cleaned regularly, although Litchurch ward had an incomplete record in March 2018 containing four omissions.
- The clinic room on Wyvern ward was too small to accommodate an examination couch. When necessary, staff completed physical examinations in patients' rooms or a private area on the ward where the closed circuit television was masked to prevent viewing.
- All wards had access to examination equipment necessary for carrying out physical health checks. Clinic cleaning records did not prompt staff to complete and record cleaning of portable examination equipment.
- Staff made checks of clinic room and medicine fridge temperatures. However, records did not always demonstrate that this occurred daily on all wards. Records were complete on Alvaston and Wyvern wards. On Litchurch ward, we found eight omissions occurring in December 2017 and three in March 2018. Where omissions had occurred, we saw that this had been identified by the ward manager with recorded actions to raise this in supervision with the responsible nurse.
- Emergency grab bags including oxygen, an automated external defibrillator, and emergency drugs were stored securely in locked ward offices. This was because not all ward staff had immediate access to the clinic room. Other emergency equipment included ligature cutters and door anti-barricade bolts. Records showed that staff checked all emergency equipment regularly. The hospital provided staff with intermediate life support training as part of mandatory training requirements.
- The hospital had one extra care facility, used when patients required seclusion or long-term segregation. The extra care facility was located on Litchurch ward. Litchurch ward staff checked the facility when it was not in use during daily ward environment checks. The facility had two access points. Litchurch ward patients accessed the facility directly from the ward. Patients from Alvaston ward and Wyvern ward accessed it from a private corridor external to Litchurch ward.
- The extra care facility had an intercom system that allowed for communication when the door was locked and had toilet facilities and a clock that was visible to patients from within the room. Staff observed patients through observations windows, although this required staff using an external courtyard window if a patient positioned them self on the floor behind the bed.
- Staff kept ligature knives, equipment for checking physical observations and safe bedding in a locked cupboard within the facility. Staff also had access to seclusion and long-term segregation policies, and the correct paperwork to record the care and treatment provided in the extra care facility.
- All ward areas appeared clean and well maintained. Ward decoration included purchased pieces and examples of patients' own work. Staff reported that patients contributed to decoration decisions. Overall, ward furnishing appeared comfortable and in good order. The hospital employed three maintenance staff that contributed to an on-call rota to provide 24-hour cover. The hospital had an annual maintenance schedule in place. Maintenance staff were present and contributed updates to monthly heads of department meetings.
- The hospital completed Patient Led Assessments of the Care Environment (PLACE) as part of infection control audits. In March 2018, patients on Litchurch ward rated ward cleanliness and the condition/appearance of the ward as passes. This meant that all items assessed met the guidance as set out on the assessment form.
- Staff adhered to infection control principles including handwashing. The hospital provided staff with infection control training as part of mandatory training requirements. We saw posters demonstrating correct handwashing techniques located at sink points around all wards. Hand gel dispensers were located throughout the hospital including entrances to ward. We saw staff using them as they moved around the hospital.
- Cleaning records were up to date and demonstrated that the hospital was cleaned regularly. The hospital employed four whole time equivalent housekeeping staff who provided cover seven days a week. The hospital's operations manager checked cleaning records to ensure that domestic staff had completed all weekly cleaning tasks. The hospital manager and

operations manager toured the hospital monthly to check all cleaning and maintenance. Housekeeping updates were provided at monthly heads of department meetings.

- Staff completed environmental risk assessments regularly. This included daily ward environment checks, ligature audits, infection control audits and fire risk assessments. Action plans to address identified risks were in place and monitored at integrated governance meetings.
- Reception staff checked and activated personal alarms before giving them to ward staff. During the inspection, we saw all staff carrying personal alarms and observed staff responding promptly to alarm calls from around the hospital. Nurse call points were present in all bedrooms, ward bathrooms and some areas of the main ward environments. There were no call points in patients' individual ensuite bathrooms. However, the hospital reported no incidents as a direct result of this.

Safe staffing

- The total number of substantive whole time equivalent qualified nurses was 26. The hospital had six whole time equivalent qualified nurse vacancies. Wyvern ward had three vacancies, Alvaston ward had two, and Litchurch ward had one.
- The total number of substantive whole time equivalent nursing assistants was 36.5. The hospital had two whole time equivalent nursing assistant vacancies; these were both on Alvaston ward.
- The hospital had plans in place to ensure staff recruitment and retention. This included an established preceptorship programme for newly qualified nurses, flexible working hours for all staff and an increased benefits package for middle grade doctors. The hospital also supported nursing assistants to become qualified nurses through its bursary scheme. This would see a minimum of two qualified nurses return to the hospital each year until 2022.
- Between 1 December 2017 and 28th February 2018, bank staff filled 330 shifts to cover staff sickness, absence or vacancies. Wyvern ward had the greatest number of shifts covered by bank staff, 198 in total.
- Between 1 December 2017 and 28th February 2018, agency staff filled 106 shifts to cover staff sickness, absence or vacancies. Alvaston ward had the greatest number of shifts covered by agency staff, 80 in total.
- During this period, the hospital had filled all bank and agency shifts resulting from staff sickness, absence or vacancies.
- The staff sickness rate in the last 12 months was 4.1%. This was lower than the NHS average of 4.8%.
- In the same period, the hospital had a 22.6% turnover rate of all substantive staff leavers. Staff turnover on Wyvern ward was identified on the hospital's risk register. This included a full description of the risk and planned actions to reduce the risk.
- The hospital used an electronic staffing tool called 'hours per patient per day'. The tool identified the core number of staff required based on the bed occupancy of the ward. It identified the numbers of qualified nurses and nursing assistants needed for each shift.
- The 'hours per patient per day' tool allowed ward managers to 'bank' hours to use later. For example; rota additional staff on ward round days, busy shifts or at weekends to cover additional activities.
- Ward managers had the flexibility to adjust staffing levels daily to take account of patient needs, escort duties, observation levels and staffing of the extra care facility.
- The hospital had introduced a daily morning meeting where senior staff met to discuss staffing levels. We saw that discussions included staff numbers, a breakdown of permanent, bank and agency staff and identified where staff moves were required to cover patient activity and planned staffing levels for weekends
- Staff worked two shifts to cover the 24-hour period. Staffing numbers during the day were two qualified nurses and five nursing assistants for Alvaston ward, two qualified nurses and two nursing assistants for Litchurch ward, and two qualified nurses and four nursing assistants for Wyvern ward. Staffing numbers during the night were two qualified nurses and three nursing assistants for Alvaston ward, two qualified nurses and two nursing assistants for Litchurch ward, and one

qualified nurse and three nursing assistants for Wyvern ward. Ward managers worked during the day Monday to Friday and were supernumerary to ward staffing numbers.

- Staff reported that wards were rarely short staffed. Between February 2017 and February 2018, only two incidents of short staffing were reported. However, some staff from Litchurch ward believed that their own ward was sometimes left short staffed when required to assist in managing incidents on Alvaston ward.
- The hospital employed its own bank of staff that had completed induction and training to work on wards. The hospital held a contract with a local nurse agency and where possible only used agency staff that were familiar with their wards. The hospital attempted to fill shifts with bank staff before contacting the nurse agency. Bank and agency staff were required to attend handovers at the start of a shift; this informed them of individual patient needs.
- A qualified nurse was present on the ward at all times. This was confirmed by our observations, and interviews with staff and patients.
- There were enough staff so that patients could have regular one to one time with their named nurses. Staff, patients and our observation of records confirmed this.
- Staff identified escorted leave as a priority for patients. Leave was sometimes postponed but rarely cancelled. Patients we spoke with confirmed this. Staff reported that ward activities could sometimes be cancelled because of incidents, staff moves or staff facilitating visits. Three staff and one patient identified that access to the gym and information technology suite was sometimes cancelled during the evening. The recovery college was staffed specifically to avoid cancellations. Staff reported that ward teams and occupational therapy worked together to facilitate escorted leave and ward activities.
- There were enough staff to carry out physical interventions including observations and restraint. Staff received mandatory training in manual handing and the prevention and management of violence and aggression.
- Staff reported they called for assistance from other wards when additional staff were needed to assist in physical interventions. Alvaston ward manager reported resistance amongst some staff from other wards to work on Alvaston ward, believing this to be because of concerns about not knowing patients and their needs thoroughly. To address this, the hospital manager met with staff that had refused to move to assist Alvaston ward, and made additional support and supervision available to staff with concerns about working there. The hospital had a culture of staff rotation around wards to broaden skills and develop experience. This included induction and preceptorship practices.
- Each ward had a 0.5 whole time equivalent consultant psychiatrist and one whole time equivalent middle grade doctor. Consultants and doctors contributed to an on-call rota that ensured adequate medical cover day and night.
- Ward managers and clinical team leaders contributed to an on-call rota that ensured managerial cover day and night. The hospital and clinical manager contributed to a second on-call rota to provide additional support to staff when needed.
- The hospital provided all staff with mandatory training. The hospital monitored completion rates monthly and reported on them as part of key performance indicators at ward governance meetings. Between December 2017 and February 2018, monthly compliance for mandatory training had not fallen below 95%. Mandatory training included fire awareness, infection control, and information governance.

Assessing and managing risk to patients and staff

- Between September 2017 and February 2018, the hospital reported 12 incidents of seclusion. In the same period, the hospital reported one incident of long-term segregation. All incidents of seclusion and long-term segregation involved patients from Alvaston ward. At the time of the inspection, the reported incident of long-term segregation was still in progress, having commenced in February 2018. The patient in long-term segregation was being supported each shift by three additional staff. The hospital had identified a placement for the patient on a medium secure unit and was actively liaising with the provider to identify when this would become available. The hospital had a policy for seclusion and long-term segregation in place that

included examples of best practice to guide staff. Staff reported that seclusion and long-term segregation was rarely used and used only as a last resort to maintain safety.

- We reviewed the record of the patient in long-term segregation. We found staff had completed the necessary reviews in accordance with the Mental Health Act Code of Practice. This included daily reviews, responsible clinician reviews and external review. We saw that staff had informed the local safeguarding team and NHS commissioning manager. Management plans included jointly agreed goals to terminate segregation. Staff wrote daily records that were thorough and included details of presentation, behaviour, mood and activity.
- Between September 2017 and February 2018, the hospital reported 241 incidents of the use of restraint relating to nine patients. Alvaston ward had experienced 239 incidents relating to seven patients and Litchurch ward had experienced two incidents relating to two patients. During this period, Wyvern ward had experienced no incidents of the use of restraint. Guidance on the use and monitoring of a patient during and following restraint was included in the prevention and management of violence and aggression policy. Staff reported that restraint was rarely used. The hospital was a member of the Restraint Reduction Network and through this was promoting initiatives to reduce all restrictive practice including physical restraint.
- Of the 241 incidents of the use of restraint, 71 resulted in the use of prone (face down) restraint. All incidents of prone restraint occurred on Alvaston ward. Staff told us that prone restraint was taught as part of prevention and management of violence and aggression training, and only as a last resort to manage violence. The hospital's prevention and management of violence and aggression policy included guidance for staff on prone restraint.
- Seventeen of the 71 incidents of prone restraint had resulted in the use of rapid tranquilisation. Guidance on the use and monitoring of a patient following rapid tranquilisation was included in the prevention and management of violence and aggression policy. This also referenced guidance on practice from the National Institute for Health and Care Excellence. Staff reported they rarely used rapid tranquilisation but were aware of the policy to guide practice and the book used to record monitoring of physical observations.
- All care records reviewed demonstrated that staff completed a risk assessment of every patient on admission. Records also showed that staff updated risk assessments regularly and following incidents. Risk assessments were detailed and informed care plans relating to risk management.
- Staff used recognised risk assessment tools, including the Short Term Risk Assessment and Treatability tool (START) and the Historical, Clinical Risk assessment (HCR20). The START considered a number of risk categories including violence, self-harm, substance misuse, self-neglect and vulnerability. The HCR20 assesses a patient's probability of violence. Staff received training in risk management and START as part of mandatory training requirements.
- The hospital had a reducing restrictive practice strategy and delivery plan in place. Ward managers reported on restrictive practices at heads of department and ward integrated governance meetings including restraint, rapid tranquilisation, and blanket restrictions. Blanket restrictions are the restrictions on the freedoms of patients receiving mental healthcare that apply to everyone rather than being based on individual risk assessments The hospital had introduced reducing restrictive practice leads and a patient-led reducing restrictive practice work group. Staff from different locations met to discuss and share practice at regional delivery board meetings.
- The hospital was implementing the Safewards model, a nationally recognised initiative to improve patient involvement and help staff understand why wards can be unsafe at times. Alvaston ward was actively implementing Safewards interventions and Litchurch ward had implemented Safewards 18 months ago. Litchurch ward manager reported it had reduced feelings of confinement for patients.
- Alvaston ward had recently introduced zonal observations as part of a reducing restrictive practice initiatives. Many patients referred to the hospital had been prescribed enhanced observation levels, observed directly by one or two staff. The hospital believed that

some enhanced observations negatively affected patient behaviour and staff engagement. Zonal observation aims to enhance observation of a group of patients while also involving individual patients in the management of their own risk. Staff on Alvaston ward had received additional training in zonal observations. The hospital continued to recognise that enhanced observations were required for the short-term management of behavioural disturbance or during periods of distress to prevent suicide or serious self-harm. We saw that enhanced observations involving three staff were being used to support a patient subject to long-term segregation.

- The hospital provided staff with an engagement and observation policy to guide practice. It also provided site-specific training on how to undertake observations and how to record them. This included how to carry out observations in patients' bedrooms and check for signs of life. Staff allocated hourly responsibility for completing patient observations each shift and this was displayed in ward offices. Staff recorded observations on individual sheets indicating the level of observation that each patient was prescribed. We saw that patient observations were recorded at the time staff saw the patient and occurred at random times within an hour. Staff also recorded if a patient was on leave.
- The hospital provided staff with policies and training to guide practice when searching patients. Staff individually assessed the need to search patients on Wyvern ward. On low secure wards, staff searched all patients before leaving the ward and on return from visits or leave. We saw staff carried out patient searches in pairs and in a private area of the ward. Staff identified this as a blanket restriction and we saw plans in place to introduce practice from Wyvern ward to low secure wards.
- The hospital provided staff with training in de-escalation and restraint techniques as part of prevention and management of violence and aggression training. The training had recently been extended to include the management of patients in seclusion and use of rapid tranquilisation. Staff reported that restraint was used rarely and only if de-escalation techniques had failed. The hospital had a prevention and management of violence and aggression policy in place to guide staff practice. This included guidance on de-escalation techniques.
- The hospital provided staff with safeguarding training for adults and children. There were also safeguarding policies in place and an identified safeguarding lead to guide staff practice. Staff knew what to report and how to report it. Staff reported safeguarding concerns as an incident, recorded information in patients' care records and developed care plans to protect patients. Staff reported good communication and feedback from concerns raised with the local safeguarding team. Managers reported on safeguarding concerns at monthly ward governance meetings.
- Between February 2017 and February 2018, the hospital raised 21 safeguarding concerns to the local authority safeguarding team. The hospital kept a record of all safeguarding concerns raised. The record included incident reports, investigation reports and notifications to the CQC. The hospital held monthly safeguarding meetings and reported on safeguarding at local board meetings.
- The hospital had established medicines management practices in relation to ordering, deliver and checking medicines. There was a contract in place for the disposal of clinical waste. Staff had access to current British National Formularies for reference. The hospital held a contract with an independent pharmacy provider who visited weekly and policies relating to medicines management were in place.
- The hospital provided staff with training in medicines management as part of mandatory requirements. Records showed that all eligible staff had completed this. Qualified nurses received an annual assessment of medicines management practices including administration. Two staff administered all medicines to patients. The hospital trained nursing assistants to check medicines administered by a qualified nurse.
- During the inspection, we reviewed 28 medicine charts. We found two medicine charts where staff had either not signed to confirm administration of medicine or record a reason why the medicine had been omitted. We also found two records of high dose antipsychotic monitoring records that staff had not kept updated with

the correct dates and outcomes of physical health checks. We brought this to the attention of the ward doctor and immediate changes were made to correct this.

- The hospital had systems in place to manage medicine administration errors, most commonly recording omissions. When an error was identified, the qualified nurse responsible was required to complete a reflective account and undergo a further assessment of medicines management practices. The hospital reported a reduction in medicine administration errors because of this.
- An identified pharmacist visited wards weekly to audit medicine administration charts and medicines management practices. Reviews included medicines reconciliation, high dose antipsychotic prescribing, administration omissions, rapid tranquilisation incidents and storage of controlled drugs. The pharmacist fed back to staff following the visit through an electronic system and attended integrated governance meetings.
- Staff were aware of specific outlier issues like falls and pressure sores. Staff liaised with ward doctors and developed management plans for patients identified at risk of falls. Staff assessed patients for pressure ulcers as part of a physical health assessment on admission and referred concerns to a tissue viability nurse attached to the general practitioner service. Staff used a specific measurement tool to assess and monitor patients' risk of pressure sores.
- Staff reported falls and pressure ulcers as incidents. Between February 2017 and February 2018, the hospital reported 43 falls. In the same period there were no incidents involving pressure ulcers.
- The hospital had safe procedures for children that visited the hospital. Hospital social workers assessed the suitability and risk of children visiting prior to visits taking place. All visits involving children occurred in the visiting room. The hospital provided visiting information that included arrangements for children visiting on its website.

Track record on safety

- Between February 2017 and February 2018, the hospital recorded 34 serious incidents. This included accidents, infection control incidents and one patient death.
- The hospital recorded one patient death following an incident involving a ligature. We saw that the hospital had completed a root cause analysis investigation that identified good practice, service delivery problems and contributory factors. Recommended improvements in safety have included changes to storage of emergency equipment and individual staff performance factors to be addressed at supervision. We saw that incident feedback was a standing agenda item at integrated governance meetings and board meetings. The hospital manager attended quarterly Cygnet governance meetings where corporate lessons were shared.

Reporting incidents and learning from when things go wrong

- All staff we spoke with knew what events to report as an incident. This included episodes of restraint, medication errors, accidents and patient absences without leave. Staff used an incident reporting form to record incidents, recorded details of the incident in patients care records and updated risk assessments. Staff had access to an incident reporting and management policy to guide their practice.
- Staff reported all incidents that should be reported. Between February 2017 and February 2018, staff reported 2825 incidents. Alvaston ward accounted for 2193 incidents, Litchurch ward 305, Wyvern ward 299, and 28 in other areas of the hospital. Categories of incidents reported included accidents, medication errors, episode of self-harm and episodes of violence.
- Senior staff met to discuss all reported incidents at the daily morning meeting. Ward managers reviewed all incidents and reported on all serious untoward incident investigations at monthly ward governance meeting.
- Staff received feedback from investigations of incidents and met to discuss feedback at staff meetings, handovers, and during supervision. Staff were able to give examples of lessons learned from incidents occurring at other Cygnet locations.

Good

Forensic inpatient/secure wards

- Staff were open and transparent and explained to patients if and when something went wrong. The hospital's policy for patient safety incident reporting and management detailed what Duty of Candour applies to and the requirements and processes for staff to follow.
- There was evidence of change made because of learning from the outcomes of incident investigations locally and from other Cygnet locations. This included the introduction of a 'good lives group' for all male patients to facilitate the positive transfer from hospital to a community setting. This was implemented following increased numbers of absences without leave from Wyvern ward.
- Staff received debrief and support after incidents. They reported debriefs happened immediately after incidents and another meeting happened later giving staff opportunity to reflect and consider lessons learned. Staff also reported that patients were offered a debrief that encouraged reflection after incidents.

Are forensic inpatient/secure wards effective?

(for example, treatment is effective)

Good

Assessment of needs and planning of care

- We reviewed 17 care and treatment records. All contained a comprehensive assessment that staff had completed at the initial patient assessment. Areas of assessment included mental health history, medical history, social history and substance misuse. All patients admitted to the hospital had a three month assessment period during which assessments were updated.
- All records reviewed demonstrated that staff completed a full physical health examination on admission and provided ongoing monitoring of physical health needs. We saw evidence of Clozapine monitoring, blood sugar monitoring, liaison with external specialists and monthly physical health observations. Patients reported feeling confident about the physical healthcare provided to them.
- Care plans were present in all the records reviewed. The majority of records contained care plans that were detailed, written in the first person, linked to assessments and covered a full range of needs. Plans were recovery focussed, demonstrating patients' strengths and goals. Occasionally, we saw that some plans lacked detail or focussed on staff actions rather than partnership working with patients. Records demonstrated that staff shared copies of care plans with patients and made plans available in other formats, including easy read.
- Records demonstrated that staff had updated care plans during a patient's admission. This included following multi-disciplinary reviews, one to one named nurse sessions or when staff and patients identified a new care need.
- Information needed to deliver care was stored securely and was available in an accessible form to staff when they needed it. Staff used a combination of paper and electronic notes to record care and treatment provided to patients. Paper notes were stored securely in locked offices and included comprehensive assessments, risk assessments and care plans. Electronic notes had only been recently introduced and only included a patient's daily risk assessment and continuous record. Staff accessed electronic notes with individual passwords. Staff reported that electronic notes would eventually include risk assessments and care plans.

Best practice in treatment and care

- Staff reported using National Institute for Health and Care Excellence guidance when prescribing medication. This included guidance specific to psychosis and schizophrenia, personality disorders, and the management of violence and aggression. Medical staff also used the Maudsley Prescribing Guidelines and the British National Formulary when prescribing medicines.
- The hospital offered psychological therapies recommended in National Institute for Health and Care Excellence guidance. Each ward had a psychologist and an assistant psychologist employed as part of its multi-disciplinary team. Interventions included cognitive behavioural therapy, dialectical behavioural therapy, trauma work and relapse prevention. Cognitive behavioural therapy and dialectical behavioural therapy are designed to help people change patterns of behaviour that are not helpful, such as self-harm, suicidal thinking and substance abuse. Some members

of ward staff had also received training in providing patients with dialectical behavioural therapy. Staff assessed a patient's need for therapy during an initial assessment period following admission. Following this, there were no waiting lists to access therapies.

- There was good access to physical healthcare and the hospital had a physical healthcare policy in place. Middle grade ward doctors led on physical healthcare including physical examinations, blood tests and electrocardiograms. Ward doctors reviewed results and, if necessary, referred concerns to the general practitioner. The general practitioner was then responsible for escalation and referral to specialists when needed. The hospital had facilities for, and some doctors were able to perform catheterisation, suturing and removal of foreign objects. This meant that patients requiring these interventions were not always sent to hospital.
- Staff made monthly checks of patients physical health observations and recorded them on a shared electronic record. The record also included test due dates, the results of tests and external appointments dates, including dental and optician.
- All patients were registered with a local general practitioner surgery. A doctor from the surgery attended the hospital once a week and visited each ward. Patients able to attend at the surgery to see a doctor were encouraged to make an appointment and do so. The general practitioner surgery provided patients with preventative interventions including vaccinations such as flu jabs.
- Substance misuse and smoking cessation workers were present on wards. They provided interventions including one to one sessions and substance misuse groups based on self-management and recovery training. The hospital had implemented a smoke-free policy in April 2017 and staff were trained in smoking cessation interventions to support patients. Nicotine replacement therapy was available to patients admitted.
- 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. The Recovery Star provided a visual record of a patients' recovery progress and teams reviewed scores at care programme approach meetings. Staff also provided examples of using physical health rating scales with patients, including the modified early warning score.
- Staff of all grades participated in clinical audit. Staff completed a range of audits, including clinic rooms, physical healthcare, ligatures, clinical notes, patient monies, observations and infection control. Many audits referenced National Institute for Health and Care Excellence guidance. Ward managers fed back on completed audits and actions to achieve improvements at heads of department meetings. Integrated governance meetings included updates on audits and resulting action plans.

Skilled staff to deliver care

- In addition to qualified nurses and nursing assistants, each ward had a multi-disciplinary team. This included a consultant psychiatrist, a middle grade doctor, an occupational therapist, an occupational therapy assistant, a social worker, an assistant social worker whose role included numeracy and literacy, a psychologist, an assistant psychologist, and a substance misuse and smoking cessation worker.
- Additional visiting professionals contributed to the multi-disciplinary team. This included the general practitioner service, speech and language therapist, dietician, podiatrist, pharmacist, complementary therapist, and music therapist.
- Employment records demonstrated that staff were qualified and experienced for the positions they held. Employment records were stored electronically and accessed only by approved senior staff with individual passwords. Interviews were structured specifically to the role applied for and followed a scoring system. The hospital made checks of qualified staff's professional registration and revalidation. Professional references were obtained to cover a minimum period of two years. Disclosure and Barring checks were completed prior to starting work and updated every three years. The hospital had a safe recruitment, selection and appointment policy to support managers through the recruitment process.
- The hospital held a service level agreement with a local NHS trust to provide a programme of vaccinations and support for needle stick injuries to all staff.

- The hospital provided all staff with an induction. Induction packages included those 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. Induction used the Care Certificate standards as a benchmark for nursing assistants.
- Patients on Wyvern ward, as part of the recovery college, had developed an induction book for staff and students new to the ward. Patients mentored staff and students to assist them to complete the book. The hospital was a finalist in the 2017 National Service Users Awards for this project.
- The hospital provided staff with supervision. Supervision is a meeting to discuss case management, to reflect on and learn from practice, personal support and professional development. The hospital had a target supervision rate of 90% and records showed that all wards exceeded this target in the 12 months to February 2018. Staff recorded, signed and shared copies of supervision discussions. Senior staff monitored supervision rates during integrated ward governance meetings.
- Managers provided staff with appraisals of their work performance. Appraisals were annual, but staff met to review progress and goals every six months. Appraisals included discussion about continued professional and career development. The hospital had a target appraisal rate of 100%. The percentage of non-medical staff that had an appraisal in the 12 months to February 2018 was Litchurch ward 94%; Wyvern ward 82% and Alvaston ward 89%. Staff sickness, absence or maternity leave accounted for shortfalls in completed appraisals.
- Managers planned team meetings to occur monthly. Staff reported that team meetings followed an agenda, were recorded and all staff were sent a copy of the resulting record. Records showed that staff meetings included discussions about incidents, lessons learnt, training and positive comments.
- Managers discussed learning needs with staff during supervision and appraisals. Staff had access to additional training that included self-harm management, boundaries, resilience, sex offender training and dialectical behaviour therapy training. Leadership training was available for ward managers. One doctor reported that although they held a non-training role, the hospital had supported them to access additional training that included the approved clinician course. The hospital encouraged medical staff to attend national and international conferences. Attendance in 2017 had included The Royal College of Psychiatrists National Conference and the American Medical Association Psychiatric Conference.
- Ward managers initially addressed poor staff performance in supervision. This included developing plans to improve performance and support to achieve it. Managers demonstrated when and how to escalate concerns higher in the organisation and had recently received training on employment law. In the 12 months to February 2018, the hospital reported no incidents of staff supervised practice or suspensions.

Multidisciplinary and inter-agency team work

- Staff held regular and effective multi-disciplinary meetings. Each ward held a weekly multidisciplinary meeting. Staff discussed all patients on the ward but only saw individual patients in the multidisciplinary meeting once every two weeks. We observed one multidisciplinary team meeting. Discussions included physical health, risk assessments, planned leave and discharge plans. Staff spoke kindly with the patient and involved them in discussions about their care
- Effective handover meetings between ward staff took place at changes of shift during the day. Staff recorded patient information on an electronic record to handover information to all staff commencing a shift. This information included Mental Health Act status, observation levels, identified risk, medication administered, mental health presentations and significant history from the previous seven days. Staff discussed each patient, highlighting individual needs and appointments. Staff stored and accessed completed handover sheets on computers. Following handover, the nurse in charge commencing duty completed an initial observation of all patients. We observed one ward handover meeting and saw staff listened and contributed to discussions about patients.

- Senior and multidisciplinary team staff attended daily morning meetings at 9.30am. Staff discussed staffing levels, incidents, patient risk levels, patient observation levels, and patient community leave. We observed one meeting during which staff discussed a physical health incident that occurred overnight, and planned staffing levels for the weekend ahead.
- Staff worked with clinical commissioning groups and community mental health teams to plan for discharges. Staff invited care co-ordinators and commissioning leads to care programme approach and Section 117 discharge planning meetings. Staff did report slow communication from the Ministry of Justice that resulted in delays to access leave for some patients. Staff regularly contacted the Ministry of Justice for updates and assisted patients to make complaints.
- We spoke with one commissioning manager and one general practitioner and both reported effective working relationships with staff at the hospital.

Adherence to the MHA and the MHA Code of Practice

- Trained and competent staff members examined Mental Health Act papers when detained patients were admitted to the hospital.
- The service kept records of the leave granted to patients. Leave recording forms detailed the type of leave a patient could access, durations, frequency and if any escorts were required. Patients were required to sign leave forms to demonstrate their involvement in the decision to grant leave and indicate if they would like staff to share a copy of the leave form with family members or carers. We found that staff did not routinely record return details on the leave risk assessment form. This meant that a record of the outcome of leave was not maintained to inform future decision-making.
- The hospital provided staff with Mental Health Act and Code of Practice training as part of mandatory training requirements. When we visited, 87% of eligible staff had received training. Staff we spoke with demonstrated an understanding of the Mental Health Act, Code of Practice and guiding principles.
- We saw that staff adhered to consent to treatment and capacity requirements. We reviewed 28 medicines charts and found that all had correctly completed legal authorisation forms attached. This meant that nurses administered medicines to patients under the right legal requirements.
- Staff provided information to patents in line with section 132 of the Mental Health Act. Staff explained to patients' their rights under the Mental Health Act and provided information leaflets. Staff recorded in care records when this had been completed.
- The hospital employed three staff, one for each ward, in the role of Mental Health Act administrator, medical secretary and care programme approach administrator. Administrators reminded clinical staff of meetings, renewal dates and made regular audits of Mental Health Act paperwork. Staff knew who their Mental Health Act administrators were and how to contact them.
- Staff stored Mental Health Act paperwork securely. Original documents were kept in the Mental Health Act administrator's office and copies were on wards, filed in patients' care records.
- Mental Health Act administrators carried out regular audits to ensure that the Mental Health Act was being applied correctly. Monthly audits included section132 rights, consent to treatment forms present and correct with medicine charts, and section17 leave forms. Audits were presented at bi-monthly integrated governance and clinical audit meetings. Records from these meetings demonstrated learning from audits.
- Patients had access to information about independent Mental Health Act advocacy services and posters were on display at the wards we visited. Staff were aware of advocacy services and knew how to contact them. We spoke with a visiting advocate who reported that they visited wards regularly, attending ward rounds and care programme approach meetings to support patients.

Good practice in applying the MCA

- The hospital provided staff with Mental Capacity Act training as part of mandatory training requirements. When we visited, 95% of eligible staff had received training. Staff demonstrated an understanding of the Mental Capacity Act and particularly the five statutory principles.

Good

Forensic inpatient/secure wards

- Between September 2017 and February 2018, the hospital had made no Deprivation of Liberty Safeguard applications.
- The hospital had a policy on the Mental Capacity Act that included Deprivation of Liberty Safeguards. Staff were aware of the policy and knew how to access it. We saw posters displayed reminding staff of the five statutory principles of the Mental Capacity Act.
- Staff described how they provided patients with assistance to make specific decisions for them self before they assumed that the patients lacked the mental capacity to make it. This included providing information and leaflets in a variety of formats. Records demonstrated that staff made and recorded capacity assessment for significant, specific decisions including the capacity to consent to treatment.
- When patients lacked capacity, staff described how they would make decisions in a patient's best interests, recognising the importance of the person's wishes, feelings, culture and history. Although staff identified no recent best interests meetings, they were aware of practices to inform decisions about patient care.
- Staff we spoke with demonstrated an awareness of the definition of restraint, as outlined in the Mental Capacity Act.
- Staff knew where to get advice regarding the Mental Capacity Act and Deprivation of Liberty Safeguards. This included accessing the policy and speaking to Mental Health Act administrators or senior clinical staff in the hospital.
- Mental Health Act administrators monitored adherence to the Mental Capacity Act. This included regular audits that staff shared and discussed at bi-monthly integrated governance and clinical audit meetings.

Are forensic inpatient/secure wards caring?

Good

Kindness, dignity, respect and support

- On all wards, we saw examples of positive staff interactions providing patients with help and support, all delivered with warmth and respect. Staff met patients' needs in a timely manner, offered practical support with tasks, facilitated ward activities and encouraged patient participation.
- We spoke with seven patients using the service. All reported that staff were caring, respectful, and polite and took interest in patients as individuals. Patients described how staff practices protected their privacy and dignity. This included knocking before entering bedrooms or looking through observation windows, and the care staff took at night not to wake sleeping patients.
- Conversations with, and our observations of staff, demonstrated that staff knew the patients and had a good understanding of their needs.

The involvement of people in the care they receive

- The hospital had an admission process that informed and oriented patients. Staff provided patients with a ward booklet and completed an induction checklist with patients. There was also a 'buddy' system to help new admissions settle onto wards. This worked by identifying an established patient from the ward to act as a point of contact and support to the newly admitted patient. Staff on Litchurch ward had developed a 'knowing each other folder', this informed patients of staff likes, hobbies and interests. This encouraged patients to talk to staff who shared similar interests.
- All patients we spoke with felt involved in decisions about their care and confirmed that staff shared copies of care plans with them. Records in paper notes demonstrated that staff offered patients copies of their care plans. We saw that care plans had a recovery focus, and identified patients' strengths and independence.
- Staff ensured that patients could access advocacy. We saw advocacy posters displayed in ward areas and patients were aware of advocacy services.
- The hospital had initiatives in place to involve family members and carers. They included carer assessments, monthly updates from patients named nurses, a carer's forum/meet the team event that occurred every four months, tours of the hospital environment and quarterly surveys that were monitored by the board of directors.
- The hospital enabled patients to give feedback on the service they received. We saw a suggestion box located

in the hospital's reception, staff emptied the box and reviewed suggestions at monthly heads of department and ward integrated governance meetings. Wards held morning meetings between patients and staff. These allowed patients to make daily requests regarding their leave or appointments with multidisciplinary team staff. It also allowed patients to provide feedback on the service they received and patients confirmed that they often used this opportunity. The hospital completed quarterly patients and carer surveys.

- The hospital had established a People's Council for patients and staff at the hospital. The council met monthly and was chaired by a patient representative. There was documentation relating to the Council's responsibilities, goals and ground rules of attendance. We also saw a resulting local action plan that identified issues, actions required, action leads and a completion date.
- The hospital provided opportunities for patients to be involved in making decisions about the service. Staff invited a patient representative to monthly heads of departments meetings where they provided feedback from patient led environmental audits and the People's Council meetings. Records from these meeting demonstrated that the hospital had made changes because of patient involvement. For example, the introduction of easy read activity schedules on wards and a food focus group. The hospital also provided patients with a small financial reward for their involvement is some activities. This included participation in staff interview panels and assisting to organise service user awards. Patients confirmed this.
- Care and treatment records included discussions about advance statements. Advance statements record how patients would like to be treated if they are unable to make that decision in the future. Staff recorded if patients declined to make an advance statement. The hospital audited notes every four months for the inclusion of advance statements.

Are forensic inpatient/secure wards responsive to people's needs?
(for example, to feedback?)

Good

Access and discharge

- Beds on the low secure wards were commissioned by NHS England specialist commissioners and patients came from England and Wales. Beds on Wyvern ward, the locked rehabilitation ward, served the local catchment area of Derbyshire, Nottinghamshire, Staffordshire and Shropshire.
- The hospital's website included information on bed availability and how to make a referral.
- Each ward had documented guidance on admission and discharge criteria. These clearly identified each ward's client group, admission criteria, specific exclusions and discharge criteria. Guidance also detailed actions that staff would take when a patient was discharged from their detention under the Mental Health Act.
- Between September 2017 and February 2018, the average bed occupancy was 77% on Alvaston ward, 93% on Wyvern ward and 99% on Litchurch ward. This meant that beds were not always available when NHS England commissioners and clinical commissioning groups made referrals. The hospital manager reported that 50 to 60% of referrals were declined, identifying the importance of therapeutic mix to maintain safety as a priority over full bed occupancy.
- Between September 2017 and February 2018, the average number of days from referral to initial assessment for Alvaston ward was nine days, Wyvern ward was five days and Litchurch ward eighteen days. Only Wyvern ward met Cygnet's corporate guidance target to assess referrals with five days of receipt. Staff explained that high referrals rates, coordination, and having the right staff available to assess a referral sometimes led to delays in making an initial assessment.
- Between September 2017 and February 2018, the average number of days from initial assessment outside of the service to admission to the hospital for Alvaston ward was 71 days, Wyvern ward was 100 days and

Litchurch ward was 181 days. Delays in the onset of treatment occurred because of waits for wards to be stable enough to accept an admission and high referral rates.

- The hospital employed a recovery model to assist patients in accessing less secure hospital or community placements. The hospital had an average length of stay target of 400 days. As of February 2018, the actual average length of stay was 478 days for Alvaston ward, 398 days for Wyvern ward and 417 days for Litchurch ward.
- Patients always had access to a bed when they returned from leave.
- Female patients were not moved between wards during an admission to Cygnet Hospital Derby. Male patients could be moved as part of a clinical pathway between the low secure ward and locked rehabilitation ward.
- There were eight delayed discharges reported from September 2017 to February 2018. All were patients on Alvaston ward. The reasons for delays included availability of a bed at the discharge destination and funding disagreements. The hospital raised concerns of all delayed discharges with the patient's commissioning manager.
- Care plans identified that staff planned for discharge or transfer. This included section 117 aftercare meetings and identification of aftercare services to be provided for relevant patients.

The facilities promote recovery, comfort, dignity and confidentiality

- The hospital provided a full range of rooms and equipment to support treatment and care. Wards had clinic rooms, activity rooms, large communal lounges and quiet areas. The hospital also provided patients with a gym, information technology suite, therapy training kitchens, recovery college and a multi-faith room.
- All patients had a single bedroom with ensuite shower and toilet. Following a risk assessment, staff provided keys to bedrooms and encouraged patients to personalise their rooms. Access to bedrooms throughout the day was also individually risk assessed. On Alvaston ward, some patients did not have access to their rooms during the day and were required to use bathrooms in communal areas.
- Wards had locked rooms where staff stored patient's sharps or risk items in individual lockers. This was in addition to wardrobes and a large locked storage cupboard in each bedroom. Within wardrobes, patients had access to their own safe for storage of valuables. All patients and carers reported that possessions were safe on the ward.
- Following a risk assessment from staff, patients could carry their own mobile phones. Mobile phones were basic models and none had cameras. Staff asked patients to sign agreements with guidance on safe phone use and respecting the confidentiality of others.
- For patients without a mobile phone, wards had payphones available in areas that provided privacy. Staff reported that incoming or outgoing calls from the office phone could be transferred to the payphone.
- Patients had access to outside courtyard areas. However, for patients on Alvaston and Litchurch wards, courtyards could only be accessed with staff supervision. Patients did not report any delays in accessing courtyards areas.
- Visiting did not take place on wards. The hospital provided a visitor's room located near the main reception. Although there was only one visitor's room available for all three wards, the hospital had two meeting rooms that could be used as additional visitor areas. Carers reported that visits were easy to organise and visiting rooms were available when they needed them.
- The hospital had its own kitchen that prepared meals on site daily. In March 2018, the local authority provided the hospital with a food hygiene rating of five (very good). The hospital changed menus every three months and examples of the menu were displayed in the hospital's reception area and on the website. In addition to the menu choices, patients could opt for salads, wraps or omelettes. The hospital ran a food focus group for patients to suggest items they would like on the menu

and determine how best to describe dishes and the ingredients used to prepare them. Five of the patients we spoke with were satisfied with the quality and choice of food available.

- Wards had different arrangements for patients to access hot drinks and snacks throughout the day. Patients on Wyvern ward could access both when they chose. On Alvaston ward, the kitchen was locked, but staff made fruit and squash available to patients in communal areas. Patients' own snacks were stored in the kitchen and could be accessed on request from staff. The communal hot water tap was locked. Following a risk assessment from staff, some patients on Alvaston ward had keys to access hot water independently. Again, on Litchurch ward, the kitchen was locked but there was communal access to the hot water tap. Staff made milk and squash available in communal areas. Snacks including cereal bars, fruit and yoghurts were available from staff on request.
- Patients had access to activities, including at weekends. Our interviews with staff and patients confirmed this. Each ward had a dedicated occupational therapist and occupational therapy assistant. Between December 2016 and December 2017, staff offered patients between 30 and 50 hours of activity during the week. In the same period, actual patient uptake of activity was between 25 and 35 hours. At weekends, staff offered patients between 8 and 12 hours of activity. In the same period, actual patient uptake of activity was between 6 and 9 hours. Actual patient activity hours during the week and at weekends were lowest on Litchurch ward.

Meeting the needs of all people who use the service

- The hospital had made adjustments for people requiring disabled access. All doors provided disabled access and wards had access to assisted bedrooms and bathrooms. We saw three evacuation chairs located above ground floor level and records demonstrated checks and maintenance. The hospital had guidelines identifying when and how staff would make an evacuation assessment for a patient or staff.
- Wards had a range of information available to patients. The subjects included advocacy, the Mental Health Act, how to complain, safeguarding and activities. All information was in English but staff told us how they could get information translated into other languages. We did see examples of information presented in easy-read formats.
- The hospital had a locally contracted interpreting and signing service. Staff were familiar with and knew how to access these services.
- Staff completed equality, diversity and disability training as part of mandatory training requirements. When we inspected, all staff had completed this training. The hospital also ran an equality and diversity group for patients and staff that met every eight weeks. Staff made an equality and diversity assessment on all policies and procedures introduced at the hospital. Equality and diversity impact assessments help organisations to make sure they do not discriminate or disadvantage people.
- The hospital offered a choice of food to meet dietary requirements of religious and ethnic groups. This included Halal and vegetarian options.
- The hospital supported patients' spiritual needs. There was a multi-faith room onsite and the hospital manager described links with local representatives from different religious groups.

Listening to and learning from concerns and complaints

- Between March 2017 and February 2018, Alvaston ward received 38 complaints, Litchurch ward received 13 and Wyvern ward 12. Of the 63 total complaints received, 20 were upheld. No complaints had been referred to the Ombudsman.
- Staff had access to a complete record of complaints made and the outcomes of investigations into them. This allowed them to identify themes and address concerns.
- The hospital had identified three main themes of complaints, patient property going missing, alleged poor communication from staff to patients, and alleged inappropriate behaviour between patients. There were plans in pace to reduce the number of complaints in these areas.
- Patients we spoke with knew how to make a complaint and felt confident to do so. Patients believed they could

speak to staff about complaints and would be listened to. We saw posters and information on how to make a complaint displayed in communal areas around the hospital.

- Staff knew how to respond to complaints or concerns raised with them. Firstly, staff tried to address and resolve complaints locally. If this failed, staff assisted patients to make written complaints or to speak with the ward manager. Advocacy staff reported that the hospital's response to complaints was quick and caring.
- Senior staff met to discuss complaints and the outcomes of investigations at ward governance meetings. Meeting records identified actions resulting from complaints, lessons learned and actions taken to share best practice. Ward staff reported they received feedback on the outcome of the investigation of complaints through handovers, supervision or during team meetings.

Are forensic inpatient/secure wards well-led?

Good

Vision and values

- The hospital had values to be helpful, responsible, respectful, honest and empathetic. These were available to view on the hospital's website. Staff knew and agreed with the hospital's values. The staff survey for 2018 had 105 respondents. It identified that 99% of respondents understood the hospital's values.
- The hospital's objectives reflected the organisations values and objectives. This was demonstrated in the hospital's overarching local action plan that brought together all the actions from risk assessments, incidents, the People's Council, peer review assessments, and staff, patient, and carer surveys. The organisations values were also used in staff recruitment and appraisal practices.
- The hospital and clinical managers were visible and accessible to staff and patients. Staff reported they were approachable and they listened, supported, inspired and thanked staff for their work. Patients knew both senior managers by name and we saw that patients felt comfortable to approach them directly. Ward managers were visible and accessible to staff and patients on wards. Staff reported that executive directors toured the hospital and met with staff and patients following local board meetings.

Good governance

- The hospital had effective ward systems that ensured staff received mandatory training. Monthly compliance for mandatory training was consistently high and reported as part of key performance indicators. Beyond mandatory requirements, there was a programme of training available to staff. The hospital believed that quality training led to quality care and staff retention.
- Supervision was available to staff and wards consistently exceeded target supervision rates. Supervision practices contributed to staff learning from feedback, complaints and incidents. Staff received appraisals, although this fell below the hospital's target rate because of staff sickness, absence or maternity leave.
- Senior staff ensured that all shifts were covered by a sufficient number of staff of the right grades and experience. Staff met daily to plan and discuss the hospital's staffing needs. Staffing was supported by established staff recruitment processes. Staff and patients felt safe on wards.
- Each ward was supported by an administrator. This allowed staff to maximise their shift-time on direct care activities.
- Staff knew when and how to report an incident. The hospital manager reported they were the highest reporting hospital in the Cygnet group. Senior staff and ward staff met to discuss incidents and learn from investigation outcomes. We saw evidence of change as a result of lessons learned.
- The hospital had established systems to ensure that staff followed safeguarding, Mental Health Act and Mental Capacity Act procedures.
- The hospital had established systems in place to manage governance. People's Council, heads of department and ward integrated governance meetings occurred monthly and integrated governance and clinical audit meetings occurred every two months. These meetings informed local board meetings that

occurred every six months. The chief executive officer, corporate governance director and chief operating officer attended local board meetings. The local board was a subcommittee of Cygnet's main board.

- The hospital used key performance indicators to gauge the performance of ward teams. These included incidents, safeguarding, medicines management, complaints, training and restrictive practices. The measures were presented in an accessible monthly report, they tracked performance against other Cygnet hospitals, and senior staff met to discuss them. Reports included actions to address areas of improvement.
- Ward managers believed they had sufficient authority to do their jobs and felt supported by senior managers. All ward managers had access to administration support.
- The hospital had a local risk register in place. Staff reported they could submit items to the risk register through the People's Council or escalate concerns directly with the hospital manager. Integrated governance meetings included discussions about the risk register.
- The hospital reported that the Commissioning for Quality and Innovation targets set by NHS England had been fully achieved. This included reducing length of stay, preventing ill health from risky behaviours and reducing restrictive practice.
- In addition to The Care Quality Commission inspections, the hospital received inspections from care commissioning groups and quality visits from NHS England and NHS Wales.

Leadership, morale and staff engagement

- The staff sickness rate in the last 12 months was 4.1%. This was lower than the NHS average of 4.8%. The hospital reported no incidents of staff suspensions or supervised practice.
- The hospital reported no bullying and harassment cases. The clinical manager reported that staff were asked about bullying and harassment during supervision and leaver exit interviews.
- Staff knew how to use the hospital's whistleblowing process. Staff showed us contact details printed on their staff identity cards. Staff survey results showed 97% of staff knew how to report a concern about fraud, malpractice or wrongdoing.
- Staff felt confident to raise concerns without fear of victimisation.
- Staff spoke positively about working at the hospital. This included morale and job satisfaction. Staff survey results showed 89% of staff enjoyed working for Cygnet Health Care. However, only 42% of staff believed that, compared to their duties and responsibilities, their pay was fair.
- The hospital provided staff with opportunities for leadership development. This included Cygnet's apprenticeship scheme, National Vocational Qualification in management and leadership, and university accredited management courses. All staff we spoke with confirmed this.
- Staff generally spoke positively about teamwork and support. However, some staff had concerns about staff moves and believed they had a negative impact on their own ward areas. Staff survey results showed 84% of staff believed there was a feeling of team spirit in their area of work.
- Staff were open and transparent and explained to patients if and when something went wrong.
- Staff believed they had the opportunity to give feedback on services and input into service development. This included the yearly staff survey and through a staff representative group monthly meeting. The chair of the staff representative group met with the hospital manager and attended board and corporate meetings.

Commitment to quality improvement and innovation

- In October 2017, the hospital commissioned an independent review of practice on Alvaston ward. The review looked at the introduction of zonal observations, and factors that have enabled good practice to develop on Alvaston ward. The review identified many examples of good practice including high standards of care, high standards or record keeping, and policies that were in keeping with national guidelines.

Good

Forensic inpatient/secure wards

- In 2017, Alvaston ward received a Royal College of Psychiatrist Enabling Environment Award.
- The hospital's trainee forensic psychologist had developed a resilience training packaged and had delivered this at preceptorship events, including Cygnet's National Preceptorship Days.
- The hospital held a Gold Investors in People Award from December 2014.

Outstanding practice and areas for improvement

Outstanding practice

- The hospital had a recovery college with established links to recovery campuses from two NHS providers. The college offered educational and recovery focussed courses that were co-produced and facilitated by staff and patients.The spring 2018 prospectus had over 20 courses for patients to choose from. This included basic life support, learning to live with bereavement, learning to live with hope, the benefits of physical activity, and learning to knit.We saw patients attending the college throughout the day of our visit. Outcome measures demonstrated the effectiveness of the college and patients described the college's activities as meaningful.

Areas for improvement

Action the provider SHOULD take to improve

- The provider should ensure that clinic cleaning records prompt staff to complete and record cleaning of portable examination equipment.
- The provider should ensure that staff maintain a full record of medicine administration on medicines charts.
- The provider should ensure that staff maintain a complete and accurate record of high dose antipsychotic monitoring records.
- The provider should ensure that staff complete records detailing the outcome of leave taken by patients.