

Cygnnet Hospital Blackheath







Quality Report

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

Ratings

Overall rating for this location		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 Cygnet Hospital, Blackheath as good because:

- Patients told us they felt supported at the service and that staff treated them with respect and dignity.
- Staff reported incidents effectively and the hospital had systems in place to ensure that learning from incidents, complaints and near misses was captured and led to learning throughout the hospital and the organisation. We saw examples of changes which had taken place in response to incidents, complaints and patient feedback.
- Staff were positive about working for the hospital and had access to mandatory and specialist training.
- Supervision was up to date and staff were able to access reflective practice sessions.

- There were multidisciplinary teams, which used the different professional skills effectively to meet the holistic needs of patients.
- Ward staff delivered care in a clean environment.

However,

- Tyler ward did not have a dedicated seclusion room. Seclusion incidents had taken place in patients' bedrooms. However, if a patient required seclusion, they were transferred to an alternative facility.
- Some patients told us that they did not have copies of their care plans.

Summary of findings

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Good



Cygnnet Hospital Blackheath

Services we looked at

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

Forensic inpatient/secure wards

Summary of this inspection

Background to Cygnet Hospital Blackheath

Cygnet Hospital, Blackheath has two wards:

Tyler ward is a psychiatric intensive care ward for men who are over 18 and has 15 beds. At the time of our inspection, two bedrooms were being converted into ensuite rooms so were closed.

Meridian ward is a low-secure rehabilitation ward for men and has 17 beds. It was full at the time of our inspection.

Cygnet Hospital, Blackheath has been inspected eight times since 2009. At the most recent inspection, in July 2014, it was fully compliant with all regulations.

Cygnet Hospital, Blackheath is registered for the following regulated activities:

Treatment of disease, disorder or injury

Assessment or medical treatment of persons detained under the Mental Health Act 1983

The registered manager for the service is Sharon Fox.

Our inspection team

The team that inspected Cygnet Hospital, Blackheath consisted of three CQC inspectors, one assistant inspector, one nurse, one expert by experience, one CQC policy officer and one CQC observer.

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?

Before the inspection visit, we reviewed information that we held about the location, asked a range of other organisations for information and sought feedback from patients at three focus groups.

During the inspection visit, the inspection team:

- visited two wards at the hospital, looked at the quality of the ward environment and observed how staff were caring for patients
- spoke with 18 patients who were using the service and one family member and collected feedback from five patients using comment cards.
- spoke with the hospital manager, the clinical manager and the ward managers for each of the wards
- spoke with 16 other staff members, including doctors, nurses, occupational therapists, psychologists and social worker
- received feedback about the service from two commissioning organisations, NHS England and South London and Maudsley NHS Foundation Trust.
- spoke with an independent advocate

Summary of this inspection

- attended and observed one multidisciplinary meeting
- looked at 14 care and treatment records of patients
- checked medication records and prescription charts on both wards

- checked 42 incident reports
- checked the complaints log within the hospital

looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the service say

We spoke with 18 patients and one family member. Most of the feedback we received was positive. We also received feedback from five patients on comments cards. Three of these were positive, one was negative and one was neutral. The main positive themes related to staff support and attitude.

The hospital carried out quarterly patient satisfaction surveys. The feedback was collated in a newsletter for patients. In the most recent report, dated October 2015, ten patients responded and all were content with the ward as a whole. All those who responded were based on Meridian ward. There were plans in place to extend the survey to Tyler ward.

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?

We rated safe as good because:

- The service provided care in a clean and hygienic environment.
- Staff had a good awareness of incident reporting procedures and there was a strong learning culture with information about recent incidents across the hospital shared across the wards and the organisation.
- Administration and dispensing of medicines was carried out safely.
- Staff were aware of safeguarding procedures that were in place. The hospital reported safeguarding concerns to the local authority and to the Care Quality Commission as necessary.
- Risk assessments both of individuals and the environments, including ligature risk assessments were up to date and staff were aware of the key risks in the service.
- Staff used observation levels and understanding of individual patient risk to mitigate the risks presented by the ward environment including blind spots and ligature anchor points.

However:

- Seclusion on Tyler ward had taken place on four occasions in the past year in patients' bedrooms. On two occasions this had not been recorded according to the procedures specified in the Mental Health Act Code of Practice
- The lack of a seclusion room meant that when necessary, patients on Tyler ward may be transferred to an alternative facility at a time of particular vulnerability.

Good



Are services effective?

We rated effective as good because:

- Patients' care plans were comprehensive and up to date with information.
- Patients were involved in care planning on Meridian ward and there was clear evidence of this in the care planning documentation we saw.
- Patients had access to a wide range of therapeutic input. Physical health was monitored and staff were aware of relevant local and national guidance related to physical health monitoring. On Tyler ward an audit had been carried out of physical health monitoring which had led to greater awareness and better practice to ensure people's needs were met.

Good



Summary of this inspection

- There was good multi-disciplinary working and staff had a good understanding of the Mental Health Act.
- However:
- Training related to the Mental Capacity Act was not compulsory for all staff members and some staff did not demonstrate a good knowledge of the relevant parts of the Mental Capacity Act.

Are services caring?

We rated caring as good because:

- Patients told us that staff treated them with respect and that their dignity was respected. We observed that staff had a very good understanding of patients' needs and displayed kindness and care in their interactions with patients.
- Patients had the opportunity to feedback information about the services through regular community meetings and patient forums.
- Patients on Meridian ward completed quarterly feedback surveys and the results of these were published in newsletter format.
- Patients had regular access to advocacy services and were aware of how to contact an advocate.

However:

- There were fewer ways for patients on Tyler ward to be involved and feedback information to the service. Although this was an area the hospital were working on at the time of our inspection.

Good



Are services responsive?

We rated responsive as good because:

- Patients had access to facilities on the wards which included private telephone areas and rooms which were used for meetings and activities. Patients also had access to locked spaces for personal belongings.
- Patients were able to personalise their bedrooms.
- The hospital was able to meet the needs of patients from different cultural, religious and linguistic groups and had access to interpreting services as necessary.
- There was a robust complaints procedure in place. Patients knew how to complain. The hospital management tracked complaints to ensure that they were followed up according to the hospital policy.

However:

- There was no designated seclusion room on either ward.

Good



Summary of this inspection

- There was not a designated visiting area for children.

Are services well-led?

We rated well-led as good because:

- Staff morale was strong and staff felt supported by their management team. There was a feeling that the new leadership within the organisation was positive.
- Strong governance systems were in place with information available on a ward and hospital level about staffing issues but also about incidents and themes on the ward and these were picked up so that learning could take place.
- All staff had access to the site level action plan and risk register.
- Information was disseminated through the service through meetings at different levels and newsletters.
- Staff and patients had participated in quality improvement initiatives such as 'Starwards' on Meridian ward.

Good



Detailed findings from this inspection

Mental Health Act responsibilities

Staff were trained in the Mental Health Act and its Code of Practice, with 98% having completed this training which was mandatory. Staff demonstrated an understanding of the rights of detained and informal patients. Consent to admission and treatment were recorded on patients' files.

There was detailed information displayed on the wards regarding patients' rights to advocacy and how the advocacy service could be accessed. Patients that we spoke to on Tyler ward confirmed that they had received support from the advocacy service when they had requested it. An independent advocate visited the service weekly. We spoke with the advocate who also confirmed that they visited and that patients were able to access them for support. They told us that the service encouraged advocacy.

All patients had their rights explained to them when they were first detained. However, for three patients on Tyler ward, there was no evidence that further attempts had been made to explain their rights when necessary.

There was a Mental Health Act administrator based on site. Audits were carried out regularly both locally and centrally within the organisation into the use and paperwork which related to the Mental Health Act. Information and learning from Mental Health Act visits formed part of clinical governance meetings. Staff knew how to contact them for advice where necessary. The social worker on site also accessed additional training related to the use of the Mental Health Act.

Mental Capacity Act and Deprivation of Liberty Safeguards

Senior staff in the hospital had received training related to the Mental Capacity Act. This training was not mandatory for all staff. However, the staff who had received this training disseminated this information as necessary.

When asked, some staff were able to demonstrate knowledge of some of the guiding principles of the Mental Capacity Act. However, other staff had no knowledge of it at all.

Staff were aware of how they could access support and advice related to the Mental Capacity Act.

Staff have not made any applications for Deprivation of Liberty Safeguard authorisations in the past 12 months

Overview of ratings

Our ratings for this location are:

Detailed findings from this inspection

	Safe	Effective	Caring	Responsive	Well-led	Overall
Acute wards for adults of working age and psychiatric intensive care units	Good	Good	Good	Good	Good	Good
Forensic inpatient/secure wards	Good	Good	Good	Good	Good	Good
Overall	Good	Good	Good	Good	Good	Good

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

Good 

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

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

Good 

Safe and clean environment

- The layout of parts of the ward allowed staff to observe patients directly. However, there were certain areas which were difficult to observe due to being out of direct lines of sight. Staff on Tyler ward had mitigated these risks by placing CCTV cameras and mirrors in those areas that were more difficult to observe. These CCTV cameras were not constantly monitored. However, staff also used observation levels to mitigate the risks of blind spots on the ward.
- The ligature risks on the ward had been assessed by a ligature audit. Staff had completed this audit in April 2015. There was ongoing work to remove existing ligature risks in patient bathrooms. These risks were caused by the taps on the sinks. Out of 15 bedrooms two new bathrooms had been installed at the time of our visit and staff were in the process of refurbishing a further two. A team leader told us that where patients were at risk of harming themselves they did not give them rooms that had the old taps.
- The ward did not have a seclusion room. Staff said that in situations where a patient became very unwell and needed to be taken away from other patients, staff usually took them to their bedroom. Occasionally a separate 'de-escalation' room was used for this purpose.

- The ward was visibly clean, including the communal bathroom used by patients who did not have their own bathroom. The furnishings were mostly in a good condition.
- Staff adhered to infection control principles. Hand washing facilities were available throughout the wing including by the entrance.
- Equipment on the ward was well-maintained. There was a defibrillator on the ward, but not all staff were clear on how it should be used. The clinic room on the ward had some clutter including empty pill sleeves on the floor. This did not present a risk to patients.
- Each member of staff carried an alarm. In addition, the wing had two radios for staff members to contact staff on other wards, if they needed assistance. Alarms were also available for visitors.

Safe staffing

- The wing had six core staff members day and night, made up of three qualified nurses and three healthcare support workers. The staff level rose where extra staff were required to perform specific tasks, such as close observation.
- Up to the end of September 2015, the total establishment for qualified nurses was 10 and 25 healthcare assistants. There was one vacancy for a qualified nurse and three vacancies for healthcare assistants.
- The ward regularly employed both bank and agency workers in order to meet its staffing requirements.
- In the previous 12 months the staff sickness rate on the ward was approximately 3%. The approximate rate of staff turnover was 29%.
- The service determined staffing levels by comparing with similar services within the organisation and making adjustments based on levels of acuity and size of wards.

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

Good 

- Bank and agency workers were employed to ensure that sufficient staff were available to meet the needs of patients on the wards. Staff told us that the numbers of bank and agency workers had decreased over the past 12 months. Some staff thought that the number had previously been too high and was now better. Between January 2015 and September 2015, 2024 shifts had been covered by bank or agency workers. There were no unfilled shifts in this period.
- Wherever possible, the ward employed bank and agency workers who had worked on the wing before and were familiar with its layout and its procedures and policies. It also helped ensure continuity of care for patients.
- The ward manager said that staffing resources were usually available in order to meet the needs of the ward. This was evidenced by the additional staff on the day of our visit to undertake close observations of patients.
- There were enough staff employed so that one qualified nurse could be available on the ward. However, the manager said that the core staffing level of three qualified nurses could be insufficient to ensure that a qualified nurse was always on the ward. This was because sometimes qualified nurses were required to perform other duties, such as escorting patients who were being transferred from the ward, or attending ward rounds.
- Staff said there were enough staff for patients to have regular 1:1 time with their named nurse. However, one patient told us that over two weeks they had spent little time with their named nurse.
- There were enough staff to ensure that patients could be taken on escorted leave and to undertake ward activities most of the time. However, staff had to sometimes cancel leave or activities. This occurred if they were required at short notice to escort patients transferring back to the part of the country where they lived and received other support.
- There were enough staff to carry out physical interventions. If more staff were required then staff used a 'pinpoint' alarm system to summon assistance from other parts of the location. This system alerted other staff members to exactly where assistance was required on the ward.
- There were doctors available to provide medical cover day and night, including 8 on call doctors.

- Out of 29 mandatory training courses the completion rate in the last 12 months was 93%. Rates did not fall below 75% in any single course.

Assessing and managing risk to patients and staff

- Between July 2014 and October 2015 there had been four incidents where a patient was secluded in their bedroom. Over the same period no patients had been in long-term segregation. When patients were secluded, staff recognised that patients were in seclusion in their bedrooms. However, in two of the periods of seclusion, we were unable to locate documented evidence that the procedure for seclusion had been completed according to the Mental Health Act Code of Practice.
- Staff told us that if, during an admission, a patient's behaviour deteriorates whereby seclusion is necessary, then the patient is transferred as soon as possible to an alternative placement deemed appropriate. This meant that there was a risk that patients would be transferred to alternative facilities, sometimes outside the immediate local area, at a time of particular vulnerability.
- Between March 2015 and August 2015, there had been 74 incidents of restraint on 33 different patients, 13 of which had been in the prone position. 11 restraints in the prone position had resulted in rapid tranquillisation.
- Risk assessments were undertaken of every patient upon admission. After every incident the patient's risk assessment was updated. Risk assessments were also reviewed weekly in every ward round. Risk assessments we checked were up to date.
- Staff used a risk assessment tool to assess all the patients on the ward. This was called the short term assessment of risk and treatability (START). In the six patient files we looked at all the risk assessments were fully completed and the information carried over into each patient's care plan. This was in order to plan how to manage and decrease the risk for each patient. For example one risk assessment identified that a patient was at risk of self-neglect. This risk was written in his care plan along with steps as to how staff would support greater insight and self-care.
- No blanket restrictions were placed on patients other than in respect of a list of items that were not allowed to be brought onto the ward.
- Generally informal patients were not admitted to the ward because it provides intensive care for patients who

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

Good 

are very unwell. However, on the day of our visit one patient was assessed as not requiring detention and had agreed to stay informally. Staff confirmed that the patient was free to leave if they wished.

- An observation policy was in place to inform and guide the use of close observation. On the day we visited 5 patients were on 1:1 close observation. The ward manager stated that it was more common for patients to be on 2:1 or 3:1 observation. In the 6 patient records we saw all patients had been under close observation during their time on the ward.
- The ward manager told us that two years ago the levels of observation had been even higher and they had sought to reduce it. They also said that the current rate of close observation was clinically necessary to keep patients safe and that many who were admitted were very unwell. Staff also told us multidisciplinary teams made decisions about the levels of close observation and these decisions were kept under constant review. Where staff then decided that a patient should come off close observation this was then done immediately. However, although all the patient records we looked at gave a reason for initially placing a patient under close observation, no clear and detailed reasoning was recorded in any of them for either continuing or discontinuing that observation.
- Staff used de-escalation techniques prior to restraining patients. Restraint was carried out in accordance with Prevention and Management of Violence and Aggression training that was mandatory for staff. Bank workers were only used when they had completed this training. However, the manager told us that they do not know what qualifications agency staff have who they have not used before.
- All permanent staff received mandatory training in safeguarding and bank staff completed safeguarding training online. Ward data showed that mandatory safeguarding training had been completed by 88% of staff. Staff also demonstrated a good understanding of how and in what circumstances to raise a safeguarding alert.
- Children were not allowed to visit the ward. However, there was room within the hospital for children to visit family members off the ward.

related to a death on the ward, which was linked to natural causes, although the investigation had not been completed at the time of the inspection and other incidents related to violence or abuse between patients.

Reporting incidents and learning from when things go wrong

- Staff demonstrated a good knowledge of how to report incidents taking place on the ward.
- Staff said when incidents took place on the ward they spoke with patients to let them know what happened. One patient we spoke with confirmed that this. However, another said that he was not given information when things went wrong.
- Staff were provided with information from incidents at handovers, ward rounds, debriefings and monthly meetings. Two nurses confirmed that managers also discussed incidents with them and looked at what happened in order to learn from those incidents. Both gave examples of managers looking at CCTV images from ward cameras with them to analyse how they restrained a patient. The nurses said this process was helpful.
- The staff we spoke to said that the monthly meetings were useful for discussing incidents and how to learn from them. For example, one staff member said that a recent staff meeting allowed staff to coordinate how smoking breaks would be managed so that the same information was always given to patients.
- The service ensured that incident information was reviewed at a specific incident learning meeting with the senior management on a regular basis. This information was also fed into the integrated governance meetings on a monthly basis and the service produced a monthly newsletter where information from minutes and relevant learning points were distributed directly to staff as well as being incorporated into ward team meetings.

Track record on safety

- Between 10 September 2014 and 27 August 2015, 21 serious incidents took place on Tyler ward. One incident

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

Good 

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

(for example, treatment is effective)

Good 

Assessment and planning of care

- Each patient was assessed upon admission with a risk assessment completed and care records written to reflect the identified risks. The ward used initial 72 hour care plans when patients were first admitted and would write up more comprehensive recovery-focussed care plans within 72 hours of admission. Care plans were reviewed fortnightly, or more frequently if necessary.
- Care records that we looked at showed that patients were examined in respect of their physical health and physical health problems such as diabetes were regularly monitored.
- Care records that we looked at were up to date and detailed. Most had multiple objectives, such as reducing aggression or attaining personal insight into behaviour. Some described how patients were to be supported and cared for to achieve recovery but this was not the case in all plans. Some records also showed evidence of patient involvement.
- Records were securely stored and relevant information concerning patients was available. Staff largely relied upon paper based systems and these were well managed and complete.

Best practice in care and treatment

- Patients had access to psychological therapies while on the ward including 1:1 appointments with a psychologist. The multi-disciplinary team either referred patients for this support or patients could also refer themselves.
- Staff used a number of outcome measures to determine the impact of interventions. For example, the occupation therapy outcome scales used included the model of human occupation and assessment of communication and interaction skills.
- As stays on the intensive care ward were short term, patients remained registered with their GPs. If they

required input from primary health services, the hospital arranged temporary registration with a local GP practice. Patients were supported to attend the local hospital if necessary.

- Clinical staff participated in all clinical audits. In addition the team leaders undertook administrative audits of the work of the staff on the ward and the qualified nurses audited each other's clinical notes.
- The hospital had developed local and organisation wide governance systems to ensure that best practice, including updates on relevant national institute for health and care excellence (NICE) guidance was embedded in practice and policies on the ward and within the hospital.

Skilled staff to deliver care

- A range of professionals were available to support patients. This comprised medical and nursing staff, an occupational therapist, and an activities coordinator, who were based on the ward. In addition a psychologist and a social worker were based on site, covering the two wards and a pharmacist visited regularly to provide additional support.
- Most staff were experienced in working on a male psychiatric intensive care unit. Care was taken to ensure that temporary agency and bank workers were not only similarly qualified but also previous experience of working on Tyler ward. The service also sought to recruit new staff with suitably relevant qualifications. For example one new healthcare support worker had previous experience working with male patients in a forensic setting.
- The service developed inductions which were to incorporate Care Certificate training for new health care assistants.
- Staff told us they received supervision from every four to six weeks. Records confirmed this. This supervision was described as helpful and supportive. One staff member said they were encouraged to speak their mind and make contributions as to how the service should be run. Another staff member said that their manager was very approachable in supervision to ideas and that any matters could be raised. Staff also received clinical supervision and a yearly appraisal. In addition the staff met on a monthly basis to discuss issues on the ward and best practice as a part of their team meeting.

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

Good 

- Staff on the ward had access to additional training beyond the mandatory training for their roles. For example, one member of staff told us that they had accessed phlebotomy training and nurse prescriber training.

Multi-disciplinary and inter-agency work

- Members of the multi-disciplinary team joined the monthly staff meetings where there was a need to discuss clinical issues amongst all staff.
- Daily handovers took place between day and night staff. Information passed between the staff concerning the patients was detailed in the patients' notes.
- Staff worked effectively with the outside agencies, including the local authority, police and GP services to support patients on the ward. Feedback we received from external agencies including the local authority and the advocacy service was positive.

Adherence to the Mental Health Act and Code of Practice

- Staff were trained in the Mental Health Act and its Code of Practice, with 98% having completed their mandatory training.
- Staff demonstrated an understanding of the rights of detained and informal patients.
- There was detailed information displayed on the ward regarding patients' rights to advocacy and how the advocacy service could be accessed. Both patients that we spoke to confirmed that they had received support from the advocacy service. An independent advocate visited the service weekly.
- All patients had their rights explained to them when they were first detained. However, for three patients there was no evidence that further attempts had been made to explain their rights when necessary.
- There was a Mental Health Act administrator based on site. Staff knew how to contact them for advice where necessary. The social worker on site also accessed additional training related to the use of the Mental Health Act.

Good practice in applying the MCA

- Senior staff in the hospital had received training related to the Mental Capacity Act. This training was not mandatory for all staff. However, the staff who had received this training were disseminating this information as necessary.

- Understanding of the Mental Capacity Act was mixed. When asked some staff were able to demonstrate a knowledge of some of the guiding principles of the Act. However, other staff had no knowledge of it at all.
- Staff were aware of how they could access support and advice related to the Mental Capacity Act.
- The staff have not made any applications for Deprivation of Liberty Safeguards in the past 12 months.

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

Good 

Kindness, dignity, respect and support

- Staff were observed treating patients in a supportive respectful manner. For example one nurse was seen discussing with a patient what activities he was interested in and giving him information about how they could be beneficial.
- One patient described staff as helpful and supportive, saying they answered his questions about care and treatment and looked after him well. However, another patient said that, while some of the staff were caring, the agency workers did not treat him with respect.
- Staff showed an understanding of the individual needs of patients and knew the needs of the patients who were on the ward at the time of the inspection.

The involvement of people in the care they receive

- The patients received a detailed booklet upon admission to the ward describing the support they could receive as well as summarising their rights.
- The majority of care plans indicated patient involvement and gave clear indications of patient desires and concerns. However, one patient said that staff did not involve him in his care and did not ask for his opinions.
- There was a weekly community meeting held on the ward. This was for patients to feedback issues about the service. Minutes from these meetings with action points were displayed on a noticeboard in the ward.
- The psychology team were developing a local carer strategy. They had sent out initial questionnaires to involve family members and this would inform the strategy.

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

Good 

- The mental health advocacy service was advertised on the patient notice board on the wing. This information gave the name of the advocate, when they were visiting the ward and the support they could provide.

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

Good 

Access and discharge

- The average bed occupancy rate in the past 6 months was 75%. Out of 15 beds on the ward 6 were reserved for patients from the South London and Maudsley NHS Foundation Trust. At the time of our inspection, two beds were closed as the rooms were being refurbished so they were not available to be used.
- The service took admissions from patients across the UK from a variety of commissioning bodies.
- Staff said that they were not always able to transfer patients to an external location at an appropriate time of day. This was because the ward often received notification that another service, such as a rehabilitation placement, was available for the patient at very short notice. This could sometimes happen in the evening. Also, the available service was sometimes located many miles away in the part of the country where the patient lived. This meant that staff sometimes needed to transfer patients long distances out of working hours.
- Discharge from the ward was sometimes delayed for non-clinical reasons. This was because appropriate services, such as a bed on an acute ward or housing for patients were not always available when the patient was otherwise ready for discharge. There was one discharge delayed at the time of our inspection.

The facilities promote recovery, comfort, dignity and confidentiality

- There were a variety of facilities on the ward for patients. This included a lounge, a TV room, a quiet room, an activities room with gym equipment, two shower rooms for patients who did not have their own bathroom and a

treatment room. A pool table was available for patients to use in the lounge. Drinks vending machines and a small outside smoking area were also available for patient use.

- There were two rooms used for patients to meet visitors, one which was mostly used as a quiet area and the other an all-purpose room.
- There was a dedicated phone room on the ward for patients to make private phone calls.
- There was garden where staff took the patients twice a day if staff numbers allowed for this.
- Recorded patient comments from community meetings indicated that they were generally happy with the food provided on the ward.
- There was an area on the ward where patients could make drinks for themselves day and night.
- Patients' bedrooms were personalised with items such as books and games and framed pictures. Each room had locked storage space for patients' possessions.

Meeting the needs of all people who use the service

- Information was displayed for patients covering a range of subjects. This included how to contact local solicitors, advocacy services and how to make complaints.
- The ward had access to interpreter services when necessary and staff were aware of how to make referrals.
- Patients had access to spiritual support from a range of faiths through links with local religious groups. .

Listening to and learning from concerns and complaints

- Over the past 12 months 19 complaints had been made on the ward of which 2 were upheld. None of the complaints were referred to an ombudsman.
- Information was displayed on the ward for patients regarding how to make a complaint. One patient said that he had made two complaints and had received support from the mental health advocate when doing so. Staff on the ward had also provided him with a form to complete to detail his concerns.
- The ward manager looked at complaints and discussed with the hospital manager who led on complaints. Following this, the hospital manager allocated a member of staff to lead on the complaints investigation. This ensured that patients who complained received timely responses.

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

Good 

- Staff had recently put up a 'You said, we did' board on the ward in order to record comments and complaints from patients and how staff responded to them. At the time of our visit this board was blank.

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

Good 

Vision and values

- Staff on the wards knew the managers within the service. They told us that the management team was accessible. Senior managers within the organisation had visited the service and staff had a good understanding of the values of Cygnet Health Care. The staff we saw reflected these values in their approach towards patients.
- Staff were aware that the ownership of the organisation had changed. Some staff told us that they felt the new CEO and parent company were forward-looking. One member of staff told us it was like a "breath of fresh air".
- In the 2014/5 staff survey which covered Cygnet Hospital, Blackheath and Cygnet Lodge, Lewisham, 86% staff responded positively that they understood Cygnet's values.

Good governance

- Records indicated that staff were up to date with their mandatory training and that they received regular supervision.
- We saw that there were sufficient staff to care for patients and that staff were not occupied only with administrative tasks.
- There were a number of meetings across the organisation where information was shared. For example, incident learning meetings, integrated governance meetings, meetings between mental health act administrators and a medical advisory meeting. We saw from the minutes of these meetings that information flow around the organisation was cohesive.
- Board members came to the site for a board meeting twice a year. This increased the visibility of leadership across the organisation.

- Ward managers had a small meeting on a weekly basis to ensure that information was shared relating to incidents and audits which had taken place.
- The hospital had an overarching action plan, in common with all Cygnet Health Care services. This collated information from internal audits, visits from regulators and the risk register into one document which ensured that continuous improvement was built into the actions of the service. We saw this document and the local risk register and saw that the issues identified were clearly detailed. The organisation had a clear view of the areas for improvement necessary.
- The hospital had developed specific action plans with incorporated review dates in response to the staff survey from 2014/5. This included introducing reflective practice sessions for ward-based staff which had been actioned. This meant that the organisation learnt from feedback from staff.
- The hospital group had developed a reducing restrictive interventions plan. This had the support of a project worker who was assigned to work specifically in this area and was being developed to ensure that the Mental Health Act Code of Practice, NICE guidelines relating to violence and aggression: short term management in mental health, health and community settings and the Department of Health Positive and Proactive Care documents were embedded in practice throughout the Cygnet hospitals. This plan included identifiable and time limited action points, many of which had been achieved at the point of the inspection, such as an update of the policy but also work on sharing best practice across the group as a whole.
- Staff on the wards said that they valued and respected the leadership given by the ward manager.
- There was a location level and organisation level risk register. This was compiled by the senior management team at the hospital site on the basis of integrated governance meetings. The service managers were clear about the processes for information and issues to be added to the risk register, escalated to a company-wide risk register and removed from the risk register. The risk register for the service and the overarching action plan were stored on a shared drive which all staff were able to and encouraged to access.

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

Good 

- Cygnet Health Care incorporated 'mock' CQC inspections to ensure that areas for improvement could be identified internally. Wards were given this feedback in written form and where necessary, the wards developed action plans following on from this.
- We saw examples of how good practice issues were shared across the organisation. For example, the work which had been done on Meridian ward to monitor and audit physical health was being used to develop audits in Cygnet services throughout the country.

Leadership, morale and staff engagement

- The sickness and absence rate in the hospital over 12 months was 3%. There were not any bullying or harassment cases in 12 months prior to the inspection visit.
- No cases of staff bullying have ever been recorded on the ward.
- In the most recent staff survey, which covered Cygnet Hospital, Blackheath and Cygnet Lodge, Lewisham, 66% of respondents stated that they enjoyed working for Cygnet Health Care and 71% stated that their managers motivate and support them to do their job.
- All members of staff who we spoke to said that they were happy working on the ward and that the staff supported each other.
- Three staff members said they enjoyed working on the ward and their morale was good. One staff member said that there were a lot of training opportunities and that the team worked well together. Another staff member said that they were encouraged to discuss with management any external training opportunities they were interested in.
- The hospital management encouraged staff to actively make suggestions and give feedback about how the service could be made more effective.

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

- The ward was clean with a lounge area and access to a small garden. The bedrooms were spacious and personalised with private toilets and sinks. There was a four year plan in place to renovate and install showers in all bedrooms.
- The shape of the ward meant that there were some blind spots. Risk was mitigated by staff through the allocation of rooms, with higher risk and new patients nearer the nursing station. There was also functioning closed circuit television through the public areas in the ward.
- The clinic room was clean and tidy with air conditioning and a functioning sink. The fridge was in working order with temperatures checked regularly. There were scales, and an electrocardiography machine which were checked every month.
- There was an emergency grab bag checked every week with oxygen, airways suction, emergency drugs and a ligature cutter. There was a medication cabinet with a controlled drugs safe within it. All medication was checked regularly. The order process for new medication was clear. If an order was made by 2pm there was same day courier delivery.
- Staff and visitors to the ward had personal alarms which worked and were checked every day.

Safe staffing

- Meridian ward was fully staffed at the time of the inspection. There were no vacancies.

- There was a matrix system in place to ensure safe staffing levels. With 17 patients the matrix indicated that there had to be two nurses and three support workers. On Tuesdays this was raised to 3 and 3 because of ward rounds. At night there were two nurses and two support workers.
- The staff comprised one ward manager, two nurse team leaders, eight nurses and nine support workers.
- Between January 2015 and September 2015, 406 shifts had been covered by bank or agency workers. No shifts had been unfilled.
- Staff told us they felt safe at work and there were always sufficient staff members on duty to meet people's needs. They used the daily planning meeting with patients who used the service to allocate staff for escorted leave and other tasks. They said this helped people to understand why their trip out could sometimes only take place at a certain time.
- Nursing staff told us they completed extensive on-line medicines administration training and then their competency was observed before they administered medicines without supervision. After this, their competency in this area was checked annually or more frequently if errors were made.
- It was sometimes necessary to use bank workers. The ward manager said there was a Cygnet bank and that they knew the bank workers. The ward manager was authorised to access bank workers without senior management approval. This helped staffing planning for annual leave and other absences.
- Doctor availability was good. The consultant was on the ward every Tuesday and was also accessible by phone. The ward doctor was present nine to five Monday to Friday. There was a list of doctors on the out of hours

Forensic inpatient/secure wards

rota. Calling the on call doctor was usually just for advice but it normally only took 15 to 30 minutes from them to get to the ward if necessary. Often medical cover came from Tyler ward.

- Sickness rates were low. The hospital provided a figure of 0.49% sickness on this ward from April to August 2015.
- Some patients told us that leave was, on occasion, cancelled or postponed because of staffing levels.

Assessing and managing risk to patients and staff

- We observed a multi-disciplinary team ward round where risks associated with individual patients were routinely reviewed, often with the person themselves present. All participants were asked for their views on a range of potential risks and a collective decision was recorded. All risks were taken into account when escorted and unescorted leave requests were considered.
- All care records contained very comprehensive risk assessments using the short term assessment of treatment and risk (START) and historical, clinical, risk 20 (HCR20) formats.
- The psychology department had recently started to use a positive behaviour support (PBS) approach with people who used the service. We saw one PBS plan which had been drawn up and it contained detailed guidance for staff about how best to support a person to manage their anger. It had been discussed with the person and they had explained what was most helpful to them. There was a planned seminar on the second day of the inspection visit to explain the PBS approach to the wider staff team.
- Two patients had oral medication prescriptions which clearly stated to consider intramuscular medication if the patient were to refuse oral medication. One of these patients had medication prescribed above British Nursing Formulary (BNF) limits and it was not clear if the intramuscular medication would be above BNF limits as well. Good practice would entail having two separate prescriptions for oral and intramuscular medication and a clear rationale given.
- Staff said that there was very low use of restraint. Between March 2015 and August 2015 there were 3 incidents of restraint on two different people. One of these was a restraint in the prone position which resulted in rapid tranquillisation. However, incident records for August and September showed four

restraints of which two were not noted in the restraint book. There was no seclusion room on the ward and staff said they felt comfortable with the use of de-escalation techniques.

- Staff understood safeguarding procedures and this was up to date on the mandatory training record.
- Children were not allowed on the ward as it was felt there was no safe space. However, there was space in the hospital away from the ward.
- Patients indicated that there was substance misuse on the ward. This was confirmed by incident reports and money being lent between patients. This was addressed by the ward and service action plan and was indicated on the risk register.

Track record on safety

- The hospital reported one serious incident on Meridian ward in the past year. This related to potential financial abuse between two patients on the ward.

Reporting incidents and learning from when things go wrong

- Staff members told us they tended to over-report incidents, because they did not want to miss anything which could later turn out to be significant. Two staff members separately gave the same example of learning from incidents. They said the multi-disciplinary team no longer considered shouting to be an incident, unless it was abusive, bullying, prolonged or accompanied by threats. They told us occasional shouting was now seen as a normal response to the frustrations of daily life and recognition of this had reduced the number of incidents recorded and the number of times they had to use restraint.
- Every Monday at the senior managers meeting the ward manager discussed the incidents that had happened on the ward. There was an incidents learning session every month with all the managers and therapy staff.
- We looked 42 incidents recorded between August and September. Eight related to cannabis use and four to smoking in the rooms.
- The hospital held a local risk register which had four current risks listed: Physical and verbal abuse from service users, safeguarding processes not being adhered to, engagement and observation policy not being adhered to by staff and physical health observations not being completed. These risks were being addressed with action plans and timescales to follow up. Staff were aware of the key issues on the ward level risk register.

Forensic inpatient/secure wards

Are forensic inpatient/secure wards effective?

(for example, treatment is effective)

Good



Assessment and planning of care

- We looked at eight care records. For each patient there was a small file for current risk assessment, care plans and continuous written records and a large file for the initial medical assessment, OT plans, ward round write ups, and full physical health assessments.
- There were two types of risk assessments which were completed after the patient had been on the ward for a month or more. These were all very detailed and considered and related to the care plans.
- The care plans followed the My Shared Pathways process. This meant that there were care plans for recovery, behaviour, insight, substance misuse, making feasible plans, staying healthy, life skills and relationships.
- Each record also contained a care plan evaluation form, including a summary and update. The ward round notes contained up to date capacity assessments which were reviewed as necessary.
- Care plans for physical health needs were comprehensive and reflected the identified needs of patients.
- On two files the consent/capacity section on the initial medical assessment had not been completed. On one file the initial medical assessment was missing but was referenced in the continuous written records.
- The ward doctor had completed a clinical audit on physical health assessments on all patients over the year. They fed back to the ward the need to improve on getting family and personal histories and completing blood tests, despite patients' reluctance. This audit had been repeated and significantly better outcomes had been recorded. The organisation was looking into using some of the learning from this audit at other Cygnet Health Care sites. They also told us that the ward doctor said it was their role to research any unusual or infrequent physical health issues, such as sickle cell management, and update the ward staff on it.
- We found the multi-disciplinary team was well-informed about people's individual needs and life histories. We

saw one member of the team, after seeking permission from the patient involved, checking and developing a patient's history in conjunction with a family member, thereby involving them

- Two members of nursing staff separately told us they always took age, cultural and other preferences of people into account when they were assessing needs or planning care. For example, they recognised it was unrealistic to expect many young men to avoid alcohol when out to a social event on unescorted leave, so their risk assessments and care plans reflected this.

Best practice in care and treatment

- People were offered blood and other tests to monitor their response to medicines. We saw staff took people's preferences into account when they could. For example, a person only wanted to give one regular blood sample, so the staff were looking into arranging for several tests to be carried out on the one sample.
- Physical health care needs were routinely addressed during the ward round, with people being referred for tests or for follow up with the ward doctor. Most people were registered with a local GP practice, although there was a long-standing problem with securing agreement from the Ministry of Justice for some people to attend the practice to register. However, these people could be seen as temporary GP patients in the ward if the need arose.
- The ward was switching to become a non-smoking environment from 1 January 2016. Staff had consulted with people about this and assessed their individual needs. Smoking cessation advice and aids, including medicines, were going to be provided from 1 November 2015 in preparation.
- The hospital had developed local and organisation wide governance systems to ensure that best practice, including updates on relevant national institute for health and care excellence (NICE) guidance was embedded in practice and policies on the ward and within the hospital.

Skilled staff to deliver care

- Recently appointed nursing staff said they had received a full induction before they joined the ward rota. This included a week of classroom based learning followed by the opportunity to shadow colleagues.

Forensic inpatient/secure wards

- The psychology team based onsite provided people with a range of therapies, such as cognitive behaviour therapy or psychotherapy. There was also access to dance and movement therapy and art psychotherapy. We saw the provider supported staff to attend external courses to acquire new skills or enhance existing skills, for example, an assistant psychologist was due to attend cognitive behavioural therapy training.
- The ward manager said that all nurses were encouraged to do mentorship training. Two nurses were to be sent on substance misuse training including motivational interviewing techniques.
- Supervision duties were shared between the ward manager and team leaders. We saw records indicating that all staff had had supervision on a monthly basis over the year and that all appraisals had been completed.

Multi-disciplinary and inter-agency work

- Staff described strong working relationships across disciplines within the service. This was observed during the ward round. A new member of staff said their opinions were valued.
- The hospital had built good relationships with local mental health resources, colleges and other community services. One person was supported to carry out voluntary work, having completed a relevant qualification at a local college. Some people attended an African-Caribbean mental health project and there were links with a lesbian, gay, bisexual, transgender project which some people had attended in the past. People also attended local gyms and sports centres.

Adherence to the MHA and MHA Code of Practice

- 98% of staff across the hospital had completed training related to the Mental Health Act and the Code of Practice.
- During the ward round staff members explored whether or not people understood the section of the Mental Health Act which applied to them and their right of appeal. From their responses, it was clear this had been discussed with people on previous occasions too. Nurses told us they would routinely refer people to the independent mental health advocate if they felt they did not understand why they had been detained or their right to appeal. An independent mental health advocate visited the ward weekly.

- There was a mental health act administrator based on the site. Staff knew where they could ask for assistance if they required clarification. There were both local and organisation wide audits relating to documentation specifically required by the Mental Health Act. Staff were aware of the expectations regarding documentation and ensuring people were aware of their rights under the Mental Health Act.

Good practice in applying the MCA

- Training related to the Mental Capacity Act was not mandatory within the service. Staff had a mixed understanding of the basic principles of the Mental Capacity Act and the need to use it within the ward.
- The ward doctor said that capacity was assessed formally when it was required and had a good understanding of the practical use of the Mental Capacity Act within a forensic rehabilitation service.
- Capacity was discussed and documented during ward rounds where it was relevant to a person's circumstances. We were told about examples when capacity had been assessed formally.

Are forensic inpatient/secure wards caring?

Good 

Kindness, dignity, respect and support

- We observed staff speaking politely to patients. Staff told us there was a culture in the ward of most people taking themselves off to their bedrooms when they were distressed which helped to maintain their dignity and privacy, even though staff would follow to ensure their safety.
- The majority of patients we spoke with said that staff were kind and respectful.

The involvement of people in the care they receive

- During the ward round, we observed that patients who wanted to be involved were present throughout the discussions held about them during the ward round. They were invited to contribute and to comment on the views of the multi-disciplinary team. Each person was directly asked for their views on their medicines and they were listened to and responded to appropriately.

Forensic inpatient/secure wards

- A user-led daily debrief session was supported by nursing staff each evening. People who used the service chose to call it the salvation group. Staff told us it was an opportunity for everyone to say how their day had gone and to receive congratulations or commiserations from the other attendees. A team leader said people who used the service were generally supportive of each other and understood people's differences and this was something the staff encouraged.
- Staff spoke highly of the regular independent mental health advocacy service provided to people who used the service. An IMHA attended the ward on a weekly basis and the advocacy provider issued the ward with a regular report on the number of visits and issues raised.
- We spoke with a carer who was visiting a patient on the ward who was very positive about the care given and the way they were involved.

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

Good 

Access and discharge

- The ward received referrals from a number of places including locked rehabilitation services, medium secure services and other low secure services. The target time was a week from referral to acceptance. This was usually met.
- Cygnet Hospital, Blackheath had a sister site with the same management team based locally. Sometimes patients would 'step down' to this service as it was a locked rehabilitation unit. This pathway was open to patients at Blackheath, depending on their needs and as well as commissioning arrangements.
- There was some difficulty with the discharge of patients subject to section 37/41 with the Home Office and with local commissioners placing people in suitable accommodation.
- The average stay on the ward was nine months to two years.

- When speaking about recent admissions, nursing staff told us they had received appropriate reports and information in advance of people being admitted to the ward.

The facilities promote recovery, comfort, dignity and confidentiality

- There was a patients' pay phone room which was private. There was an all-purpose room which had gym equipment. There was an OT kitchen. There was a health promotion board, a board for the day with nursing and other staff names. There was a "you said we did" board. There were medication leaflets on display for patients to take. There was not a separate area for visitors. There was some outdoor space with a large balcony.
- Patients had safes in their bedrooms for the safekeeping of personal items.
- The lounge a pool table, a drinks dispenser and table football and TV.

Meeting the needs of all people who use the service

- We asked how the needs of people with learning disabilities were met and we were told a registered learning disabilities nurse was on the staff team, so other staff members could easily seek advice when needed. Positive Behaviour Support was being introduced to benefit people with learning disabilities and, potentially others. During the ward round staff members were careful to check that people understood what was being discussed.
- Staff told us that although there were good relations with the kitchen, which was run by a neighbouring healthcare provider, they occasionally found it hard to respond to people's individual requirements for food and drink out of hours if these had not been anticipated.

Listening to and learning from concerns and complaints

- A staff member described how a person who used the service had accused them of giving them incorrect medicines. The staff member offered the person the opportunity to use the complaints system as they thought it would be helpful to the person.
- The ward manager looked at complaints and discussed with the hospital manager who led on complaints.

Forensic inpatient/secure wards

Following this, the hospital manager allocated a member of staff to lead on the complaints investigation. This ensured that patients who complained received timely responses.

- Patients discussed complaints and concerns in the community meetings. For example patients wanted more variety in choice of food especially Caribbean and African food, they wanted more chairs in lounge and more choice about group outings. All these issues had been successfully addressed through patients raising these issues at the meetings.
- Complaints were discussed within the local clinical governance meetings to ensure that learning could be disseminated.

Are forensic inpatient/secure wards well-led?

Good 

Vision and values

- Staff were aware that the Cygnet group had recently been taken over by a larger company. They said they felt the values of the organisation would stay the same and that they thought these values were about providing a high quality and personalised service to all patients.
- Staff said they identified with the hospital more than the wider Cygnet group.

Good governance

- Staff told us they had access to the risk register on the shared drive.
- There was a weekly ward meeting for staff, handover meetings between each shift and a morning weekday handover with members of the multi-disciplinary team who did not work shifts.
- Records indicated that staff were up to date with their mandatory training and that they received regular supervision.
- We saw that there were sufficient staff to care for patients and that staff were not occupied only with administrative tasks.
- There were a number of meetings across the organisation where information was shared. For example, incident learning meetings, integrated

governance meetings, meetings between mental health act administrators and a medical advisory meeting. We saw from the minutes of these meetings that information flow around the organisation was cohesive.

- Board members came to the site for a board meeting twice a year. This increased the visibility of leadership across the organisation.
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- The hospital had developed a specific action plans with incorporated review dates in response to the staff survey from 2014/5. This included introducing reflective practice sessions for ward-based staff which had been actioned. This meant that the organisation learnt from feedback from staff.
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- Staff on the wards said that they valued and respected the leadership given by the ward manager.
- There was a location level and organisation level risk register. This was compiled by the senior management team at the hospital site on the basis of integrated governance meetings. The service managers were clear about the processes for information and issues to be added to the risk register, escalated to a company-wide

Forensic inpatient/secure wards

risk register and removed from the risk register. The risk register for the service and the overarching action plan were stored on a shared drive which all staff were able to and encouraged to access.

- Cygnet Health Care incorporated 'mock' CQC inspections to ensure that areas for improvement could be identified internally. Wards were given this feedback in written form and where necessary, the wards developed action plans on the back of this.

Leadership, morale and staff engagement

- All staff members described an open, responsive leadership style and good team working. They said managers knew people who used the service well and they could approach them easily to discuss any concerns. New staff told us they had received a friendly welcome from managers.
- Staff were enthusiastic about the reflective discussion sessions which were held regularly to discuss challenging issues. When asked the ward staff how they ensured they worked in line with the values of the service, a team leader spoke about using supervision sessions to reflect on practice. Staff also told us the psychology department had been helpful to them when they were struggling at work.

- Staff said that they could report any issue without fear and that they were working in a team that was well led. The staff we spoke with were aware of local whistleblowing policies.
- The ward doctor said the consultant was very supportive and encouraging.

Commitment to quality improvement and innovation

- A team leader described some of the audit processes which took place on the ward. For example, they checked clinical records monthly to ensure all required information was present. They identified any trends and summarised them. We were told they were discussed in management meetings and other meetings if required. We noted the audit focused mainly on the presence and completion of documentation in people's clinical records, there was less emphasis on the quality of the information.
- The ward had achieved the 'Full Monty' award through the Starwards initiative. This meant that they had reached a number of patient focussed standards which were externally validated.
- The service was a member of the forensic quality network and some members of staff had been involved in peer visits to similar services nationally.

Outstanding practice and areas for improvement

Outstanding practice

- The service had achieved the 'Full Monty' award through the Starwards initiative on Meridian ward. This meant that they were committed to constant improvement and a user centred approach.
- All staff had access to the hospital risk register through the shared drive and there was a commitment to sharing information on complaints and incidents through a staff newsletter.
- The service had used a clinical audit tool relating to physical healthcare on Meridian ward to drive improvement and this was being used across the organisation.
- The development of the user-led salvation group on Meridian ward which gave patients the opportunity to feedback and reflect on their days in a facilitated group setting.

Areas for improvement

Action the provider **SHOULD** take to improve

- The provider should ensure that all episodes of seclusion and restraint are recorded comprehensively according to the Mental Health Act Code of Practice.
- The provider should continue to explore the ways to reduce restrictive practices including the use of seclusion and the use of very high levels of observation to ensure that the least restrictive options are preferred
- The provider should ensure that patient involvement is integrated in the care planning process on Tyler ward.
- The provider should ensure that all staff have knowledge of the Mental Capacity Act which is relevant to the area in which they work.