Cygnet Health Care Limited

Cygnet Hospital Ealing

Inspection report

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

Ratings

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

Summary of findings

Overall summary

Our rating of this location improved. We rated it as good overall, with requires improvement in safe because:

Patients told us they felt safe. The ward environments were safe and clean. Since our last inspection, a nurse call system had been installed throughout the hospital. Sunrise ward had been refurbished and all bedrooms were now single and en-suite.

The wards had enough nurses and doctors. Staff assessed and managed risk well. They minimised the use of restrictive practices, managed medicines safely and followed good practice with respect to safeguarding.

Staff developed holistic, recovery-oriented care plans informed by a comprehensive assessment. They provided a range of treatments suitable to the needs of the patients and in line with national guidance about best practice. Staff engaged in clinical audit to evaluate the quality of care they provided.

The ward teams included or had access to the full range of specialists required to meet the needs of patients on the wards. Managers ensured that these staff received training, supervision and appraisal. The ward staff worked well together as a multidisciplinary team and with those outside the ward who would have a role in providing aftercare.

Staff understood and discharged their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005.

Most staff treated patients with compassion and kindness, respected their privacy and dignity, and understood the individual needs of patients. They actively involved patients and families and carers in care decisions.

Staff said they felt respected, supported and valued. They could raise any concerns without fear.

However:

Staff did not always record observations of patients in line with the provider's policy. Intermittent observations were recorded at regular and predictable intervals. There was a risk that the patients would know when observations would take place and they could plan any actions around this.

On New Dawn ward some of the staff did not engage with the patients or show a caring attitude towards them. Staff at times would be using their mobile phones when they were observing the patients.

Staff were not always able to take their break when escorting patients to the emergency department.

The provider had made significant improvements since our last inspection. Overall, governance processes operated effectively, and arrangements were in place for the management of performance and risk. However, issues identified with the recording of patient observations required improvement.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Specialist eating disorder services	Good 	Our rating of this service improved. We rated it as good because: See the summary above for details.
Personality disorder services	Good 	Our rating of this service improved. We rated it as good. See the summary above for details.

Summary of findings

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Summary of this inspection

Background to Cygnet Hospital Ealing

Cygnet Hospital Ealing is made of up two wards.

Sunrise Ward is a ward for women over 18 requiring treatment for complex eating disorders. The service offers psychological therapies as well as support and care relating to physical and mental health. The ward can accommodate up to 14 patients.

New Dawn Ward is a specialist service for women over 18 with personality disorders. It has nine beds and predominantly offers a dialectic behaviour therapy treatment model.

The service is registered to undertake the following regulated activities:

Care and treatment for persons detained under the Mental Health Act 1983

Treatment for disease, disorder or injury

There was a registered manager in post at the time of the inspection.

We have inspected Cygnet Hospital Ealing four times since 2015. At our last comprehensive inspection in January 2020 we rated the specialist eating disorder service and personality disorder services as requires improvement in safe and well-led. We rated effective, caring and responsive as good. At that inspection we rated the hospital as requires improvement overall.

We found breaches in relation to:

Regulation 12 (safe care and treatment)

Regulation 17 (good governance)

At our comprehensive inspection in June 2019, the service was rated as inadequate overall, with an inadequate rating for the specialist eating disorder service provided on Sunrise ward, and a rating of requires improvement for the personality disorder service provided on New Dawn ward. The service was placed in special measures following the inspection as they had not addressed the requirements in the previous warning notices.

In November 2018 we carried out a focused inspection in response to concerns raised. At that inspection we took enforcement action and issued the provider with warning notices.

What people who use the service say

We spoke to twelve patients and overall feedback we received was positive. Patients said they were treated with kindness, were supported in their recovery and there were some very caring staff. Patients told us they were involved in their care and treatment and staff were responsive to requests for support. Patients on New Dawn ward said the consultant psychiatrist was excellent, that they listened to them, involved them in their care and provided clear information.

Summary of this inspection

However, on New Dawn ward patients reported that some staff were not as engaged with them as other staff. For example, they would not engage in conversation or would not always speak kindly or caringly. On Sunrise ward, patients told us that agency staff needed further training to understand eating disorders and better communication at mealtimes.

Patients told us they enjoyed the variety of activities including the recreational activities such swimming and personal training. Patients were able to give feedback on the service so that improvements could be made, through community meetings and feedback questionnaires.

All patients told us they were supported to maintain contact with family and carers.

We received feedback from three carers we spoke with. All carers told us that they were involved in their family members' care and staff were kind and caring. Carers told us they valued the carers group and the psychoeducation provided. Two carers on Sunrise ward told us that communication between them and the ward staff could be improved.

How we carried out this inspection

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

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

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

During the inspection visit, the inspection team:

- visited both wards at the hospital, looked at the quality of the ward environment and observed how staff were caring for patients
- spoke with twelve patients who were using the service and three carers or family members of patients who were using the service. Interviews with carers were completed by telephone. Our final carer interview was on 16 May 2022
- spoke with the clinical nurse manager, hospital manager and medical director
- spoke with 24 other staff members: including consultant psychiatrist, doctors, nurses, occupational therapists, chef, healthcare assistants, clinical psychologist, assistant psychologist, facilities manager, administrator, dietician and social worker
- spoke with an independent advocate
- attended and observed two situation report meetings and one multidisciplinary team meeting
- attended a ward round, multidisciplinary team meeting and observed a daily risk assessment meeting on New Dawn ward
- observed a post meal group on Sunrise ward
- looked at fourteen care and treatment records of patients
- carried out a specific check of the medicine management on both wards
- looked at a range of policies, procedures and other documents relating to the running of the service

Summary of this inspection

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

Areas for improvement

Action the service MUST take to improve:

- The service must ensure that staff undertake observations of patients in line with the provider's observation policy.

Action the service SHOULD take to improve:

- The service should ensure that patients on New Dawn ward have regular one-to-one sessions with their named nurse.
- The service should ensure that the caring attitude of some staff on New Dawn ward is brought up the standard of the majority of staff.
- The service should ensure staff are able to take breaks when attending the emergency department with a patient.
- The service should continue to further improve and embed governance arrangements so that auditing and monitoring is robust.

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Specialist eating disorder services	Requires Improvement	Good	Good	Good	Good	Good
Personality disorder services	Requires Improvement	Good	Good	Good	Good	Good
Overall	Requires Improvement	Good	Good	Good	Good	Good

Good

Specialist eating disorder services

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

Are Specialist eating disorder services safe?

Requires Improvement

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

Safe and clean care environments

All wards were safe, clean well equipped, well furnished, well maintained and fit for purpose.

Safety of the ward layout

Staff completed and regularly updated thorough risk assessments of all wards areas and removed or reduced any risks they identified.

Staff could not directly observe patients in all parts of the wards. The ward was split over two floors. This risk was mitigated through regular observations and mirrors. We identified one blind spot where three new bedrooms had been created as part of the ward refurbishment programme. The service took immediate action and installed a convex mirror within the inspection period. The service had closed-circuit television (CCTV) in all communal areas and corridor areas. CCTV was recorded and was used to review incidents on the ward.

Where individual patients were identified as being at risk, increased observations, including one-to-one, were used.

At our last inspection in January 2022 we required the service to ensure that the ground floor risk assessment clearly identified the management and mitigation plans in place to keep patients safe. At this inspection we found improvements, the ground floor risk assessment detailed the plans to manage each identified risk.

Staff knew about any potential ligature anchor points and mitigated the risks to keep patients safe. For example, by using observation, engagement and individual risk management plans for each patient. A ligature audit had been carried out in January 2022 which included photographs of ligature points. A ligature 'heat' map was on display in the nurse's office. However, we found one ligature anchor point that had not been identified on the ligature audit but had been identified on the photographs. The service took immediate action and updated the ligature risk audit to reflect this. Ligature cutters were present in both the nursing office and clinic room, and staff knew where to get them and how to use them.

Good

Specialist eating disorder services

At our last inspection the patient call alarm system had been deactivated and patients could not call for help from staff if they needed too. At this inspection we found improvements. The service had installed a nurse call system that patients could access. All staff carried alarms to summon assistance from colleagues if needed. These were tested daily.

Fire safety arrangements were in place. Staff completed fire safety training as part of their role. All drills, testing and servicing was recorded in a fire folder, which was up-to-date with current information. Personal emergency evacuation plans (PEEPS) were in place for all patients on the ward so that staff were aware of all patients who may require assistance in the event of an emergency.

Maintenance, cleanliness and infection control

Ward areas were clean, well maintained, well-furnished and fit for purpose.

The ward had been refurbished to a high standard and all bedrooms were now single and had ensuite facilities.

Staff made sure cleaning records were up-to-date and the premises were clean. Housekeeping staff were seen cleaning high touch areas throughout the day.

Staff followed infection control principles including appropriate handwashing techniques, use of personal protective equipment and hand sanitiser was readily available. We observed all staff wearing face coverings in all parts of the service.

Clinic room and equipment

Clinic rooms were fully equipped, with accessible resuscitation equipment and emergency drugs that staff checked regularly. Resuscitation equipment was checked every day by ward staff. This included checking the oxygen tank, emergency drugs and the defibrillator.

Staff checked, maintained, and cleaned equipment. Staff ensured that equipment was correctly calibrated. Equipment in the clinic room was visibly clean and clean stickers were clearly displayed.

Staff recorded daily room temperatures and fridge temperatures and knew the actions to take if these were out of range.

Safe staffing

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

Nursing staff

The service had enough nursing and support staff to keep patients safe with the use of bank and agency staff. Staffing was reviewed daily with the senior management team and for the following 24hrs within the daily situation report meeting. Staffing levels were increased to safely meet individual patient needs, for example one-to-one observations.

At the time of the inspection the ward had vacancies for three registered nurses, and three vacancies for non-registered nurses. The service was actively recruiting into these positions including overseas recruitment. Plans were in place to offer a preceptorship programme across three Cygnet Hospitals for newly qualified nurses.

The service used agency staff and their own bank staff to cover vacant regular shifts and when additional staff were needed. When the service used agency or bank staff, managers requested staff familiar with the service so that patients received continuity of care. Managers made sure all bank and agency staff had a full induction and understood the service before starting their shift.

Managers accurately calculated and reviewed the number and grade of nurses and healthcare assistants for each shift. The service used a staffing matrix which determined the numbers of staff required dependent on the number of patients and their acuity. The clinical nurse manager could adjust staffing levels according to the needs and risk level of the patients.

Patients had regular one-to-one sessions with their named nurse. Patients we spoke with confirmed they knew who their named nurse was and that they spent regular time with them.

Patients rarely had their escorted leave or activities cancelled, even when the service was short staffed.

The service had enough staff on each shift to carry out any physical interventions safely if needed, including nasogastric feeding. However, physical interventions including nasogastric feeding rarely took place. All permanent staff received training in delivering nasogastric feeds and safe restraint techniques.

Staff shared key information to keep patients safe when handing over their care to others, for example, situation report meetings were held daily as well as handover meetings between shifts. Staff told us they used these meetings to discuss any incidents that had occurred and update patient risk information. Staff completed a comprehensive handover document which included detailed risks, meal plans, observation levels, physical observations, allocated key worker for one-to-one session. This ensured that information was passed onto staff coming onto shift.

Medical staff

The service had enough daytime and night-time medical cover and a doctor available to go to the ward quickly in an emergency. The ward had an assigned consultant psychiatrist, ward doctor and speciality doctor. Patients were seen and monitored in a timely way. The service operated an on-call system for out of hours.

Managers could call locums when they needed additional medical cover. Managers made sure all locum staff had a full induction and understood the service before starting their shift.

Mandatory training

Staff had completed and kept up-to-date with their mandatory training. Mandatory completion rates for all courses were at 95% and above for Sunrise ward. The mandatory training programme was comprehensive and met the needs of patients and staff. 100% of staff had completed intermediate life support training.

Good

Specialist eating disorder services

Staff we spoke with said they felt confident carrying out their role and applied training to their practice. All staff we spoke with reported that they had undertaken specialist eating disorders training and were fully supported to carry out any additional required training. Managers monitored mandatory training and alerted staff when they needed to update their training.

We reviewed the mandatory training programme and found it comprehensive, covering a wide range of subjects suitable to the service.

Assessing and managing risk to patients and staff

Staff assessed and managed risks to patients and themselves well and followed best practice in anticipating, de-escalating and managing challenging behaviour. Staff used restraint after attempts at de-escalation had failed. The ward staff participated in the provider's restrictive interventions reduction programme. However, patient observations were undertaken in a predictable way for patients and there were gaps in the MARSI-MEWS charts.

Assessment of patient risk

Staff completed risk assessments for each patient on admission using a recognised tool.

Staff completed the 'Management of really sick patients with anorexia nervosa' (MARSIPAN) risk assessment. Risk assessments were updated regularly, and as risks changed, for example following incidents or changes in physical or mental health presentation.

Risk assessments were comprehensive and covered physical and mental health. For example, skin assessments were carried out for patients at risk of developing a pressure ulcer.

A mental state assessment was completed on admission, which helped staff to determine whether there were risks of suicide or self-harm.

Management of patient risk

Staff knew about any risks to each patient and acted to prevent or reduce risks. All staff we spoke with had a good understanding of each patient and the risks they posed. All care records for patients had up-to-date risk assessments.

Patient risk assessment and management was discussed in the daily situation report meetings, at handovers and in the weekly multidisciplinary meetings. This enabled staff to focus on the current risks and review how effective management and mitigation plans were working.

Staff identified and responded to any changes in risks to, or posed by, patients, for example where required additional observations were carried out, or additional staff rostered on shift.

Staff used the MARSI-MEWS to monitor patients vital signs. MARSI-MEWS is an early warning score for evaluating an inpatient with anorexia nervosa. This was developed out of MARSIPAN (Management of Really Sick Patients with

Anorexia Nervosa). Clinical observations such as blood pressure, pulse and temperature were carried out as prescribed by the ward doctors. We reviewed nineteen MARSI-MEWS charts and found gaps in each record. Gaps in MARSI-MEWS charts had been identified during an audit in April 2022. The provider had detailed in their actions that improvements would be completed by the end of May 2022.

Staff followed procedures to minimise risks where they could not easily observe patients. Staff had undertaken training in patient engagement and observation. Staff we spoke with understood the different types of intermittent observations and how they were to be carried out. Staff were to observe patients four times per hour, with a maximum of 15 minutes between checks. These observations were to be undertaken at unpredictable times so that patients were not aware when the observation would take place. However, three out of seven observation records showed that most staff recorded observations at regular and predictable times. This meant that patients would be aware at what time the staff would check them. Audits of the observation records had not identified this.

Staff applied some blanket restrictions on the ward. These restrictions worked in accordance with the therapeutic model of treating patients with an eating disorder, for example the night before the patients' weekly weight check bathrooms were locked so that patients could not water load. Staff did not impose any inappropriate blanket restrictions.

Staff followed policies and procedures when they needed to search patients or their bedrooms to keep them safe from harm.

Use of restrictive interventions

Staff had a good understanding of the provider's restrictive interventions programme, which met best practice standards. Staff made every attempt to avoid using restraint by using de-escalation techniques and restrained patients only when these failed and when necessary to keep the patient or others safe.

The hospital also used elements of the 'Safe wards' model. The model addresses how to assess and change ward culture, de-escalation and alternatives to restrictive interventions. This included the use of positive and 'soft' words when speaking to patients.

All permanent staff working on the ward were trained to administer nasogastric feeds under restraint.

Levels of restrictive interventions were low. There had been no episodes of restraint or rapid tranquilisation between 1 November 2021 to 30 April 2022 on this ward.

Levels of restrictive interventions, including restraints, prone restraints and rapid tranquilisation were reviewed at the monthly clinical governance meeting.

The ward had a nominated patient who worked with the reducing restrictive practice lead in reviewing and feeding back on restrictive practices on the ward, for example feedback had been used to prescribe an additional 250mls of water for patients who had been assessed by the dietician as part of their hydration plan.

Safeguarding

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

Staff understood how to protect people from abuse and the service worked well with other agencies to do so. All staff said they had training appropriate for their role on how to recognise and report abuse, and they knew how to apply it. Staff felt confident that if they did raise concerns they would be listened to and action taken.

At the time of the inspection 100% of staff were up-to-date with their level 3 safeguarding training.

Safeguarding concerns were regularly discussed in multi-disciplinary meetings and handover meetings and referrals were discussed in clinical governance meetings. Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff told us that if they had concerns that someone was at risk of abuse they spoke with the social worker and the safeguarding lead who would make the necessary referrals.

The social worker tracked all safeguarding referrals and communicated with the local authority safeguarding team on the progress and outcomes of any investigations. All safeguarding incidents were reviewed at the monthly integrated governance meeting.

Patients were supported by the hospital advocate to raise any safeguarding concerns.

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

Staff access to essential information

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

Patient notes were comprehensive, and all staff could access them easily.

Although the service used a combination of electronic and paper records, staff made sure they were up-to-date and complete

Records were stored securely.

Medicines management

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

The service used systems and processes to safely prescribe, administer, record and store medicines. Staff regularly reviewed the effects of medicines on each patient's mental and physical health at the weekly multidisciplinary team meeting. Systems were in place to safely store and check controlled drugs. The service ensured people's behaviour was not controlled by excessive and inappropriate use of medicines.

The pharmacist carried out weekly visits and undertook monthly medicine audits. Results of the audits were sent to the service and any shortfalls were discussed at the integrated governance meeting.

Staff checked the temperature of the clinic room and the fridges where medicines were stored. Staff checked to ensure the fridge temperatures were within the correct range. Records showed that staff administered patients' medicines as prescribed.

Staff regularly reviewed the effects of medicines on each patient's mental and physical health in line with guidance from the National Institute of Health and Care Excellence. Staff carefully considered patients Body Mass Index (BMI) when establishing appropriate doses of medicine to prescribe. The consultant psychiatrist provided advice and information on the medicines prescribed.

Track record on safety

The ward had a good track record on safety.

The ward had no serious incidents in the previous 12 months. When serious incidents happened, these were discussed at the integrated governance meetings and any immediate learning identified and shared with the clinical teams.

Reporting incidents and learning from when things go wrong

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

Staff knew what incidents to report and how to report them. At our last inspection we found the incident reporting system to be complex. At this inspection we found improvements. The service now had one electronic incident reporting system. Staff reported this was much easier to use. Staff told us that they would report any incident of harm, potential harm, near misses and/or risks to safety.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong. For example, staff apologised to a patient who had been given a meal that had not been agreed within the meal plan.

Arrangements were in place for de-brief sessions to take place for both staff and patients following a serious incident. This was to ensure that staff and patients were provided with appropriate support. The clinical psychologist facilitated any significant debrief sessions. The hospital was also trialling a new programme of supporting staff wellbeing following incidents called Trauma Risk Management (TRiM) a trauma-focused peer support system designed to help staff who have experienced a traumatic, or potentially traumatic, event.

When something went wrong there was a thorough review or investigation which involved members of the MDT, patients and their family members as appropriate.

At our last inspection we found that further improvements were required on the way learning from incidents was shared with staff. At this inspection we found some improvements. Two out of the three team meeting minutes we viewed detailed learning from incidents. Staff discussed incidents at handover, supervision and MDT meetings. However, four staff we spoke with were not able to articulate any learning from incidents, despite the clinical manager showing us emails and information that they had sent staff.

Good

Specialist eating disorder services

Staff received feedback from investigation of incidents, both internal and external to the service. Staff were able to describe how they met to discuss the feedback and look at improvements to patient care, for example discussions had taken place regarding contraband items and patient searches.

There was evidence that changes had been made as a result of feedback, for example, staff were required to undertake dysphagia training following a choking incident at another Cygnet Hospital.

Regular unannounced emergency simulation scenarios were carried out by the managers. They acted out an unannounced emergency scenario such as a ligature incident and assessed how staff responded. Where shortfalls were identified during the exercise an action plan was developed to ensure that the chance of errors occurring when a real emergency incident happened were reduced.

Are Specialist eating disorder services effective?

Good

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

Assessment of needs and planning of care

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

Staff completed a comprehensive mental health assessment of each patient either on admission. This included a mental state examination and an assessment of any risk the patient presented.

All patients had their physical health assessed soon after admission and regularly reviewed during their time on the ward. Staff supported patients with their physical health needs and worked collaboratively with specialists when needed.

Comprehensive physical assessments were completed and plans for on-going monitoring of health conditions and healthcare investigations were developed. This included regular monitoring of blood samples, heart rate, pulse, urine tests, temperature, weight monitoring, BMI (body mass index), the sit up, squat and stand up (SUSS) test of muscle function in anorexia nervosa and electrocardiogram (ECG). Bone density scans were completed for patients who needed them.

Patients could make an appointment to attend the weekly physical health clinic where they could address any physical health concerns with the ward doctor. Each patient had a detailed dietetic and occupational therapy assessment, which were reviewed regularly.

Staff developed a comprehensive care plan for each patient that met their mental and physical health needs. Care plans were personalised, holistic, recovery-oriented and regularly reviewed. Care plans reflected the views of patients and their relatives about their care and treatment. Staff worked with patients to regularly review and update care plans when patients' needs changed. The multidisciplinary team reviewed every patient each week and regularly updated each patient's care plan with the patient's involvement actively encouraged and supported.

Good

Specialist eating disorder services

Best practice in treatment and care

Staff provided a range of treatment and care for patients based on national guidance and best practice. They ensured that patients had good access to physical healthcare and supported them to live healthier lives. Staff used recognised rating scales to assess and record severity and outcomes. They also participated in clinical audit, benchmarking and quality improvement initiatives, however some audits did not identify concerns.

Staff provided a range of care and treatments suitable for the patient group and consistent with national guidance on best practice. Patients had access to psychological therapies as recommended by the National Institute for Health and Care Excellence (NICE). Staff offered patients a range of therapies to help them develop coping skills to manage their eating disorder. This included cognitive behavioural therapy, dialectical behavioural therapy, psychodynamic psychotherapy, MANTRA (Maudsley Anorexia Nervosa Treatment for Adults), CREST (Cognitive Remediation and Emotion Skills Training), SSCM (specialist supportive clinical management), family, occupational, art, yoga and complementary therapies.

Staff used the 'Management of really sick patients with anorexia nervosa' (MARSIPAN) guidelines. These guidelines provide guidance on the clinical management and care of really unwell patients with anorexia nervosa. The MARSIPAN guidelines are approved by the Royal College of Psychiatrists and Royal College of Physicians and help staff to carry out safe re-feeding, risk management and monitoring.

Staff identified patients' physical health needs and recorded them in their care plans. Staff made sure patients had access to physical health care throughout their admission, including specialists as required. Staff had positive working relationships with other professionals at the local acute hospital including gastroenterologists and cardiologists. For example, the consultant psychiatrist and nursing team had worked closely to share information on refeeding syndrome with the medical team at the hospital where a patient from the ward had been admitted.

The clinical team were working on developing an autism and eating disorder strategy. Staff gave examples of how they managed to support patients with autistic traits and their sensory and communication needs, for example for one patient meals were provided in the patient's bedroom rather than the main dining room.

Staff met patients' dietary needs and assessed those needing specialist care for nutrition and hydration. The dietician and staff carried out comprehensive nutritional and hydration assessments for all patients upon admission to the ward to ensure that refeeding was carried out safely including nasogastric feeding. Patients could make appointments to attend a weekly dietician clinic where they were able to address any dietetics and meal plan concerns.

Patients who were identified as being at risk of water loading had their hydration monitored effectively by staff. Water loading is where individuals consume large quantities of water so they feel less hungry or to increase their weight before being weighed. It can lead to dangerous consequences including water intoxication which can lead to seizures.

Staff helped patients live healthier lives by supporting them to take part in programmes or giving advice. A physical trainer visited the ward weekly and carried out group and individual exercise sessions designed for people an eating disorder. The consultant psychiatrist and dietician ran a weekly education group on the effects of an eating disorder that patients attended.

Staff used technology effectively to support patients. During the pandemic managers had successfully introduced online virtual family visits to maintain family contact for patients. The service had made changes to the carers group which was now held virtually every fortnight.

All carers we spoke with confirmed that this had allowed them to maintain regular contact and attend Care Programme Approach (CPA) meetings.

All families were offered evidence-based family interventions that addressed eating disorders and the majority of families took part.

Staff took part in clinical audits, benchmarking and quality improvement initiatives. In most cases, managers used results from audits to make improvements by implementing and monitoring action plans. However, audits of therapeutic intermittent observation records had not identified that checks were not being carried out in a randomised manner in line with the policy.

A quality review of the service had been completed in May and November 2021 this included a review of safety of the service, record keeping, effectiveness, leadership, governance, patient and carer involvement. Where areas of improvement had been identified the service had developed a comprehensive action plan which was reviewed at the monthly compliance meeting.

Skilled staff to deliver care

The ward team included or had access to the full range of specialists required to meet the needs of patients on the ward. Managers made sure they had staff with the range of skills needed to provide high quality care. They supported staff with appraisals, supervision and opportunities to update and further develop their skills. Managers provided an induction programme for new staff.

The service had a full range of specialists to meet the needs of the patients on the ward. This included consultant psychiatrist, nursing staff, ward doctor, specialist registrar, psychologist, assistant psychologist, occupational therapists and social worker.

Managers gave each new member of staff, including bank and agency staff, a full induction to the service before they started work. All new permanent staff were allocated an induction 'buddy' who supported them through the induction process. Recently appointed staff told us they had been well supported and received a comprehensive induction.

All staff we spoke with confirmed they had access to regular clinical, managerial and group supervision. Clinical supervision was facilitated by an external supervisor. The percentage of staff that had completed clinical supervision was 80% and managerial supervision 89%. Staff reported that they used supervision to discuss the current patients, to reflect and learn from practice, incidents and for personal support and professional development. Staff supervision records reflected these discussions. Regular bank and agency staff also received regular supervision.

Managers supported staff through regular, constructive appraisals of their work. The percentage of staff that had had an appraisal in the last 12 months was 100%. Medical staff appraisals were at 100%.

Managers made sure staff attended regular team meetings or gave information from those they could not attend. Where staff were unable to attend team meeting minutes were available.

The continuing development of staff skills, competence and knowledge was recognised as an essential component for providing high quality care and treatment. Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge, including accessing specialist training, for example, the Prevention of Violence and Aggression (PMVA) lead for the service was undertaking a teaching qualification.

Good

Specialist eating disorder services

Managers made sure staff received any specialist training for their role. All staff completed 'a minimum you need to know about eating disorders' workbook. This covered areas including managing mealtimes, identifying re-feeding syndrome, water loading etc. Staff completed a final assessment to ensure they understood how to apply this knowledge in day to day clinical practice. However, one patient told us that ad-hoc agency staff required more training to understand eating disorders.

The consultant psychiatrist, psychologist and dietician were available to staff for training and advice on supporting patients with an eating disorder.

Managers recognised poor performance, could identify the reasons and dealt with these through supervision and performance management plans.

Multi-disciplinary and interagency teamwork

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

Staff held regular multidisciplinary meetings to discuss patients and improve their care. All members of the multidisciplinary team and staff worked together to understand and meet the range and complexity of patient's needs. Patients were invited in to discuss their care and treatment and where patients had given consent family members could also attend the meeting either in person or virtually.

Staff made sure they shared clear information about patients and any changes in their care, including during handover meetings. The hospital had daily situation report meetings each morning which discussed staffing, incidents, referrals, admissions, planned discharges, diary appointments and any other relevant issues. These were well attended by managers and the wider clinical team. Each shift held a handover where incidents, patient care and risk were discussed.

Staff worked effectively together and with other health and social care professionals to deliver effective care and treatment. Care co-ordinators regularly attended care programme approach meetings. Staff reported that they had good relationships with commissioners, local authority social services and other mental health providers.

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

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

Staff received and kept up-to-date with training on the Mental Health Act and the Mental Health Act Code of Practice and could describe the Code of Practice guiding principles. 100% of staff had completed the Mental Health Act training.

Staff had access to support and advice on implementing the Mental Health Act and its Code of Practice.

Staff knew who their Mental Health Act administrators were and when to ask them for support.

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

Patients had easy access to information about independent mental health advocacy and patients who lacked capacity were automatically referred to the service. There was a dedicated advocate who visited the ward one day per week to support patients with tribunal hearings and complaints.

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

Staff made sure patients could take section 17 leave (permission to leave the hospital) when this was agreed with the Responsible Clinician. All section 17 leave was risk assessed beforehand by the MDT. Patients we spoke to told us they were able to take their leave.

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

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

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

Care plans included information about after-care services available for those patients who qualified for it under section 117 of the Mental Health Act.

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

Good practice in applying the Mental Capacity Act

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

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

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

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

Staff gave patients all possible support to make specific decisions for themselves before deciding a patient did not have the capacity to do so.

Staff assessed and recorded capacity to consent clearly each time a patient needed to make an important decision. Staff checked that patients had the mental capacity to consent to care and treatment at admission and at appropriate intervals.

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

Good

Specialist eating disorder services

Are Specialist eating disorder services caring?

Good

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

Kindness, privacy, dignity, respect, compassion and support

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

Patients received high quality care and support from a staff team that worked within a strong person-centred culture. We observed staff treating patients with compassion and kindness. The staff and management team spoke with understanding, empathy and respectfully about the people they cared for. Staff talked of valuing people and respecting their human rights and diverse needs.

Staff were discreet, respectful, and responsive when caring for patients. The interactions we observed between staff and patients were kind and respectful. Patients told us they felt they were treated with dignity and respect. Patients reported that staff were responsive to their needs, gave help, emotional support, and advice when they needed it.

However, one patient reported that ad-hoc agency staff needed more training to understand eating disorders and better communication at mealtimes. Another patient told us that a member of agency staff was on the phone when they were meant to be carrying out one to one observation. They had reported this to the management team. We saw the actions that the provider had taken to address this.

Staff supported patients to understand and manage their care, treatment and condition. Care plans detailed discussions that members of the MDT had with the patient relating to their physical and dietary needs. Nurses met patients individually and patients were invited to attend ward rounds with their consultant.

Staff directed patients to other services and supported them to access those services if they needed help. For example, staff supported patients to access services at the local acute hospital and attended appointments with them.

Staff understood and respected the individual needs of each patient. We observed staff discussing patients in the multi-disciplinary meeting and during our interviews. This was done in a respectful manner and recognised people's individual needs

Staff felt that they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards patients. Staff created safe spaces for patients to talk about any inequalities they had experienced. The occupational therapist had carried out sessions with patients following the Black Lives Matter Movement.

Staff followed policy to keep patient information confidential. Staff maintained the confidentiality of information about the patients. Information was stored electronically and could only be accessed by staff authorised to do so. Any patient discussions were held in offices and meeting rooms to ensure patient confidentiality.

Good

Specialist eating disorder services

Involvement in care

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

Involvement of patients

Staff introduced patients to the ward and the services as part of their admission. Staff used the admission process to inform and orient patients to the ward. Patients received a welcome pack during the pre-admission assessment period. The welcome pack provided comprehensive information about the service.

Patients were active partners in their care. Staff were fully committed to working in partnership with patients in developing and reviewing their care plans and risk assessments. There was a strong focus on co-production and care plans and risk assessments demonstrated patient input.

Staff made sure patients understood their care and treatment and found ways to communicate with patients who had communication difficulties.

For patients who had difficulty understanding English staff ensured interpreters were booked for care programme approach (CPA) and ward round meetings. Staff made sure patients could access advocacy services. The advocate supported patients at the ward round, CPA meetings and to raise any concerns if the patient requested this. The advocate produced a quarterly report on key themes that patients had raised.

Staff involved patients in decisions about the service, when appropriate. For example there was a nominated patient who worked with the reducing restrictive practice lead on the ward. Patient feedback on water restriction had been raised with the lead and following discussion and assessment by the dietician an additional 250mls had been agreed for individual patients. Previous and current patients had been involved in the development of the service model.

Patients could give feedback on the service and their treatment and staff supported them to do this. A weekly community meeting took place. This was attended by patients and the MDT. Minutes were available and detailed the feedback and requests that patients had made. Staff updated patients on any actions completed from the previous meeting and delays to any outstanding issues.

Patients were encouraged to complete a friends and family survey throughout their admission. Feedback was collated and reviewed at the integrated governance meeting to make improvements to the service. Patients were also supported by the expert by experience team within the organisation and could attend the monthly patient's council meeting.

Involvement of families and carers

Staff supported, informed and involved families and carers appropriately. We spoke with two carers and overall feedback from carers was positive about the care and treatment their family member received. They told us the treatment programmes were comprehensive and they were invited to CPA meetings. However, both carers commented that communication could be improved with ward staff.

One carer told us they were involved in discussions around discharge planning and kept in close contact with the hospital social worker.

Staff helped families to give feedback on the service. The ward manager facilitated a virtual carers' group every fortnight. Carers were able to share their experience of eating disorders at the group. Staff also provided psychoeducation for carers and families to ensure they understood eating disorders.

Good

Specialist eating disorder services

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

Are Specialist eating disorder services responsive?

Good

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

Access and discharge

Staff managed beds well. A bed was available when a patient needed one. Patients were not moved between wards except for their benefit. Patients did not have to stay in hospital when they were well enough to leave.

Bed management

Staff managed beds well. A bed was available when needed. Patients were not moved between wards unless it was in the best interest of the patient. 14 patients were being treated at the time of the inspection.

The service worked closely with the North West London provider collaborative and other commissioning teams for admissions to the service.

Since our last inspection the service had implemented a new model of care for eating disorders and changed the criteria for admission to the service. The service did not admit patients with complex mental health needs. Plans were in place to evaluate the model to determine the effectiveness of the treatment programme.

Clinical staff assessed patients before they were accepted into the service. Pre-admission assessments were carried out to ensure that the level of risk presented by the patient could be managed and the patient could fully engage in the treatment programme.

Managers regularly reviewed length of stay for patients to ensure they did not stay longer than they needed to. These reviews took place at the weekly ward round.

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

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

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

Discharge and transfers of care

Staff carefully planned patients' discharge and worked with care managers and coordinators to make sure this went well. The ward held a weekly multidisciplinary meeting which was also used to plan patient discharges. Patients families and care coordinators were invited to join in person or remotely. Care co-ordinators were invited to care programme approach (CPA) meetings prior to discharge.

Managers monitored the number of patients whose discharge was delayed. Delayed transfers were discussed at the senior leadership and clinical governance meetings. Each patient's progress was tracked. There were no delayed discharges on the ward at the time of our inspection.

The average length of stay on the ward was five months.

Staff supported patients when they were referred or transferred between services. This included patients who needed admission to hospital for physical health problems.

Facilities that promote comfort, dignity and privacy

The design, layout, and furnishings of the ward supported patients' treatment, privacy and dignity. Each patient had their own bedroom with an en-suite bathroom and could keep their personal belongings safe. There were quiet areas for privacy. The food was of good quality and patients access to drinks and snacks was in line with the treatment programme.

Each patient had their own bedroom, which they could personalise. Since our last inspection the ward had been redeveloped and all bedrooms were now single with an en-suite bathroom. Patients had a secure place to store personal possessions and were able to personalise their room.

Staff used a full range of rooms and equipment to support treatment and care. This included a large dining room, communal lounge, meeting rooms and a sensory room. Access to outdoor space was limited. The patients had a terraced area which was accessible from the first floor. This area was supervised by staff dependent on the risks presented by individual patients.

The clinic room was located on the ground floor. A couch was available if physical examinations of patients were needed. Any nasogastric feeds were carried out in patient bedrooms.

The service had quiet areas and a room where patients could meet with visitors in private.

Patients could make phone calls in private. Patients could use their own mobile telephones and access the internet without restrictions. Where patients presented with specific risks phone usage and internet access were monitored. Patients could also access a cordless landline telephone.

Availability of drinks and snacks were considered on an individual basis and were agreed as part of patient meal plans. These were produced in collaboration with patients. Staff were able to facilitate most dietary requirements, such as vegetarian diets, by using alternative substitutes to meet patients' daily nutritional intake. The dietician and chef attended the community meeting to obtain feedback on the quality of food provided. Care plans demonstrated where patients were ready for discharge the dietician worked with patients to plan, shop and prepare meals in the rehabilitation kitchen.

Patients' engagement with the wider community

Staff supported patients with activities outside the service, such as work, education and family relationships. Patients accessed the local community as part of their treatment programme, for example a weekly community snack session was facilitated by the occupational therapist. This supported patients to transfer skills they had learned on the ward in relation to food related activities in the community.

Vocational drop-in sessions were available and patients were supported with work related opportunities, online training and support with job applications.

Staff supported patients to maintain contact with their families and carers. Where patients consented, families and carers attended care programme approach meetings. Care records demonstrated that regular contact was maintained with family members and carers as agreed with the patient.

Staff encouraged patients to develop and maintain relationships both in the service and the wider community.

Meeting the needs of all people who use the service

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

The service could support and make adjustments for disabled people and those with communication needs or other specific needs. The ward was located over the first and ground floor. Lift access was available. Staff risk assessed all patients for any mobility difficulties when they were referred to the service, this was because patients were expected to use the stairs.

Staff made sure patients could access information on treatment, local service, their rights and how to complain. The ward had a number of notice boards which displayed a range of information for patients and carers, including information about how to complain, safeguarding, eating disorders, carers support, local services and advocacy services.

Staff made information leaflets available in languages spoken by patients if requested.

Managers made sure staff and patients could get help from interpreters or signers when needed.

Patients had access to spiritual, religious and cultural support. Staff responded to individual requests for support.

Listening to and learning from concerns and complaints

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

Patients, relatives and carers knew how to complain or raise concerns. The service provided information on how to make a complaint on the patient noticeboards and in the patient and carers welcome guide.

Patients told us that they felt listened to by staff and were supported by the advocate to raise any complaints.

The service clearly displayed information about how to raise a concern in patient areas.

Staff understood the policy on complaints and knew how to handle them. The service had a comprehensive complaints policy that all staff could access through the intranet.

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

At our last inspection we found that the provider did not respond to complaints within the timeframe as set out in the complaints policy. At this inspection we found improvements. Complaints were logged and responded to within the timeframe. Where this was not possible the complainant was kept updated. The complaints register was reviewed at the monthly clinical governance meeting.

Good

Specialist eating disorder services

At our last inspection we found that informal complaints were not recorded. At this inspection we found improvements. Informal complaints were recorded and any themes identified. All complaints were discussed at the clinical monthly clinical governance meetings and any themes or trends identified shared with the wider team.

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

Patients received feedback from managers after the investigation into their complaint.

Managers shared feedback from complaints with staff and learning was used to improve the service. Staff told us complaints were discussed in handovers, clinical governance and staff meetings, this information was used to inform patient care.

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

Are Specialist eating disorder services well-led?

Good

Our rating of well-led improved. We rated it as good.

Leadership

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

Leaders had appropriate skills, knowledge and experience to perform their roles. The senior leaders within the service had a good knowledge of the eating disorders service. They could explain clearly how the teams were working to provide high quality care. The registered manager knew where improvements were required to ensure that patients received safe and effective care that was person-centred and of high quality.

The registered manager reported that they were supported by senior leaders within the service. Staff knew who the senior leaders in the service were and said they were visible and approachable. Staff told us that leaders when required delivered direct care, for example if there were staff shortages.

Staff could complete an online request form, asking the Cygnet Board any question anonymously. This was part of the ward to board process the service had implemented.

Vision and strategy

Staff knew and understood the provider's strategy, vision and values and how they were applied in the work of their team. Staff promoted the five values of the organisation which included integrity, trust, empower, respect and care. Throughout our inspection we saw that staff reflected these values in their daily practice. The service had a caring, positive, open and inclusive culture which centred on improving the quality of care patients received through, compassion, empowerment, partnership and involvement.

Culture

Staff said they felt respected, supported and valued. They said the service promoted equality and diversity and provided opportunities for career development. They could raise concerns without fear of retribution and that any concerns they raised were acknowledged and taken seriously by senior managers.

Staff said they were positive and proud about working for their ward team. They felt supported by the team and that the team worked well together. Staff told us they valued each other and worked effectively during the COVID-19 pandemic.

Staff reported the morale on the ward was good and that the implementation of the new care model had been very effective in improving patient outcomes and lengths of stay. They said they felt supported to do their job, enjoyed working well within the MDT and received good support from the ward manager and senior management team.

The whistleblowing policy was easily available for staff to access on the intranet system. Staff were aware of the organisations Freedom to Speak Up Guardian and how to contact them.

Managers dealt with poor staff performance appropriately when needed. Performance issues were initially addressed during to one-to-one supervision sessions and goals and objectives were introduced for staff whose performance needed to be improved.

Staff had access to support for their own physical and emotional health needs. The organisation provided an employee assistance programme where staff could access counselling, legal and financial advice. Staff also accessed the providers occupational health services when needed.

The service had implemented a survey where staff could give daily updates on how they were feeling so the managers could consider how to improve this if necessary. The service had an employee of the month programme.

Governance

Our findings from the other key questions demonstrated that governance processes mostly operated effectively at team level and that performance and risk were managed well.

At our last inspection we required the provider to embed effective governance systems to improve the quality of the service and how effectively it was being monitored. We also recommended that the improvements made to the service were sustained.

At this inspection the service had made many improvements to the governance systems and processes. Areas of improvement from our previous inspection had been sustained. Patients and staff had access to a fully operational nurse call system, structured staff meetings took place and themes from informal complaints were captured. The provider had made improvements to the incident reporting process. Bed numbers had been reduced and the ward environment refurbished. The model of care and strategic direction of the eating disorder service had changed and staff were able to demonstrate improved outcomes for patients and clinical effectiveness. However, we found some shortfalls in the auditing of patient observations. The provider told us about the actions they were taking to address this with the staff teams.

Senior managers were aware of areas where improvements could be made and were committed to improving care and treatment for patients.

Staff spoke about the extensive training they had undertaken to ensure they had the right skills and knowledge to support patients in a person-centred manner.

There was a clear framework of what must be discussed at a ward or management level in meetings to ensure that essential information, such as learning from incidents and complaints, was shared and discussed. There was a clear process for key safety and performance information to be shared from senior leaders to ward staff and vice a versa.

Staff had implemented recommendations from reviews of incidents, complaints, mental health act review visits, quality assurance visits and safeguarding alerts at the service level. Any recommendations were allocated to a clinical lead for implementation with the ward team. Actions to be implemented were tracked at the monthly hospital clinical governance meeting.

Management of risk, issues and performance

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

There was an effective process to identify, understand, monitor and address current and future risks including risks to patient safety. Staff were aware of the main risks in relation to the service they were providing. Staff concerns matched those on the service level risk register such as staff vacancies. The register was updated at the governance meetings and staff at all levels could escalate concerns when required.

The service had plans for emergencies. Staff spoke about the business continuity plans they had implemented because of the COVID-19 pandemic and actions taken to minimise the risk of infections.

Information management

Ward teams had access to the information they needed to provide safe and effective care and used that information to good effect. The service collected reliable information and analysed it to understand performance and to enable staff to make decisions and improvements. The service had a dashboard that held key data about the service. This included key information such as incident reporting, staffing, complaints and training and ensured that senior leaders had oversight of the service.

Staff had access to the equipment and information technology needed to do their work. The information technology and telephone system worked well.

Information governance systems included confidentiality of patient records. Records could only be accessed by staff that had been authorised to do so. Ninety-five per cent of staff had completed the provider's annual information governance training.

Staff knew when they needed to make notifications to external bodies including the Care Quality Commission.

Engagement

Staff received regular updates about the work of the provider through My Cygnet intranet, regular newsletters, emails, social media and updates at the team meeting. The provider had a comprehensive website and social media to keep the public informed of the work they were undertaking to support patients, families and carers.

Good

Specialist eating disorder services

The service engaged well with patients, carers and staff to help them plan and manage the way the service operated. Feedback was encouraged, and people were supported to provide feedback in a way that was best for them. Patients could give feedback through weekly community meetings, patient forums, patient council meetings and through the advocate. Families and carers provided feedback at the carer's forum and through regular surveys.

Staff had participated in the annual Cygnet staff survey in April 2021. The service had developed and implemented an action plan in response to the service and was addressing areas such as better on-site facilities for staff and training opportunities.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. The hospital was trialling a new programme of supporting staff wellbeing following incidents called Trauma Risk Management (TRiM) a trauma-focused peer support system designed to help staff who have experienced a traumatic, or potentially traumatic, event. Staff involved in this programme had been trained by a psychological health consultancy.

The activity timetable was clearly linked to NICE and The Quality Network for Eating Disorders (QED) standards.

The consultant psychiatrist and MDT had commenced a development plan on 'promoting healthier relationships with exercise'. The project aimed to provide a safe 'prescription' of exercise, staff education on exercise and negative behaviours and the appointment of an external exercise specialist.

The hospital has built a virtual library which all staff have access to. All training, articles of interest and/or the subject of journal club, websites and videos are placed in the library and can be accessed by all staff.

Good

Personality disorder services

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

Are Personality disorder services safe?

Requires Improvement

Safe and clean care environments

All wards were safe, clean well equipped, well furnished, well maintained and fit for purpose.

Safety of the ward layout

Staff completed daily risk assessments of all wards areas and removed or reduced any risks they identified. Staff completed annual environmental risk assessments. The most recent assessment was completed in April 2022.

Staff could observe patients in all parts of the ward. The ward had a constant staff presence throughout the ward, and mirrors in place to mitigate corners and blind spots. CCTV was also in use throughout the ward. Where individual patients were identified as being at risk, increased observations, including one-to-one, were used.

Staff knew about any potential ligature anchor points and mitigated the risks to keep patients safe. The ward had anti-ligature windows installed in all patient accessible rooms throughout the ward in July 2021 following a patient death in July 2019. Staff completed an annual ligature audit and there was a ligature risk policy in place. The last audit was completed in July 2021. Ligature cutters were stored in the ward office and clinic room. There was a ligature hot spot map in the ward office, however this was out of date and referred to the ward prior to July 2021. Staff replaced this with a current map during the inspection.

At our last inspection the patient call alarm system had been deactivated and patients could not call for help from staff if they needed too. At this inspection we found improvements. The service had installed a nurse call system that patients could access. Staff carried personal alarms on them. The alarms and nurse call system were checked twice a day, during the day and night shift. Records showed that faults were common, but the service was able to have these issues promptly fixed.

Fire safety arrangements were in place. Staff completed fire safety training as part of their role. All drills, testing and servicing was recorded in a fire folder, which was up-to-date with current information.

Maintenance, cleanliness and infection control

Ward areas were clean, well maintained, well furnished, however the ward was not purpose built and space was limited.

Staff made sure cleaning records were up-to-date and the premises were clean. We reviewed cleaning records, and these were up-to-date. Staff followed infection control policy, including handwashing.

Clinic room and equipment

The clinic room was fully equipped, with accessible resuscitation equipment and emergency drugs that staff checked regularly. At our last inspection we found that patients did not have space for treatment and examination on the ward clinic room. At this inspection we found improvements. Patients could be examined or treated in the shared clinic room on the ground floor. This room contained an examination couch. Staff checked, maintained, and cleaned equipment. Room temperatures were recorded daily. We reviewed the temperature checks for the medicine fridge for the six weeks prior to the inspection and they were within the correct range. Medicines were within their expiry dates, and the pharmacy completed audits of controlled drugs and expiry of medications.

Safe staffing

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

Nursing staff

The ward had high vacancy rates for nurses, however this was mitigated through the use of bank staff. The ward manager could adjust staffing levels according to the needs of the patients.

The vacancy rate for nurses was 33% and 15% for support staff. The ward had an escalation process if they did not meet the minimum staffing requirements.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants for each shift. The service used a staffing matrix which determined the numbers of staff required dependent on the number of patients and their acuity. The clinical nurse manager could adjust staffing levels according to the needs and risk level of the patients.

Managers made sure all bank and agency staff had a full induction and understood the service before starting their shift.

Most patients we spoke with told us they rarely had their escorted leave or activities cancelled, even when the service was short staffed. However, patients told us that their one-to-one sessions sometimes didn't take place with their named nurse due to staffing issues. Four patients also said they would prefer if their nurse came to them at the start of their shift, rather than the end, as it felt this was being done to tick the task off a list.

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

Staff shared key information to keep patients safe when handing over their care to others. Incidents and patient risks were shared at shift handover meetings and daily risk assessment meetings.

Medical staff

The service had enough daytime and night-time medical cover and a doctor available to go to the ward quickly in an emergency. The consultant psychiatrist worked four days a week and the ward doctor worked five days a week. There was an on-call doctor available, and this was scheduled a month in advance. Managers made sure all locum staff had a full induction and understood the service before starting their shift.

Good

Personality disorder services

Mandatory training

Staff had completed and kept up to date with their mandatory training. Mandatory training completion rates were 94% for clinical staff. The mandatory training programme was comprehensive and met the needs of patients and staff. Managers monitored mandatory training and alerted staff when they needed to update their training. The completion rates for intermediate life support training was 89% as two staff had not completed this. They were both booked in to complete this in June 2022.

We reviewed the mandatory training programme and found it comprehensive, covering a wide range of subjects suitable to the service.

Assessing and managing risk to patients and staff

Staff assessed and managed risks to patients and followed best practice in anticipating, de-escalating and managing challenging behaviour. Staff used restraint only after attempts at de-escalation had failed. When intramuscular rapid tranquilisation had been used, staff completed the patient's physical health observations monitoring as required. However, patient observations were undertaken in a predictable way for patients.

Assessment and management of patient risk

Staff completed a comprehensive risk assessments for each patient on admission and reviewed this regularly, including after any incident. Patients were referred to the service, and the multi-disciplinary team would discuss each referral for suitability for admission. The team would assess how the referred patient would fit into the current patient group, the patients' level of engagement and whether they could manage the level of risk.

Staff used a national early warning signs (NEWS) form to record checks of patients' vital signs. This form is used to assess and record the physical health of a patient with indicators that tell staff when a patient's health may be deteriorating and this needs to be escalated to a doctor. We reviewed the NEWS forms completed for three patients on the ward. NEWS clinical observations were completed at least daily for all patients.

Management of patient risk

Staff discussed each patient at the daily risk assessment meeting, discussed any incidents that had occurred in the last 24 hours and put individual management plans in place. For example, if a patient was found to be hoarding medication staff would consider crushing the medication before administration. Staff followed procedures to minimise risks where they could not easily observe patients. Staff had undertaken training in patient engagement and observation. Staff we spoke with understood the different types of intermittent observations and how they were to be carried out. Staff were to observe patients four times per hour, with a maximum of 15 minutes between checks. These observations were to be undertaken at unpredictable times so that patients were not aware when the observation would take place. We looked at four observation records for three patients. We found that staff had for 65%of the time recorded observations at regular and predicable times. This meant that patients would be aware at what time the staff would check them. Audits of the observation records had not identified this.

Use of restrictive interventions

Staff had a good understanding of the provider's restrictive interventions programme, which met best practice standards. Staff made every attempt to avoid using restraint by using de-escalation techniques and restrained patients only when these failed and when necessary to keep the patient or others safe.

The hospital also used elements of the 'Safe wards' model. The model addresses how to assess and change ward culture, de-escalation and alternatives to restrictive interventions. This included the use of positive and 'soft' words when speaking to patients.

Across both wards. levels of restrictive interventions, including restraints, prone restraints and rapid tranquilisation were reviewed at the monthly clinical governance meeting.

From 1 April 2021 to 30 April 2022 there were 48 instances of restraint. Of these eight were intramuscular rapid tranquilisation and one was oral rapid tranquilisation.

At the last inspection in January 2020 staff were not always clear about their responsibilities in relation to regular physical health monitoring following the administration of medicines by rapid tranquilisation. At this inspection we found improvements. Staff followed NICE guidance when using rapid tranquilisation. We reviewed the records for three instances of rapid tranquilisation, and these had all been managed in line with the providers policy. Staff had also completed additional de-escalation training and would discuss this during reflective practice.

Safeguarding

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

Staff understood how to protect people from abuse and the service worked well with other agencies to do so. All staff said they had training appropriate for their role on how to recognise and report abuse, and they knew how to apply it. Staff felt confident that if they did raise concerns they would be listened to and action taken.

At the time of the inspection 100% of staff were up-to-date with their level 3 safeguarding training.

Safeguarding concerns were regularly discussed in multi-disciplinary meetings and handover meetings and referrals were discussed in clinical governance meetings. Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff told us that if they had concerns that someone was at risk of abuse they spoke with the social worker and the safeguarding lead who would make the necessary referrals.

The social worker tracked all safeguarding referrals and communicated with the local authority safeguarding team on the progress and outcomes of any investigations. All safeguarding incidents were reviewed at the monthly integrated governance meeting.

Patients were supported by the hospital advocate to raise any safeguarding concerns.

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

Staff access to essential information

Staff had easy access to clinical information, and they were able to maintain high quality clinical records. The service used both paper and electronic records,

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

Patient notes were comprehensive, and all staff could access them easily.

Although the service used a combination of electronic and paper records, staff made sure they were up-to-date and complete

Records were stored securely.

Medicines management

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

Staff followed systems and processes to prescribe and administer medicines safely. Staff reviewed each patient's medicines regularly and the consultant provided comprehensive advice to patients and carers about their medicines. One patient we spoke to was able to describe in detail their medication and the side effects, and how changes in doses affected the side effects.

Staff completed medicines records accurately and kept them up-to-date. Staff stored and managed all medicines and prescribing documents safely. Staff learned from safety alerts and incidents to improve practice.

The service ensured people's behaviour was not controlled by excessive and inappropriate use of medicines. There was low use of anti-psychotic medications. Staff reviewed the effects of each patient's medicines on their physical health according to NICE guidance.

Track record on safety

From 1 April 2021 to 30 April 2022 there were six serious incidents on the ward. In the week following our inspection, there was a serious incident on the ward.

When serious incidents happened, these were discussed at the integrated governance meetings and any immediate learning identified and shared with the clinical teams.

Reporting incidents and learning from when things go wrong

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

Staff knew what incidents to report and how to report them. At our last inspection we found the incident reporting system to be complex. At this inspection we found improvements. The service now had one electronic incident reporting system. Staff reported this was much easier to use. Staff told us that they would report any incident of harm, potential harm, near misses and/or risks to safety.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong.

Arrangements were in place for de-brief sessions to take place for both staff and patients following a serious incident. This was to ensure that staff and patients were provided with appropriate support.

Good

Personality disorder services

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations.

There was evidence that changes had been made as a result of feedback. For example, following a self-harm incident patients no longer accessed the lift without a staff member being present.

Staff received feedback from investigation of incidents, both internal and external to the service. Staff were able to describe how they met to discuss the feedback and look at improvements to patient care, for example discussions had taken place regarding contraband items and patient searches.

Regular unannounced emergency simulation scenarios were carried out by the managers. They acted out an unannounced emergency scenario such as a ligature incident and assessed how staff responded. Where shortfalls were identified during the exercise an action plan was developed to ensure that the chance of errors occurring when a real emergency incident happened were reduced.

Are Personality disorder services effective?

Good

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

Assessment of needs and planning of care

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

We reviewed nine patient care records. Staff completed a comprehensive mental health assessment of each patient either on admission or soon after.

Patients had their physical health assessed soon after admission and regularly reviewed during their time on the ward. Staff supported patients with their physical health needs and worked collaboratively with specialists when needed.

Staff developed a comprehensive care plan for each patient that met their mental and physical health needs. Staff regularly reviewed and updated care plans when patients' needs changed. Care plans were personalised, holistic and recovery orientated.

Staff would complete a pre-admission questionnaire with the patient prior to admission and decide what to do should the patients mental health deteriorate.

Ward rounds took place every two weeks for patients. Notes of these multidisciplinary meetings were detailed and set out actions and future plans in relation to the patient.

Good

Personality disorder services

Best practice in treatment and care

Staff provided a range of treatment and care for patients based on national guidance and best practice. They ensured that patients had good access to physical healthcare and supported them to live healthier lives. This included access to psychological therapies, support for self-care and the development of everyday living skills. Staff used recognised rating scales to assess and record severity and outcomes. They also participated in clinical audit, benchmarking and quality improvement initiatives.

Staff provided a range of care and treatments suitable for the patient group and consistent with national guidance on best practice. Patients had access to dialectical behaviour therapy, occupational therapy and cognitive behavioural therapy. The pathway through the service for patients was discharge and recovery focused. There was a full timetable of varied activities for the patients. Patients told us they enjoyed the amount and variety of activities. The occupational therapist told us they were working on more evening activities and more life skills based activities. Staff helped patients live healthier lives by supporting them to take part in activities in the community such as swimming and yoga at the community centre. Staff would provide nicotine replacement therapy if a patient requested it.

Staff used recognised rating scales to assess and record the severity of patients' conditions and care and treatment outcomes. Staff used the health of the nation outcome scales and GAPS monthly to track a patient's mental state and emotional regulation through a series of questions. If the score went down staff would assess how to best support the patient.

The service undertook audits to monitor the quality of the service. Staff took part in clinical audits, benchmarking and quality improvement initiatives. This included monthly individual files and medication audits, and six-monthly blanket rules audit. Managers used results from audits to make improvements. For example, the blanket rules audit that took place in January 2022 showed that kitchen access was limited. To allow patients access to the kitchen patients were individually risk assessed on whether they could access the kitchen, and the occupational therapist supported patients to learn the relevant skills.

Skilled staff to deliver care

The ward team included the full range of specialists required to meet the needs of patients on the ward. Managers made sure they had staff with the range of skills needed to provide high quality care. They supported staff with appraisals, supervision and opportunities to update and further develop their skills. Managers provided an induction programme for new staff.

The ward had a full range of specialists to meet the needs of the patients on the ward. There was a lead psychologist, a psychologist and an assistant psychologist, an occupational therapist and an occupational therapist assistant, and art therapist.

Managers gave each new member of staff a full induction to the service before they started work, including agency staff.

Managers supported staff through annual, constructive appraisals of their work. The appraisal rate was currently at 90% as two staff members were on leave.

Managers supported staff through regular, constructive clinical supervision of their work. Staff had managerial supervision and clinical staff had additional clinical supervision. The supervision rates were 100% for managerial and clinical supervision.

Managers made sure staff attended team meetings or gave information from those they could not attend. Meetings were held regularly, and items discussed included learning from incidents, results from audits and the ward performance.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge.

Managers made sure staff received any specialist training for their role. Staff on the ward completed personality disorder understanding training. This was a three-month programme after which the staff member would be assessed and to identify where they need more support.

Managers recognised poor performance, could identify the reasons and dealt with these. For example, a staff member had complaints made against them by patients regarding their attitude towards the patients. The clinical services manager told us they were formalising these incidents so that they could properly performance manage this staff member.

Multi-disciplinary and interagency teamwork

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

The ward had a fully staffed multidisciplinary team. Staff held multidisciplinary team (MDT) meetings every two weeks to discuss patients and improve their care. Staff kept detailed notes of these multidisciplinary meetings that set out actions and future plans for the patient. The multidisciplinary team was involved in assessing a patient for admission. The social worker requested and is completing additionally family therapy training to better support the patients.

Staff made sure they shared clear information about patients and any changes in their risk, including during daily risk assessment meetings and handovers.

The service had effective working relationships with other teams in the organisation. Staff from different Cygnet services would share learning from incidents with each other.

The service had good relationships with teams external to the organisation. When patients were to be discharged into the community the service worked closely with home care teams and care co-ordinators to continue supporting the patients. The safeguarding lead would meet every six months with the local safeguarding team for Ealing.

At times, staff had to attend the local emergency department with patients in order to access urgent physical health interventions. Staff told us they were often unable to take their allocated break during their 12 hour shift, as it was not clear with the emergency department staff who had responsibility for one-to-one observations during this break time. Although management staff were aware of this, more robust agreements needed to be put in place to ensure that staff got their breaks and that an appropriate member of staff was able to observe the patient and respond to any risks.

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

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

Good

Personality disorder services

Staff received and kept up to date with training on the Mental Health Act and the Mental Health Act Code of Practice. The staff training completion rates for this as 100%.

Patients had access to information about independent mental health advocacy and patients who lacked capacity were automatically referred to the service.

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

Patients had easy access to information about independent mental health advocacy.

We checked the records of three patients, detained under Section 3 of the MHA, in relation to the provision and understanding of their legal rights under S132 of the MHA. Staff explained to each patient their rights under the Mental Health Act in a way that they could understand, repeated as necessary and recorded it clearly in the patient's notes each time.

Staff ensured patients could take section 17 leave if there were enough staff to facilitate this.

Staff stored copies of patients' detention papers and associated records correctly and staff could access them when needed. There were four patients detained under the Mental Health Act and five informal patients at the time of inspection. Informal patients knew that they could leave the ward freely and the service displayed posters to tell them this.

Good practice in applying the Mental Capacity Act

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

Staff received and kept up-to-date with training in the Mental Capacity Act. The completion rate for staff for Mental Capacity Act and Deprivation of Liberty Safeguards training was 100%.

Staff assessed and recorded capacity to consent when a patient needed to make an important decision.

There was a policy on Mental Capacity Act and deprivation of liberty safeguards in place.

Are Personality disorder services caring?

Good

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

Kindness, privacy, dignity, respect, compassion and support

Most of the staff treated patients with compassion and kindness. They respected patients' privacy and dignity. They understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition. However, some patients told us not all staff had a caring attitude.

Patients we spoke with said that although most staff were engaging, caring and kind, some were not. Patients told us that certain staff would at times be using their phones whilst working and would not engage in conversation with the patients. We saw a mixture of formal compliments and three formal complaints about the attitude and uncaring nature of staff on this ward. The service had taken action to address this through additional support for staff, increased one to one sessions with staff in understanding verbal and non-verbal communication and a twice monthly shared learning group.

On the day of inspection, we observed that staff were kind, respectful, and responsive when caring for patients. Patients told us they liked the activities and there were plenty of them.

Staff supported patients to understand and manage their own care or condition. One patient told us in detail their medication and the side-effects on the patient as the consultant had provided them with comprehensive advice. Staff directed patients to other services and supported them to access those services if they needed help.

Staff followed policy to keep patient information confidential. Staff maintained the confidentiality of information about the patients. Information was stored electronically and could only be accessed by staff authorised to do so. Any patient discussions were held in offices and meeting rooms to ensure patient confidentiality.

Involvement in care

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

Involvement of patients

Staff introduced patients to the ward and the services as part of their admission. Staff made sure patients understood their care and treatment.

Staff involved patients in decisions about the service, when appropriate. Patients chaired the daily planning meeting where patients could discuss the activities for the day with staff and have an opportunity to request an appointment with any of the multidisciplinary team. Patients would also be told which staff member was allocated to them for the day.

Patients chaired the fortnightly community meetings and staff member from each department attended to address matters as they arose and make any announcements, such as an upcoming swimming trip or a reminder to store personal property in their cupboards. Patients were able to provide feedback and suggestions for the ward and these were acted upon, such as requesting a blind for the large window in the lounge.

Patients could give feedback on the service and their treatment and staff supported them to do this. The service provided a survey to patients to complete. We reviewed the monthly results for the prior three months and the responses from the patients were positive.

Staff made sure patients could access advocacy services. We spoke to the advocate for the service. The advocate told us that the patients had their contact details if they needed to speak to the advocate urgently. The patients were supported to make complaints, raise safeguarding concerns and provided feedback to the advocate about their care and treatment.

Good

Personality disorder services

Involvement of families and carers

Staff informed and involved families and carers appropriately.

Staff supported, informed and involved families and carers appropriately. Feedback from carers was that staff were contactable and they had involved them with their family member's care. The carer had been involved in wards rounds and care programme approach meetings. They said staff were very good with communication.

Staff helped families to give feedback on the service using a carers survey.

During the COVID-19 pandemic the service started doing ward rounds and care plan assessments virtually, so family could attend, if the patient consented.

The service facilitated a carers forum that met twice a month. Carers wanted to know how to better communicate with their family members. The psychotherapist and assistant psychologist have run dialectical behaviour therapy skills groups so carers can learn these skills. Dialectical behaviour therapy is a type of talking therapy that is adapted for patients with personality disorders.

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

Are Personality disorder services responsive?

Good

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

Access and discharge

Staff managed beds well. A bed was available when a patient needed one. Patients were not moved between wards except for their benefit. Patients did not have to stay in hospital when they were well enough to leave.

Bed management

The service worked closely with the North West London provider collaborative and other commissioning teams for admissions to the service. There was a clear admissions criteria and process. Clinical staff assessed patients before they were accepted into the service. Preadmission assessments were carried out to ensure that the level of risk presented by the patient could be managed and the patient could fully engage in the treatment programme.

Managers regularly reviewed length of stay for patients to ensure they did not stay longer than they needed to. The average length of stay was 18 months.

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

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

Good

Personality disorder services

Discharge and transfers of care

Staff carefully planned patients' discharge and worked with care managers and coordinators to make sure this went well. The ward held a weekly multidisciplinary meeting which was also used to plan patient discharges. Patients families and care coordinators were invited to join in person or remotely. Care co-ordinators were invited to care programme approach (CPA) meetings prior to discharge.

Managers monitored the number of patients whose discharge was delayed and took action to reduce them. At the time of inspection were two patient who had delayed discharges. The service was working with commissioners to find suitable placements that would meet each of these patients' individual needs.

Facilities that promote comfort, dignity and privacy

The design, layout, and furnishings of the ward supported patients' treatment, privacy and dignity. Each patient had their own bedroom and could keep their personal belongings safe. There were quiet areas for privacy.

Each patient had their own bedroom, which they could personalise. Two patient bedrooms shared a toilet, all other patient bedrooms were ensuite. Patients had a safe in their bedrooms to store personal possessions securely. Patients could access their rooms during the day unless they were risk assessed as needing the bedroom door locked and this would be in their care plan. Patients had their own mobile phones and could make calls in private.

However, space was limited on the ward for activities. Rooms were used for multiple functions. There was an outside garden space that patients could access. There was a room that was being made into a kitchenette during the time of inspection, but was currently unavailable to the patients. This had been the case for several months. Patients we spoke with told us that the limited space and lack of sensory room could did not encourage a therapeutic environment.

Patients' engagement with the wider community

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

Staff supported patients with activities outside the service, such as work, education and family relationships. Patients accessed the local community as part of their treatment programme. Staff helped patients to stay in contact with families and carers. Families and carers are able to attend ward rounds, care programme approach and carers forums. During the pandemic when visitors were not allowed onsite, the service facilitated these taking place on virtually so that carers and families could remain involved.

Staff encouraged patients to develop and maintain relationships both in the service and the wider community.

Meeting the needs of all people who use the service

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

The ward was on the second floor and the service could support and adjust for disabled people and those with communication needs. Lift access was available. Staff risk assessed all patients for any mobility difficulties when they were referred to the service, this was because patients were expected to use the stairs.

Staff made sure patients could access information on treatment, local service, their rights and how to complain. The ward had a number of notice boards which displayed a range of information for patients and carers, including information about how to complain, safeguarding, local services and advocacy services.

Where the service had cared for a transgender patient in the past, the service found peer support for the patient from another Cygnet service.

Staff made information leaflets available in languages spoken by patients if requested.

Managers made sure staff and patients could get help from interpreters or signers when needed.

Patients had access to spiritual, religious and cultural support. Staff responded to individual requests for support.

Listening to and learning from concerns and complaints

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

Patients, relatives and carers knew how to complain or raise concerns. The service displayed information about how to raise a concern in patient areas. From 1 April 2021 to 30 April 2022 there were eight complaints made for this ward. The complaints were regarding therapeutic intervention, information management, communication between staff and patients and quality of care.

Patients were also able to raise complaints through the advocate. The advocate would then provide a quarterly report including themes for complaints.

Staff understood the policy on complaints and knew how to handle them. During the last inspection in January 2020 the provider was not responding to complaints within the timeframe set out in their complaints policy. At this inspection we found improvements. We reviewed eight complaints made for the ward, only one was outside of the timeframe however this was as one person involved in the complaint was out of the country and difficult to contact.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint. After receiving a formal complaint, the manager would send and acknowledgement letter and then investigate the complaint with the advocate. An outcome letter would be sent, and the advocate would then check that the patient was satisfied with the process.

The manager identified themes from the complaints and shared the learning from this with the team at compliance meetings and team meetings.

The service used compliments to celebrate success. There was a compliment folder, one patient said, ‘thank you for giving me my life back’.

Are Personality disorder services well-led?

Good

Our rating of well-led improved. We rated it as good.

Good

Personality disorder services

Leadership

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

Leaders had appropriate skills, knowledge and experience to perform their roles. The senior leaders within the service had a good knowledge of the service. They could explain clearly how the teams were working to provide high quality care. The registered manager knew where improvements were required to ensure that patients received safe and effective care that was person-centred and of high quality.

The registered manager reported that they were supported by senior leaders within the service. Staff knew who the senior leaders in the service were and said they were visible and approachable. Staff told us that leaders when required delivered direct care, for example if there were staff shortages.

Staff could complete an online request form, asking the Cygnet Board any question anonymously. This was part of the ward to board process the service had implemented.

Vision and strategy

Staff knew and understood the provider's strategy, vision and values and how they were applied in the work of their team. Staff promoted the five values of the organisation which included integrity, trust, empower, respect and care. Throughout our inspection we saw that staff reflected these values in their daily practice. The service had a caring, positive, open and inclusive culture which centred on improving the quality of care patients received through, compassion, empowerment, partnership and involvement.

Culture

Staff said they felt respected, supported and valued. They said the service promoted equality and diversity and provided opportunities for career development. They could raise concerns without fear of retribution and that any concerns they raised were acknowledged and taken seriously by senior managers.

Staff said they were positive and proud about working for their ward team. They felt supported by the team and felt the team worked well together. Staff told us they valued each other and worked effectively during the COVID-19 pandemic. Staff told us they felt wellbeing was a high priority. They gave examples of being supported in giving ideas about service delivery and development. For example, the lead psychologist was trying creative ways of recruiting staff.

Staff reported the morale on the ward was good. They said they felt supported to do their job, enjoyed working well within the MDT and received good support from the ward manager and senior management team.

The whistleblowing policy was easily available for staff to access on the intranet system. Staff were aware of the organisations Freedom to Speak Up Guardian and how to contact them.

Managers dealt with poor staff performance appropriately when needed. Performance issues were initially addressed during to one-to-one supervision sessions and goals and objectives were introduced for staff whose performance needed to be improved.

Staff had access to support for their own physical and emotional health needs. The organisation provided an employee assistance programme where staff could access counselling, legal and financial advice. Staff also accessed the providers occupational health services when needed.

The service had implemented a survey where staff could give daily updates on how they were feeling so the managers could consider how to improve this if necessary. The service had an employee of the month programme.

Governance

Our findings from the other key questions demonstrated that governance processes mostly operated effectively at team level and that performance and risk were managed well.

At our last inspection we required the provider to embed effective governance systems to improve the quality of the service and how effectively it was being monitored. We also recommended that the improvements made to the service were sustained.

At this inspection the service had made many improvements to the governance systems and processes. Areas of improvement from our previous inspection had been sustained. Patients and staff had access to a fully operational nurse call system, structured staff meetings took place and themes from informal complaints were captured. The provider had made improvements to the incident reporting process. However, we found some shortfalls in the auditing of patient observations. The provider told us about the actions they were taking to address this with the staff teams.

Senior managers were aware of areas where improvements could be made and were committed to improving care and treatment for patients.

Staff spoke about the extensive training they had undertaken to ensure they had the right skills and knowledge to support patients in a person-centred manner.

There was a clear framework of what must be discussed at a ward or management level in meetings to ensure that essential information, such as learning from incidents and complaints, was shared and discussed. There was a clear process for key safety and performance information to be shared from senior leaders to ward staff and vice a versa.

Staff had implemented recommendations from reviews of incidents, complaints, mental health act review visits, quality assurance visits and safeguarding alerts at the service level. Any recommendations were allocated to a clinical lead for implementation with the ward team. Actions to be implemented were tracked at the monthly hospital clinical governance meeting.

Management of risk, issues and performance

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

There was an effective process to identify, understand, monitor and address current and future risks including risks to patient safety. Staff were aware of the main risks in relation to the service they were providing. Staff concerns matched those on the service level risk register such as staff vacancies. The register was updated at the governance meetings and staff at all levels could escalate concerns when required.

The service had plans for emergencies. Staff spoke about the business continuity plans they had implemented as a result of the COVID-19 pandemic and actions taken to minimise the risk of infections.

Good

Personality disorder services

Information management

Ward teams had access to the information they needed to provide safe and effective care and used that information to good effect. The service collected reliable information and analysed it to understand performance and to enable staff to make decisions and improvements. The service had a dashboard that held key data about the service. This included key information such as incident reporting, staffing, complaints and training and ensured that senior leaders had oversight of the service.

Staff had access to the equipment and information technology needed to do their work. The information technology and telephone system worked well.

Information governance systems included confidentiality of patient records. Records could only be accessed by staff that had been authorised to do so. Ninety-five per cent of staff had completed the provider's annual information governance training.

Staff knew when they needed to make notifications to external bodies including the Care Quality Commission.

Engagement

Staff received regular updates about the work of the provider through My Cygnet intranet, regular newsletters, emails, social media and updates at the team meeting. The provider had a comprehensive website and social media to keep the public informed of the work they were undertaking to support patients, families and carers.

The service engaged well with patients, carers and staff to help them plan and manage the way the service operated. Feedback was encouraged, and people were supported to provide feedback in a way that was best for them. Patients could give feedback through weekly community meetings, patient forums, patient council meetings and through the advocate. Families and carers provided feedback at the carer's forum and through regular surveys.

Staff had participated in the annual Cygnet staff survey in April 2021. The service had developed and implemented an action plan in response to the service and was addressing areas such as better on-site facilities for staff and training opportunities.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. The hospital was trialling a new programme of supporting staff wellbeing following incidents called Trauma Risk Management (TRiM) a trauma-focused peer support system designed to help staff who have experienced a traumatic, or potentially traumatic, event. Staff involved in this programme had been trained by a psychological health consultancy.

The hospital has built a virtual library which all staff have access to. All training, articles of interest and/or the subject of journal club, websites and videos are placed in the library and can be accessed by all staff.

The service began a patient-led project in 2022 to improve the healthy eating of patients and reduce the amount of take-away food they ate. This was supported by the consultant psychiatrist with the occupational therapist. The service held cooking sessions with one or two of the patients cooking for the rest of the patients on a weekly basis.

The service was also undertaking a quality improvement project to reduce the number of one-to-one observations of staff to patients. The aim of this was to keep patients safe while also giving them back some responsibility. The project included collaborative working with patients to alter staffing and activities aiming towards a more therapeutic environment.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The provider did not ensure that staff were managing risk and safety through appropriate observations. (Regulation 12)