Cygnet Hospital Wyke

Quality Report

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

Ratings

Overall rating for this location	**Requires improvement**
Are services safe?	**Requires improvement**
Are services effective?	**Requires improvement**
Are services caring?	**Requires improvement**
Are services responsive?	**Requires improvement**
Are services well-led?	**Requires improvement**

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

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

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

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

Summary of findings

Overall summary

We rated Cygnet Hospital Wyke as **requires improvement** because:

- We had concerns about the use of physical interventions, because staff delivered intra-muscular medications to patients while using planned prone (face down) restraint which is high risk and against national guidance. The recording of restraint holds and some seclusion records did not contain sufficient detail to assure the service that practices were safe and delivered in line with management of aggression and violence training.
- Staff did not always follow infection prevention and control principles or guidance.
- Care and treatment did not always reflect current evidence-based guidance because we could not see evidence in patient care plans that staff always implemented the service's methods of positive behaviour support planning with patients who presented with behaviours which were challenging. The care plans we reviewed did not demonstrate the involvement of patients and their carers or relatives.
- On Fairfax ward staff did not always record consent in line with relevant legislation because there was a lack of consistency in how staff assessed people's mental capacity.
- Some patients who used the service and their carers had concerns about the way staff treated them in the acute and psychiatric intensive care services.
- The service did not always provide care to patients on Fairfax ward which was dignified because there was a paternalistic approach to care on the ward which had led to a number of blanket restrictions being in place. These blankets restrictions did not allow patients to have autonomy and independence. Patients on this ward had limited opportunities to give feedback. Patients did not always have somewhere to hang their clothing and not all patients had somewhere safe in their bedroom to store their possessions
- The service did not always manage complaints well. Responses were not always satisfactory and the service did not use complaints as an opportunity to learn and improve.
- On Fairfax ward there was limited information available about how to make complaints and there were no admission leaflets available for patients or carers that explained the purpose of the service and the facilities available. Fairfax ward did not meet the needs of all people using the service because it was not a dementia friendly environment.
- The approach to monitoring risks and the quality of the services did not always identify all risks and concerns. Where issues were identified, the management team did not always take action in a timely manner, and give those issues high priority.
- Time limited action plans were not in place for all areas of concern. Managers did not always discuss and record all areas of their governance agenda such as serious incidents and complaints outcomes. This meant that there was limited opportunity for learning, improvement and monitoring. Where the service had begun to take action on areas of concern relating to restraint techniques and recording and specialist training for Fairfax ward staff plans had not been recorded. The governance structure that the service had in place did not take into account the outcomes of ward level audits and there was a lack of firm and time limited action plans in place to improve areas of low compliance.

However

- Staffing levels and skill mixes were planned, implemented and reviewed to keep people safe at all times. The service responded quickly to staff shortages and ward managers managed the use of temporary staff with care. There were effective handovers and shift changes, to ensure staff could manage risks. The service monitored, assessed, and managed individual patient risk thoroughly and on a day-to-day basis. There was a clear incident reporting system in place which all designations of staff used, and staff were encouraged to report incidents and near misses.
- Since the time of our inspection in November 2017 staff had made significant improvements to environmental safety on Fairfax ward. The service managed medicines well, and there were clear audits in place to monitor this which evidenced

Summary of findings

improvement. Staff knew and understood their responsibilities to report and prevent abuse and the service was working closely with partners in the Local Authority.

- Patients had comprehensive and holistic assessments of the entirety of their needs and the service gave high priority to the monitoring and management of patients' physical health needs.
- There were clearly defined processes in place for the management of the Mental Health Act.
- A detailed clinical audit system was in place which all designations of senior staff were involved with to improve and monitor patient care. The service had a varied and skilled multi-disciplinary team who worked together to provide holistic care and treatment plans for patients and offered therapies in line with national best practice guidelines.
- Patients had access to advocates who supported them to raise complaints or concerns. Advocacy services formed part of the governance meeting each month to ensure the service embedded the importance of their use.
- Patients had discharge plans in place on the acute and psychiatric intensive care wards, and the service was discharged focussed. The acute and psychiatric intensive care services worked with patients on developing their skills for independence in preparation for discharge. Patients on all wards had access to a variety of activities and therapies to support their recovery. There were adjustments on Fairfax ward to support the needs of patients with mobility needs such as hoist and tracking equipment.
- The senior leadership team at the service were knowledgeable, experienced and qualified. The governance structure was well established and was important to the service. Staff in all areas of the service knew and understand the vision and values of the organisation. The service was open and transparent and worked well with its partners. Staff said that they felt valued and supported and the outcome of staff surveys was important to the organisation, who had put immediate action plans into place to address concerns.
- The acute and psychiatric intensive care services had implemented safe wards methodology as part of an ongoing programme to reduce restrictive practice. Austen ward had achieved accreditation of inpatient mental health services. To achieve accreditation, a psychiatric intensive care service has to demonstrate that the quality of care they provide to service users meets or exceeds the national guidelines and standards.

Summary of findings

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Cygnet Hospital Wyke

Services we looked at;
Acute wards for adults of working age and psychiatric intensive care units; Wards for older people with mental health problems.

Summary of this inspection

Background to Cygnet Hospital Wyke

Cygnet Hospital Wyke is an independent mental health hospital provided by Cygnet Health Care Ltd. The hospital provides care for 55 male patients across three different wards:

- Austen ward is a 14 bed male psychiatric intensive care unit.
- Branwell ward is a 19 bed acute mental health ward for men of working age.
- Fairfax ward is a 22 bed ward for older men with mental health problems and challenging behaviour.

The hospital has been registered with the Care Quality Commission since November 2010 to carry out the following regulated activities:

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

The Care Quality Commission last carried out a comprehensive inspection of this hospital in June 2015. At that inspection we rated the service as 'good' overall, with a rating of 'requires improvement' in the safe key question. At this inspection the hospital was in breach of two regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014:

- Regulation 13; safeguarding service users from abuse and improper treatment, because the provider had not introduced measures to reduce the use of prone restraint.
- Regulation 15; premises and equipment, because the seclusion room was not in line with national guidance.

We re-visited the hospital in July 2016 to check that the services were now compliant with the above regulations and to check on some specific concerns relating to Fairfax ward. We found that the provider continued to be breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014; premises and equipment, because areas of Fairfax ward were not clean and smelt unpleasant. However, the provider had made improvements to the seclusion room which meant that this was a different area of a breach of Regulation 15.

We visited Fairfax ward for a focussed unannounced inspection in November 2017 in response to some specific concerns about serious falls and the use of management of aggression and violence techniques with older patients on this ward. We found the provider to be in breach of a further two regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014:

- Regulation 12; safe care and treatment because of concerns about environmental safety, medications management and staff training.
- Regulation 17; good governance because contemporaneous records were not always kept and the provider was not aware of all the risks presented to patients.

At that inspection, the provider was also in breach of Regulation 18 (notifications) of the Care Quality Commission (Registration) Regulations 2009. This was because they had not made notifications to the Care Quality Commission about all allegations of abuse. We did not review previous breaches at this inspection as it was a focussed inspection of Fairfax ward only.

We reviewed all these breaches of regulation at this inspection. At this inspection we found that the service had been responsive to our concerns in November 2017 and had made a number of improvements to the environment of the ward and implemented increased staff training and new protocols around falls risks to improve patient safety.

Our Mental Health Act Reviewers visited:

- Fairfax ward (the ward for older men with a mental health problems and challenging behaviours) in February 2017
- Austen ward (the psychiatric intensive care unit) in July 2017
- Branwell ward (the acute mental health ward for men of working age) in November 2017.

At these visits, the reviewer raised concerns that there was not always evidence in the patient records that patients had their rights explained to them or that they had consented to their treatment. Also not all patients had signed their care plans and leave forms. We also reviewed these concerns during this inspection.

Summary of this inspection

At the time of our inspection the registered manager of the service had left the organisation. However the hospital manager, who was experienced and qualified, was in the process of becoming the new registered manager. The registered manager, along with the registered provider, is legally responsible and accountable for compliance with the requirements of the Health and Social Care Act 2008 and the associated regulations including the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and the Care Quality Commission (Registration) Regulations 2009.

Our inspection team

The team that inspected the service comprised three CQC inspectors including the team leader, one CQC bank inspector, one expert by experience who had experience of using, or caring for someone who uses mental health services, and four specialist advisors; three mental health nurses and one occupational therapist.

Why we carried out this inspection

We inspected this service as part of our on-going comprehensive mental health inspection programme.

We also undertook this this inspection to find out whether Cygnet Hospital Wyke had made improvements on Fairfax ward (ward for older people with mental health problems) since our last responsive inspection in November 2017.

Following the November 2017 inspection, we told the provider it must take the following actions to improve the service relating to Regulation 12 (safe care and treatment) and Regulation 17 (good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and Regulation 18 of the Care Quality Commission (Registration) Regulations 2009 (notifications of other incidents):

- The provider must ensure that staff undertake care planning and risk assessments, which include the entirety of patient's needs and ensure that staff take action when risk is identified.
- The provider must ensure that all ligature risks are assessed, monitored and removed or mitigated.
- The provider must ensure that the ward environment is safe and fit for use.
- The provider must ensure that medicines are managed safely and as prescribed.
- The provider must ensure that staff are appropriately trained in prevention and management of violence and aggression and the moving and handling of patients.
- The provider must ensure that the systems in process in place adequately monitor incidents such as restraint and falls and that action is taken when risks are identified.
- The provider must ensure that staff are trained in appropriate uses of restraint with older patients.
- The provider must ensure that staff make accurate and contemporaneous records about patients particularly in episodes of restraint.
- The provider must ensure that staff report all safeguarding concerns to the local authority and the Care Quality Commission.
- The provider must ensure that there is a defined protocol and individual care plans in place to manage the needs of patients who need support with eating and drinking.

We reviewed the actions the service had taken in response to our concerns at this inspection.

Summary of this inspection

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 service, and asked a range of other organisations for information including commissioners and advocacy services.

During the inspection visit, the inspection team:

- visited all three wards at the service, looked at the quality of the ward environments and observed how staff were caring for patients
- spoke with fourteen patients using the acute mental health ward and the psychiatric intensive care unit, and two patients on the ward for older males with a mental health problem
- spoke with three relatives or carers of patients using the acute mental health ward and the psychiatric intensive care unit, and two relatives or carers of patients using the ward for older males with a mental health problem
- carried out two short observational framework for inspection observations on Fairfax ward
- spoke with the regional manager, quality manager, hospital manager, clinical manager, management of violence and aggressions leads, the medical director, and all three ward managers
- spoke with 31 other staff members including nurses, healthcare support workers, occupational therapists, assistant psychologist, social workers, therapy staff, activity co-ordinators, and domestic, estates and ancillary staff
- looked at the care and treatment records of 17 patients across the whole hospital
- carried out a specific review of the management of medicines and reviewed the medication records of all patients admitted to the wards.
- attended and observed meetings such as handovers and multi-disciplinary team meetings
- looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the service say

We spoke with 16 patients across all three wards during the inspection. We also collected comments cards from five patients on Branwell ward (the acute mental health ward for adults of working age) and seven patients on Austen ward (the psychiatric intensive care unit). We gave opportunities to all patients admitted to the hospital to speak with us during the inspection but not everyone wished to speak with us or were able to share their views.

Patients from Austen and Branwell wards were complimentary about their care. They described staff from Branwell ward (the acute mental health ward for adults of working age) as friendly, co-operative, caring and willing to help. They said that the food and healthcare was good and told us that they felt safe on the ward. Patients on Austen ward (the psychiatric intensive care unit) described staff as respectful, excellent, and said that they felt well looked after and safe. All patients we spoke with said that the ward was clean and there were good activities and therapies available.

Patients made some negative comments about; the smoke-free environment, not understanding their detention or medication, and a dislike of staff waking them at night by using torches to check that they were safe. One patient felt that Austen ward (the psychiatric intensive care unit) needed more staff. Three patients told us that they felt staff had treated them with a lack of respect.

Summary of this inspection

Due to the nature of their illnesses, only two patients on Fairfax ward (the ward for older males with a mental health problem) wished to speak with us. One patient told us that staff 'were kind' and 'made me feel better'.

We spoke with three carers or relatives of patients admitted to the acute mental health ward and the psychiatric intensive care unit during the inspection. We attempted to contact other carers but they were unavailable. All carers said that the wards were clean and well presented. Two carers said that staff were friendly. However one carer told us that they had overheard staff being rude and disrespectful to their relative and said they would not recommend the service. Two carers told us that communication with them from Branwell ward (the acute mental health ward for adults of working age) was poor and that they always had to chase staff for updates and information.

We spoke with two relatives of patients admitted to Fairfax ward (the ward for older men with mental health problems). We attempted to contact other carers but they were unavailable. Both carers agreed that the ward was clean and described staff as welcoming, friendly and approachable. They told us that staff kept in regular contact with them, and that they invited them to meetings and discussions about the care of their relative. Both felt that they would feel comfortable raising concerns or complaints with staff.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Requires improvement 

We rated safe as **requires improvement** because:

- Staff did not always adhere to infection control principles and procedures on Fairfax ward. We found significant problems with the cleanliness and infection control measures in the laundry room and saw that staff sterilised and re-used medication pots and oral syringes rather than using disposable products.
- Staff were not up to date with mandatory training on all three wards and we saw direct impact on patient care in some areas such as; the Mental Capacity Act and Deprivation of Liberty Safeguards, and infection prevention and control. There is potential high risk impact on patients when staff do not receive training in immediate life support.
- Although the incident reporting system was robust and staff knew how to report incidents there was limited opportunity for staff to share learning due to a lack of team meetings, debrief and supervision on Fairfax ward.
- When patient's refused medication and there was a requirement to give this via an intra-muscular injection, this was delivered in a planned prone (face down) position. There is an increased risk of asphyxiation with this method of restraint and this is against national guidance.
- Nurses and doctors for patients from Austen and Branwell wards did not always undertake reviews of patients in seclusion in a timely manner and in line with the Mental Health Act Code of Practice.
- Staff did not always complete restraint forms in sufficient detail to identify the hold they used. Managers could not ensure that staff complied with their managing violence and aggression training because of this.
- There were blanket restrictions in place on Fairfax ward which included; preventing patients from accessing some ward areas, and limiting patient's access to drinks and snacks. These restrictions were not individually risk assessed.

However:

- Staff had undertaken environmental and ligature risk assessments.
- Staff had access to emergency medications, grab bags and equipment such as defibrillators.

Summary of this inspection

- All patients had risk assessments in place which staff updated regularly and the systems in place for assessing and managing patient risk were effective.
- Managers had responded well to our concerns about the safety of Fairfax ward since our last inspection in November 2017 and had made changes to the environment and introduced enhanced protocols around falls and choking risks.
- The monitoring and reporting of safeguarding concerns had improved since our last inspection and staff had developed an increased understanding and awareness.
- Medication management procedures were clear and effective and we were able to see evidence of improvements across the last twelve months.

Are services effective?

Requires improvement

We rated effective as **requires improvement** because:

- Patients did not always receive care in line with national best practice guidance because staff did not support patients presenting with difficult to manage behaviours with the use of interventions such as positive behavioural support plans. The provider had a system in place to meet this need, called 'my safety planning' but the use of this was not evidenced in patient care plans. This was particularly important for patients on Fairfax ward who were regularly restrained in order to manage behaviours which were challenging.
- Staff had a limited understanding of the Mental Capacity Act. Where patients lacked capacity to make decisions about their care or treatment, staff on Fairfax ward had not undertaken capacity assessments or best interests discussions when designing restrictive care plans to meet the needs of patients. Staff did not understand the interface between the Mental Health Act and the Mental Capacity Act.
- Staff on Fairfax ward had limited access to opportunities for de-briefs, advice and support due to a reduction in the availability of team meetings and supervision.
- Less than 70% of non-clinical staff had received an appraisal in the last twelve months.

However:

- The importance of the physical healthcare of patients was high on the agenda for the service. The service employed a registered general nurse to support patients' needs.
- Clinical staff had up to date appraisals on all wards, and received regular supervision on Austen and Branwell wards.

Summary of this inspection

- The service had a good system in place for the management and monitoring of the Mental Health Act.
- Patients had the support of a skilled on-site multi-disciplinary team who worked collaboratively to plan treatment and care.

Are services caring?

Requires improvement

We rated caring as **requires improvement** because:

- Within the last twelve months patients and their relatives or carers have raised concerns about the attitude of staff within the acute and psychiatric intensive care services.
- Patients on Fairfax ward had limited opportunity to give feedback about the service. Staff did hold community meetings with patients and there were no carers groups or forums available.
- Although care plans described the entirety of patients' needs, it was difficult to understand the patient's own voice in their care plans to explain how they preferred their care to be delivered. Staff used complex and professional wording in care plans which was difficult for some patients to understand. Care plans did not always reflect the involvement of relatives and carers. Relatives were heavily involved in decision making and part of multi-disciplinary meetings but this did not transpire into patient's care plans.
- Patients on Fairfax ward did not have communication plans in place to ensure they were able to make staff aware of their needs, choices and preferences.

However:

- On Fairfax ward we carried out observations of staff interactions with patients and found staff to be kind, caring, compassionate and responsive.
- Feedback was not entirely negative regarding the acute and psychiatric intensive care services, patients and carers described staff as caring and good listeners.
- Patients had access to the support of advocates who visited all wards weekly and we saw evidence that the advocates supported patients to make complaints and raise concerns.
- The service continued to seek feedback from patients and carers via annual surveys to review patient satisfaction and make improvements to the service.
- We saw examples on the acute and psychiatric intensive care wards where patients had raised concerns about the service and changes had been made. For example through the introduction of e-cigarettes.

Summary of this inspection

Are services responsive?

Requires improvement

We rated responsive as **requires improvement** because:

- The service did not always manage complaints well. Where investigations evidenced that the service had made mistakes in care and treatment, they did not always uphold these complaints. Quality improvement plans attached to complaints were not included in local overarching action plans, meaning there was limited opportunities for feedback and learning.
- Some patients on Fairfax ward did not have anywhere to hang their clothing and not all patients had somewhere safe to store their possessions.
- Fairfax ward did not have an admission or information leaflet to inform patients and carers about the service and what to expect. The hospital manager told us that this was being revised and was almost complete.
- On Fairfax ward the majority of patients admitted had organic mental health needs such as a diagnosis of dementia. The service had not designed the environment to be dementia friendly and staff did not design patient activities to meet the needs of all patients, such as those with functional mental health problems.
- The statement of purpose for Fairfax ward was unclear and did not evidence how the service designed care and treatment to meet the needs of a patient group with complex and varying needs.

However:

- Staff planned admissions to the service thoroughly and with the involvement of the multi-disciplinary team.
- The service had a positive focus on patient discharge and supported patients to develop skills for independence.
- Patients had access to facilities and activities on all wards.
- The service had facilities available to meet the spiritual and cultural needs of patients.
- Patients on all wards had access to a variety of information regarding their care and treatment. Austen and Branwell wards had good quality admission information to orientate patients' to the hospital and describe the facilities and care available to them.

Are services well-led?

Requires improvement

We rated well-led as **requires improvement** because:

- The service had not ensured that staff kept an accurate and contemporaneous record for all patients when they recorded

the use of restraint holds. Staff did not complete accurate and contemporaneous records for all patients when they recorded the use of restraint holds. Managers could not ensure that staff complied with their managing violence and aggression training because of this.

- There was a lack of firm local action planning taking place when things went wrong or required improvement. There were no action plans, time limits or clear escalation of issues relating to; complaints, management of violence and aggression training with older adults, infection prevention and control, the use of planned prone restraint, or the ongoing management and interrogation of restraint and falls data. Although staff told us that actions were ongoing there was no evidence to show how they had planned these actions and what time they would take to complete. This meant that the service could not be sure that they monitored and improved quality and safety.
- Despite a number of complaints from patients and their relatives, the service had not acted on concerns about the culture and behaviour of staff. Where patients had raised specific concerns, managers had not taken action to ensure the safety of patients and staff following the outcome of investigations.

However:

- Staff told us that they felt valued and supported and that they enjoyed their role.
- The service had embedded the governance pathway and we saw evidence of how managers had moved this down to ward level with the introduction of ward manager data packs.
- The provider used a range of resources to encourage feedback about the service which included staff, patient and carer surveys and had action plans in place to increase uptake.
- The acute and psychiatric intensive care services had implemented safe wards practices as part of an ongoing programme to reduce restrictive practice. Austen ward had achieved accreditation of inpatient services. Accreditation of Inpatient Mental Health Services is an initiative linked to the Royal College of Psychiatrists and the CCQI. To achieve accreditation, a service has to demonstrate that the quality of care they provide to service users meets or exceeds the national guidelines and standards.

Detailed findings from this inspection

Mental Health Act responsibilities

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

At the time of the inspection 33% of eligible staff had received training in the Mental Health Act on Fairfax ward (mental health ward for older adults). This was 78% on Austen ward (psychiatric intensive care unit), and 85% on Branwell ward (acute mental health wards for adults of working age). This training was mandatory for qualified staff and there was a plan in place to roll this out to remaining staff within twelve months. There had been impact on Fairfax ward of lower levels of training in regards to staff's understanding of the Mental Health Act's interface with the Mental Capacity Act.

The service had systems in place to ensure the proper implementation and administration of the Mental Health Act and Code of Practice, and carried out regular audits to ensure continued good practice.

All patient records we reviewed contained the relevant paperwork which was well organised. Staff made appropriate referrals for second opinion doctors where required for patients who lacked capacity to consent to their treatment. Care records evidenced that staff routinely explained to patients their rights under the Mental Health Act. Patients had access to section 17 leave as granted by the ward responsible clinician and doctors clearly recorded this in a file kept on the ward.

We reviewed the provider's policy 'for the administration of the Mental Health Act' (2016). The Mental Health Act manual for staff sat alongside this policy. The policy referenced relevant legislation including the Mental Health Code of Practice (2015).

The ward had Mental Health Act information boards visible on all wards. The hospital also had a range of information leaflets which staff gave to patients and their carers throughout admission to explain rights, and policies and procedures. Staff supported patients to access an independent mental health act advocate when they lacked capacity.

Mental Capacity Act and Deprivation of Liberty Safeguards

At the time of the inspection all staff on Austen ward (psychiatric intensive care unit), 88% of staff on Branwell ward (acute mental health ward for working age adults), and 72% of staff on Fairfax ward (ward for older adults with a mental health problem) had received training in the Mental Capacity Act and Deprivation of Liberty Safeguards. This training was mandatory for all staff.

Staff had a basic knowledge of the Act and told us that they would work with doctors and the social work team if capacity assessments and best interest discussions were required. We did not see any examples of decision specific capacity assessments, (other than consent to treatment under the Mental Health Act) taking place in any of the patient records we reviewed during the inspection on the acute and psychiatric intensive care services. However, staff told us that they had undertaken two detailed assessments with patients in the past twelve months. Staff we spoke with on these wards had a more detailed understanding of the Act.

Compliance with the principles of the Act was a concern on Fairfax ward. Staff had a limited understanding of the Act and its principles, particularly in regard to its interface with the Mental Health Act. In patient files we reviewed we did not see evidence of staff undertaking and documenting any decision specific capacity assessments or best interests discussions with patient's who staff had noted lacked capacity to make specific decisions.

We reviewed the provider's policy for the Mental Capacity Act (2016). The policy was thorough and explained the principles of the Act and contained relevant guidance including updates from the 2014 supreme court judgement in relation to Deprivation of Liberty Safeguards.

Detailed findings from this inspection

At the time of the inspection there were no patients on the ward under the authority of a Deprivation of Liberty safeguard. The service had made one application within the last twelve months which they withdrew when they discharged the patient from the service.

There was no audit in place for adherence to the Act and no Mental Capacity Act lead at the service.

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Acute wards for adults of working age and psychiatric intensive care units	Requires improvement	Good	Requires improvement	Good	Requires improvement	Requires improvement
Wards for older people with mental health problems	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Overall	Requires improvement	Requires improvement	Requires improvement	Requires improvement	Requires improvement	Requires improvement

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

Requires improvement

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

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

Requires improvement

Safe and clean environment

Cygnet hospital Wyke had one acute ward for adults of working age (Branwell ward) and, one psychiatric intensive care unit (Austen ward). Branwell ward had 19 beds and Austen ward had 14 beds. Both provided care for male patients over the age of 18.

Both wards had 'L' shaped layouts which did not allow staff a clear line of sight to observe patients. The service mitigated this risk by having staff allocated to observe patients at intervals throughout the day and night. On Austen ward the provider had installed mirrors to increase lines of sight. Staff discussed each patient's observation levels in multi-disciplinary team meetings and at handover meetings; observation levels differed according to the risk identified for each patient. Four patients we spoke with during the inspection told us that the presence of staff helped them to feel safe. However, patients on both wards told us that staff used torches to conduct night time observations and this disturbed their sleep.

Some areas of both wards contained ligature points including; the communal lounges, and patient bedrooms and bathrooms. A ligature point is something that a patient intent on self-harm could use to tie something to in order to strangle themselves. The ward managers, alongside the estates manager, had completed a ligature audit of both wards in January 2018. These ligature audits identified all the ligature points and noted the highest risk areas to be in patient bedrooms and bathrooms. Ligature maps were located in staff only areas, to highlight ligature risks to staff as a visual reminder on an ongoing basis. Staff told us that they mitigated the risk through observation levels determined by a patient's individual risk assessment.

Both wards were male only and were compliant with the Mental Health Act Code of Practice and Department of Health guidance on eliminating mixed sex accommodation.

Both wards had clinic rooms with equipment to monitor patients' physical health needs, including blood pressure monitors, electro-cardiograph machines, and weighing scales. All equipment had been marked as clean by staff and staff had ensured they had correctly calibrated it. The ward also had an emergency grab bag which the nurse in charge checked each night to ensure the emergency equipment was in order. The bag also contained a hypo-glycaemia treatment box and an anaphylaxis kit. Staff also had access to an automated external defibrillator. Neither clinic room had an examination couch in place to allow staff to examine patients, which meant that physical examinations took place in patient's individual bedrooms, patients did not say that they had concerns about this.

Both wards shared access to one seclusion room located on Branwell ward. The room met with guidance contained within the Mental Health Act Code of Practice. There were two clear areas for staff to observe patients and a two-way intercom to aid communication between patients and staff. The room contained a clock which was visible to patients so they could orientate themselves with the time of day, and an en-suite bathroom area. There were no visible ligature points within the room and staff could provide

patients with ligature proof clothing should this be required. Staff told us that it was a short walk from Austen ward to the seclusion room through an accessible door from outside the building.

Furnishings throughout the ward were clean and in good condition and the main ward areas were clean. Domestic staff cleaned the main areas of both wards and patient bedrooms during our visit. Staff made use of handwashing facilities and wore personal protective equipment such as aprons and gloves when providing meals to patients. Patients who we spoke with told us that the wards were clean. However, we did observe several staff members wearing nail varnish which is against infection control guidance.

Staff had undertaken an infection control audit on 14 February 2018. All 14 areas on Austen ward were above 86% compliance, with an overall compliance rate of 93%; Branwell ward was above 82% compliant in all areas, with an overall compliance rate of 97%.

The estates manager undertook regular environmental risk assessments alongside the ward managers and the hospital manager. These were available to staff on the wards. The hospital had a fire risk assessment in place which managers reviewed every six months, and the local fire service had visited and provided a report to the service. The hospital had gas safety, electrical wiring, and electrical safety testing certificates. Fire system and equipment checks were also in place.

During the inspection, a fire alarm sounded and we saw that staff practice on Austen ward was effective and staff followed procedures for evacuation. However, on Branwell ward staff did not follow the evacuation procedures in a timely manner. The service had a recent change to its alarm system and two members of staff on Branwell ward told us that they did not know that the sounding alarm was the fire alarm during the evacuation. The hospital manager reported this as an incident during the inspection for immediate action.

All ward staff carried personal alarms and patients had access to nurse call alarms in their bedrooms. We saw that alarms were in good working order during the inspection, and that they were regularly tested.

Safe staffing

Prior to the inspection, the service submitted data regarding their staffing levels. The hospital had 129 substantive staff, including clinical, managerial, administrative and ancillary staff.

On Austen ward there were nine whole time equivalent qualified nursing posts, and 19 whole time equivalent health care support worker posts. At the time of the inspection, seven of these posts were vacant; four qualified nursing, and three healthcare support worker posts.

On Branwell ward there were 10 whole time equivalent qualified nursing posts, and 20 whole time equivalent health care support worker posts. At the time of the inspection, two healthcare support worker posts were vacant. The hospital had the qualified staff vacancies on their local risk register as they continued to have difficulty recruiting to these posts. The provider had an overall vacancy target of less than 35%. The provider had advertised these posts for several months and had plans in place to increase uptake such as via relationships with local universities and holding job fayres.

Both wards had experienced a high turnover of staff. Between 1 February 2017 and 31 January 2018 six staff had left the service from Austen ward and five staff had left from Branwell ward. This included five qualified nurses and six healthcare support workers and was 19% of whole time equivalent staffing across the acute and psychiatric intensive care service. Although there had been a high turnover of staff in the last twelve months, the service were able to explain that staff had left the service for a variety of reasons such as; career changes, promotions and transferring to become temporary staff. The service had dismissed four staff members who they did not feel practised within the values of the service.

Between 1 February 2017 and 31 January 2018, the sickness rate was 3% on Austen ward, and 2% on Branwell ward.

Staff worked one of two available shifts per day from 7.15am to 7.45pm or 7.15pm to 7.45am, this allowed for a 30 minute handover between shifts.

The hospital used an internal staffing ladder tool to estimate the number of staff required per shift. Current staffing levels on Branwell ward were two qualified nurses and five healthcare support workers during the day and two qualified nurses and four healthcare support workers at night. This was because the ward was nearing capacity.

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

Requires improvement

On Austen ward staffing figures were slightly lower because the ward was not working to capacity; there were two qualified nurses and four healthcare support workers during the day and two qualified nurses and two healthcare support workers during the night.

Ward managers told us that they were able to bring in additional staffing according to the number of patients admitted to the ward, and their support needs. They used internal Cygnet Health Care Ltd bank nurses and healthcare support workers, and also used agency nurses and healthcare support workers.

Within the three month period between 1 September 2017 and 30 November 2017 the hospital used bank staff 47 times across both wards (15 shifts on Austen ward and 32 shifts on Branwell ward). Based on baseline staffing requirements this was 2% of available shifts on Branwell ward and 3% on Austen ward.

Agency staff were used 241 times (186 times on Austen and 55 times on Branwell). This was due to the qualified nurse vacancies and the acuity and complexities of the patient group. This was 16% of available shifts on Austen ward and 6% on Branwell ward. Data given by the provider stated that no shifts were unfilled or fell below safe staffing levels during the same time period.

We reviewed the staffing rotas from 1 January 2018 to 4 February 2018. There were always two qualified nurses working on the ward during each day and night shift. To ensure consistency the service had contracted some agency nurses to work on the ward for a longer period of time until the service had filled the vacancies. The hospital manager told us that ward managers ensured that they balanced staffing to ensure that there were no shifts managed by a team of only temporary staff.

Qualified nursing staff were available and visible to patients on the ward throughout our visit. Of the fourteen patients we spoke with across both wards; nine told us that staff were visible and that they had not had their leave or activities cancelled due to staffing shortages. The provider showed us data which they had collated confirming that staff had cancelled one occasion of patient leave between 1 October 2017 and 16 February 2018 on Branwell ward and none on Austen ward. Patients and carers told us that there was enough staff to support them; however, one patient from Austen ward told us that they felt that more staff were needed on the ward.

There was enough staff to carry out physical intervention with patients should they be required. The service had trained all staff in the management of violence and aggression and staff from other wards would also attend the wards for support as required.

There was adequate medical cover day and night. Consultants and specialty doctors supported staff during the day. At night, there was an on-call doctor who would attend the ward as required within an adequate time scale. Staff told us that doctors were always contactable and available for support.

Prior to the inspection, we asked the service to provide us with evidence of staff training. Cygnet Health Care Ltd had a training compliance target of 95%. Staff carried out mandatory training in twenty areas which included: basic and intermediate life support, food hygiene, infection prevention and control, information governance, the Mental Capacity Act and Deprivation of Liberty Safeguards and the Mental Health Code of practice.

The provider told us that eight areas of training on Austen ward and five areas of training on Branwell ward met the provider's own target. However, 60% of the mandatory training requirement on Austen ward, and 75% on Branwell did not meet the providers target level of training.

On Austen ward three areas of training were below 75% compliance which included immediate life support (50%), risk management (71%) and control of substances hazardous to health (74%). On Branwell ward only one course was below 75% compliance which was immediate life support at 63%. We were concerned about the potential impact on patient safety of low compliance with immediate life support training due to the physical interventions performed with patients by staff such as rapid tranquilisation and restraint which increased the risk of patients requiring emergency life support. In order to reduce risk, ward managers ensured that a member of staff on each shift was up to date with their training, and there responsibility to lead this on the shift, was clearly indicated on their identification badge.

The provider told us that some areas of training were below 75% because of information technology issues for three months which had prevented staff from carrying out online

training. Mental Health Act training was below 75% because the provider had recently moved from an online to face to face training package to provide more detailed training to staff.

Assessing and managing risk to patients and staff

Between 1 May 2017 and 31 Oct 2017 staff had used seclusion with 19 patients on Austen ward and eight patients on Branwell ward. Neither ward had used long term segregation with patients. We reviewed eight records of the seclusion of patients from both wards, and found them to be in good order. The use of this restrictive intervention was proportionate to the risk presented by the patient. However, there were three occasions where nursing and medical reviews did not take place in the required time limits.

Between 1 January 2017 and 1 June 2017, on Austen ward (the psychiatric intensive care unit) there were 95 restraints with 46 patients; 39 of these restraints had taken place in the prone (face down position). Between 1 July 2017 and 1 December 2017 there were 162 restraints with 72 patients, with 46 of these in the prone position.

Between 1 January 2017 and 1 June 2017, on Branwell ward there were 123 restraints with 53 patients, 25 of these restraints had taken place in the prone (face down) position. Compared to the previous six months, there had been a significant reduction in the number of prone (face down) restraints; from 1 July 2017 to 1 December 2017 there were 141 restraints with 43 patients, six of these had taken place in the prone position.

We reviewed the risk assessments of 16 of the 28 patients admitted to the wards at the time of the inspection. Every patient had a thorough and detailed risk assessment completed within 24 hours of admission. Staff updated these monthly or after any incident, and in multi-disciplinary team meetings with the involvement of all professionals. Staff used a recognised risk assessment tool; the 'short term assessment of risk and treatability'.

Both wards had worked on reducing restrictive practices. Due to this, we did not see any blanket restrictions in place on either ward during the inspection. Patients had access to their own mobile phones, and staff never locked communal areas. Staff had made efforts to significantly reduce the amount of one to one enhanced observations with patients. Both wards had implemented 'Safe wards'. 'Safewards' is a model where staff use ten interventions to support a reduction in conflict and the need for restrictive intervention with patients. Austen ward continued to work on their safe wards status but Branwell ward was further along in the process. Both ward managers carried out blanket restriction audits to continue to monitor any changes.

At the time of the inspection, there were no informal patients admitted to Austen ward, and five informal patients admitted to Branwell ward. There was a visible Mental Health Act information board, which told informal patients of their rights to leave the ward.

The provider had a search policy in place (2017) and staff practice was in line with the policy. Staff searched patient belongings on their arrival. Staff asked patients for consent before searches took place. Any further searches would only take place if there was an identified risk following an individual patient risk assessment.

Patients had differing observation levels dependent on the risk that they presented at the time. Patient observation levels varied from hourly, intermittent at 15 minutes, to continual observation. Nursing staff were able to increase observation levels should this be required. Staff discussed observation levels at twice daily handover meetings and weekly multi-disciplinary team meetings.

During the inspection, we reviewed 21 incidents of restraint which had taken place in the three months prior to the inspection on both wards. We found that the majority of restraint used by staff was low level restraint and staff made clear recordings of the actions they had taken to de-escalate situations prior to the use of restraint. On most occasions staff used restraint as a last resort to escort patients to lower stimulus environments and staff confirmed this when we spoke with them. However, patient care plans did not always discuss what interventions staff could take with patients prior to the use of restraint to reduce the need for physical interventions, such as by the use of positive behaviour support planning or by involving families in the planning of patient care.

At our last comprehensive inspection of this service in 2015 we told the provider that they must reduce the numbers of prone restraint. National Institute for Health and Care Excellence guidance (NG10) recommends avoiding prone restraint, and only using it for the shortest time possible. The Mental Health Act Code of Practice states that "unless

there are cogent reasons for doing so, there must be no planned or intentional restraint of a person in a prone position". This is because there is an increased risk of patient asphyxiation when this method is used.

Data collated by the provider demonstrated that they had continued to work on reduction of prone restraint, and between November 2017 and February 2018, the use of prone restraint had reduced on both wards to two episodes on Branwell ward, and nine on Austen ward.

Staff told us that if a patient refused oral medications and there was a clear need to give medication via an intra-muscular route, this would be performed by staff with the patient in a prone (face down) position. Care records reviewed, and patients whom we spoke with, confirmed that staff used this approach, with no evidence that staff had offered an alternative approach to the patient. Of four prone restraints used on Branwell ward, staff had noted in three of them 'planned to administer prone medication'.

However, in five records reviewed on Austen ward, staff had recorded clearly that they had offered oral medications and offered medication via standing or lying down, before delivering intra-muscular medication in the prone position to the patient; staff recorded this was the safest way to administer the medication.

As well as not being in line with national guidance, medication delivered in a planned, prone restraint was also against the provider's policies for 'medication management (2016)' and the 'management of violence and aggression' policy (2017); both state that staff must avoid intentional prone restraint.

We reviewed the provider's staff training package for the management of violence and aggression. The provider used the 'West London mental health NHS Trust' manual for training staff across Cygnet Health Care Ltd. The on-site management of violence and aggression trainer had annual refresher training on this model and then used this teaching with staff. The training model included training staff in the use of pain compliance where there was a threat to life. Pain compliance is a method of using painful stimulus on a patient to gain compliance during restraint. The Mental Health Act Code of Practice states that staff are able to use these methods in situations where a threat to life is apparent and they are designed for use as an 'immediate rescue'.

Staff confirmed that they had been taught pain compliance techniques but told us that they could not recall using them, and that they would always be a last resort in a life threatening situation. We did not see evidence in the records reviewed during the inspection that any incidents of restraint had used restraint holds that would have met the threshold for pain compliance.

Due to our previous concerns regarding complaints by patients about restraint techniques we asked the provider if they were able to provide us with any data or monitoring relating to the use of pain compliance on the wards. The management of violence and aggression lead had conducted an initial audit of all restraints on Austen ward (257) and all restraints on Branwell ward (264) between 1 January 2017 and 1 January 2018. This audit had identified 39 (15%) restraint records on Austen ward and nine (3%) restraint records on Branwell where staff had not thoroughly recorded the types of holds used during the restraint.

This meant that it remained unclear what holds staff had used in these cases. In response to the initial audit, the on-site management of violence and aggression lead and clinical manager had created an action plan which included; conducting monthly audits of restraint documentation to review any use of pain compliance in detail, and staff re-training forums. The clinical manager would share the outcomes at monthly governance meetings with team managers to disseminate to ward staff in team meetings.

Between 31 October 2017 and 20 February 2018 staff made seven notifications to the Care Quality Commission; staff had raised five of these with the Local Authority as safeguarding alerts. All five safeguarding notifications related to patients making allegations of assault against staff. There was one further notification of this during the inspection. Of these five allegations the Local Authority investigations found that three were inconclusive, one was closed, and two remained ongoing investigations with the Local Safeguarding Authority.

During the inspection, we saw that staff reported incidents of safeguarding when necessary and had a good knowledge of safeguarding and how to report. However, we did see one patient complaint on Branwell ward which contained clear safeguarding concerns and the investigator had not made a referral to the Local Authority. The clinical manager confirmed this at the time of the inspection and

agreed to take action. The service had a good system of working with the Local Authority. The clinical lead met regularly with the safeguarding lead from the Local Authority to discuss ongoing or open safeguarding concerns, and the quality of referrals. The Local Authority had commented that the quality of referrals these had improved. The hospital also had a safeguarding tracker in place to log and monitor safeguarding concerns and responses which managers reviewed in local governance meetings.

During the inspection, we checked the arrangements for managing medicines on the ward. Medicines were stored securely on both wards with fridge and room temperatures checked to ensure the correct storage of medicines. Nurses also completed nightly medication stock checks and controlled drugs checks.

A pharmacist visited the ward weekly to conduct specific checks of medication cards and storage. They also completed a detailed monthly and quarterly pharmacy audit which included checks of the clinic rooms, emergency equipment and controlled drugs. The pharmacist provided reports to the ward manager and at monthly clinical governance meetings.

We reviewed medication audits for quarter two and quarter three and found that staff had taken action following audits and made changes to practice to improve results. There was a reduction in administration errors reduced from 3% to 0.7% on Austen ward, and from 3% to 1% on Branwell ward.

We discussed prescribing practices with the lead consultant psychiatrist for the service. Doctors had prescribed some patients more than one anti-psychotic medication, and some doctors prescribed over recommended British national formulary limits. The consultant psychiatrist explained that all doctors within the hospital took part in an audit of prescribing practice to monitor this. They also said that the multi-disciplinary team meetings discussed the use of medication above limits to continually review the potential risks against the benefits of the medications prescribed. Doctors were assured that staff had undertaken regular physical health checks with these patients, and monitoring such as the use of the 'Lester tool' was undertaken.

Some patients admitted to the wards had long term physical health conditions and substance misuse needs. Patients had individual care plans in place to allow staff to regularly review these needs. The hospital's registered general nurse supported patients with long term physical health conditions.

Track record on safety

The service reported that there had been nine serious untoward incidents between 11 December 2016 and 30 May 2017 across both wards; two of these incidents occurred on Austen ward and seven on Branwell ward.

Of the seven incidents on Branwell ward; five related to patients who had not returned from planned section 17 leave or had attempted to leave the hospital without leave, one was an incident of self-harm or overdose, and one was a serious assault on a staff member by a patient in May 2017. Staff had investigated and a written response was provided for all of these incidents.

The two incidents on Austen ward related to one information breach, and one patient who described chest pain whilst in seclusion.

Staff were able to give examples of improvements in safety which the service had made following serious incidents. For example, following the serious staff assault on Branwell ward, staff had changed practices to ensure there was a lead staff member responsible during high risk situations to prevent injuries and allow clear guidance in escalating situations.

Reporting incidents and learning from when things go wrong

All staff were able to report incidents using a paper based incident recording and reporting system. Ward managers and the clinical manager reviewed all incidents.

If incidents met serious incident criteria ward managers completed 24 hour and 72 hour reports. The corporate risk manager reviewed these and decided whether a full investigation and root cause analysis were required. An external case manager completed the investigation and root cause analysis within 20 days of the date of the incident. The external investigation manager shared the final serious incident reports at monthly governance meetings. The clinical manager oversaw any actions required from reports in via the services' 'overarching local action plan'. We reviewed this plan during the inspection and found that the section marked 'incidents' was blank.

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

Requires improvement

Staff received feedback from investigation of incidents, both internal and external to the service. The service had a corporate and local lessons learned log which they disseminated to all staff. Staff were able to tell us about incidents in other Cygnet Health Care locations where they had made changes to local processes to reduce risk. Since August 2017, the service had begun to re-focus their approach to governance to ensure closer involvement at ward level. Ward managers received monthly data packs with interrogation of incident data per ward. They presented this data at monthly clinical governance meetings to discuss action they would take to reduce identified risks. There was an expectation that team managers would then share learning via the local learning lessons log and in team meetings and supervision with ward level staff. The service embedded learning from incidents into team meeting agendas and within local and corporate learning logs.

Duty of Candour

The Duty of Candour regulation explains the need for providers to act in an open and transparent way with people who use services. It sets out specific requirements that providers must follow when things go wrong with care and treatment. The provider had a Duty of Candour policy in place and staff understood the need to be open and transparent when they had made mistakes and to make written apologies when this was needed. Staff had considered their duty of candour when things had gone wrong with patient care and we saw evidence of this in incident recordings.

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

(for example, treatment is effective)

Good

Assessment of needs and planning of care

We reviewed the care records of 10 patients admitted to these wards at the time of the inspection. All patients had thorough care plans in place which staff completed within 24 hours of their admission to the service.

Staff had a clear understanding of the importance of monitoring and managing the physical health needs of patients. All patients had a physical health examination completed by the admitting doctor on arrival. Staff used the modified early warning scores system weekly to record patients' physical health observations.

Where patients had long term physical health conditions, they had a specific care plan to support these needs. Staff received support in meeting these needs from the registered general nurse based on site. The nurse was responsible for liaising with other external professionals as required.

Staff updated care plans monthly or more regularly if there had been a change in need. They also discussed care plans in weekly multi-disciplinary team meetings. Care plans were thorough and holistic and included areas including safety planning, my mental health, physical health needs, relationships, and safeguarding. We saw good evidence of discharge planning discussions in multi-disciplinary team meetings. However, it was not always possible to ascertain the voice and views of patients in all care plans we reviewed. Care plans were standardised and used complex professional language such as 'I need to discuss and agree upon mutual expectations'.

The patient care plans we reviewed did not contain positive behaviour support frameworks and planning. The provider told us that they used a method of 'my safety planning' with patients which was a model of positive behaviour support. However this was not present in the care plans we reviewed. Care plans did not discuss patient's preferences, sensory needs or reasons for behaviours that challenge, and there was no evidence that staff had discussed them with patients and their families. Staff did not always complete care plans collaboratively with patients. Staff invited patients, their carers and advocates, to multi-disciplinary meetings where they discussed the patient's progress. The involvement of family was clearer in the multi-disciplinary meeting records; however this information did not transfer into the patient care plans. This was more apparent on the Branwell ward (acute mental health) where patients had a longer length of stay.

Information required to deliver care was stored in a paper file on the ward; all staff inputted into the same file which was contemporaneous and logical to follow and stored securely.

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

Requires improvement

Best practice in treatment and care

All policy and procedures used by staff referenced current guidance such as the Mental Health Act Code of Practice and National Institute for Health and Care Excellence guidance on short term management of violence and aggression (2015). The service underpinned medication management with a range of guidance including the clinical guidelines on the management of schizophrenia (2009). The service ensured that this was embedded through regular audits of the storage and prescribing of patients' medication, and closely monitoring the physical health of patients prescribed anti-psychotic medications.

Patients had access to psychological and other therapies recommended by the National Institute for Health and Care Excellence. Psychology staff could deliver group therapy or one to one therapy based on the needs of patients; they were also able to offer cognitive behavioural therapy. Occupational therapists also followed best practice guidance with patients using the model of human occupation screening tool, and community and life skills ability evaluations. Patients we spoke with told us that there was good access to therapies and activities.

A physical healthcare policy was in place and the service employed a registered general nurse to oversee the physical long term health care needs of patients. The service continued to struggle with access to GP services. However, managers had entered this concern on the service risk register and senior managers continued to work with local commissioners to resolve the concern.

Staff used recognised rating scales to assess and respond to patients' physical health including the modified early warning score system, as well as the 'Lester' tool to assess the cardio-metabolic health of patients. The service also monitored patients' nutrition and hydration. The service used a variety of other measurement and outcome tools to support treatment and care including the mental health clustering scores and multi-agency public protection assessments.

The service undertook a variety of audits to monitor the quality and safety of the service. The hospital had an annual clinical audit programme which included audits of the following areas completed by senior staff;

- annual overview of prescribing and administration errors
- residential environmental impact scale
- restrictive practice, seclusion, restraint and prone restraint audit
- clinical file audit
- rapid tranquilisation audit
- physical health audit

Ward level staff also completed regular infection control, clinic room, and fire and environmental, audits. The management team met monthly in a clinical audit meeting where they discussed the outcomes of audits conducted each month. They identified and reviewed action plans in response to concerns or to make improvements, and identified learning to disseminate to teams. However, we noted that outcomes from audits such as infection control and environmental audits where not discussed in governance meetings. This meant that the important outcomes from these audits did not have specific action plans. It was difficult to see what action was taken when improvements where required and how this fed into governance and back to ward level.

Skilled staff to deliver care

The service had experienced and qualified staff from a range of different disciplines including; psychiatry, psychology, mental health nursing, general nursing, occupational therapy, healthcare support workers and substance misuse services. The service supported staff to complete the 'care certificate', and had sponsored staff to obtain nursing qualifications, depending on their level of experience.

Staff received an appropriate local and corporate induction; all temporary bank staff received the same induction as permanent staff. The service had an individual ward induction for new starters or agency staff.

The service provided us with data which stated that all clinical and therapy staff on both wards had received an appraisal within the last 12 months, and 70% of non-clinical or ancillary staff had received an appraisal within the last twelve months.

All Doctors who needed to had completed re-validation within the last twelve months.

The provider had a clinical supervision target of 90%. Between 1 January 2017 and 30 November 2017 clinical supervision reached an average rate of 94% on Austen ward and 91% on Branwell ward.

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

Requires improvement

Staff told us that they felt their training opportunities were high quality. In addition to mandatory training staff (dependent on their role) had undertaken training in clozapine management, engagement and observations, prescription writing and security.

Multi-disciplinary and inter-agency team work

There was a range of professional disciplines available at the service that made up the multi-disciplinary team, including psychiatry, psychology, mental health nursing, general nursing, occupational therapy, and substance misuse.

We observed two multi-disciplinary team meetings during the inspection; one on Branwell ward and one on Austen ward. The meetings included the consultant psychiatrist, specialty doctor, the patient, their relatives and any other professionals involved internally and externally to the hospital. The psychologist had also contributed to the meeting in a report format. The patient's named nurse had prepared a detailed report in advance of the meeting. The meeting discussed the patient's progress and any incidents or concerns. Staff updated risk assessments and care plans throughout the discussions. We saw that the doctor gave all parties the opportunity to contribute to action and discharge plans. Staff discussed the patient and their needs in a kind, dignified and respectful manner throughout the meeting.

There were twice daily handover meetings on the ward at the start of each shift. We observed a handover meeting of the late shift on Austen ward during the inspection. The nurse in charge of the day shift gave the handover to the incoming staff team. The handover was detailed and staff discussed each patient in turn including medication, their mental state, risks, and the outcome of leave. Staff knew patients and their needs well and there was good communication about the safety of patients and any changes to medications needed. Staff discussed a patient due to be admitted that evening; the process was thorough and detailed, and the doctor had been contacted in advance so staff were able to discuss risks and care plans prior to the patient's arrival.

We saw in patient care plans and from speaking with staff that the service had effective working relationships with professionals outside of the service. Ward managers remained in contact with commissioners and bed managers. The hospital continued to work with local GP services to enable access for patients to their services. This had been an ongoing issue for the patient group; the medical director and hospital manager met regularly with commissioners in order to find a resolution for this issue.

Adherence to the MHA and the MHA Code of Practice

At the time of the inspection 78% of eligible staff on Austen ward and 85% of staff on Branwell ward had received training in the Mental Health Act. This training was mandatory for qualified staff and there was a plan in place to roll this out to remaining staff within twelve months. The hospital manager explained that the service had recently moved from an online training course to a more detailed and updated face to face training course which had caused a reduction in training compliance. Staff we spoke with had a good understanding of the Act and knew who they could speak with for support with a complex issue.

The service had on on-site Mental Health Act administrator. Staff knew who this staff member was and told us that they were accessible and offered advice and guidance to staff.

The Mental Health Act administrator had oversight of admission paperwork, monitored the dates for patient's tribunal meetings and renewals, and provided reminders to psychiatrists when action was required. They also completed regular audits of paperwork to ensure it was correct and complete, and that staff were applying the Act appropriately. The administrator and their assistant were well qualified for their role and had robust systems and processes in place. The corporate lead for the Mental Health Act was based at the service and was also available to provide guidance and support.

We reviewed the provider's policy 'for the administration of the Mental Health Act' (2016). The Mental Health Act manual for staff sat alongside this policy. The policy referenced relevant legislation including the Mental Health Code of Practice (2015).

We reviewed the Mental Health Act paperwork of ten patients during the inspection. Paperwork was stored with patient files and in good order. All patients had valid consent to treatment assessments and treatment certificates were in place where these were required. All patients' records contained copies of their detention papers. Staff recorded that they explained patient's rights

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

Requires improvement

to them regularly as per the Act. Patients had access to section 17 leave as granted by the responsible clinician on the wards, and doctors clearly recorded this in a file kept on the ward.

The ward had a Mental Health Act information board visible on the ward for patients and their carers. The hospital gave information leaflets to patients and their carers throughout admission to explain rights, policies and procedures. Staff supported patients to access an independent mental health act advocate where they lacked capacity. However, we did not see information provided in accessible formats for patients with limited understanding. Staff told us that they could easily access this information if it was required.

Our Mental Health Act reviewer last visited Austen ward in July 2017 and Branwell ward in November 2017. They raised concerns that patients did not always sign their care plans, that there was a lack of consistency in staff explaining patients' rights to them, and in recording consent to treatment, and a 'you said we did' board which was out of date. Staff had rectified these concerns at the time of our visit. We saw staff making improvements to the service following patient feedback.

Good practice in applying the MCA

At the time of the inspection all staff on Austen ward and 88% of staff on Branwell ward had received training in the Mental Capacity Act and Deprivation of Liberty Safeguards. This training was mandatory for all staff.

We reviewed the provider's policy for the Mental Capacity Act (2016). The policy was thorough and explained the principles of the Act and contained relevant guidance including updates from the 2014 supreme court judgement in relation to Deprivation of Liberty Safeguards.

Patients could access the support of independent mental capacity act advocates if required.

Staff had a basic knowledge of the Act and told us that they would work with doctors and the social work team if the need for capacity assessments and best interest discussions was required. We did not see any examples of capacity assessments taking place in any of the ten patient records we reviewed during the inspection. However, staff told us that they had undertaken two detailed assessments with patients in the past twelve months.

At the time of the inspection, there were no patients on the ward under the authority of a Deprivation of Liberty safeguard. The service had not made any applications within the last twelve months.

There was no audit in place to monitor adherence to the Act and no Mental Capacity Act lead at the service.

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

Requires improvement

Kindness, dignity, respect and support

During the inspection, we observed staff interacting with patients in a kind, patient and caring manner. In handover and multi-disciplinary team meetings we observed staff discussing patients in a dignified and respectful manner. Staff knew patients well and were able to discuss their individual needs.

We gave opportunities to all patients admitted to the ward to speak with us during the inspection. We spoke with 14 patients across both wards during the inspection. We also collected comments cards from five patients on Branwell ward and seven patients on Austen ward.

Patients had mixed views about their care and treatment. Patients on Branwell ward described staff as friendly, co-operative, caring and willing to help. Patients on Austen ward described staff as respectful, excellent, and told us that they felt well looked after. However, four patients made negative comments where they said that the smoke free environment was unfair, they didn't understand their medication or reasons for being in hospital and that staff had treated them with a lack of respect. One patient told us that they had requested to move from Austen ward because of the way staff had treated them.

During the twelve months prior to the inspection, patients had raised a number of concerns relating to the attitude and behaviour of some staff members. Although we did not witness this behaviour at the time of the inspection, we raised our concerns about the treatment of some patients with the hospital's leadership team. In response to our

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

Requires improvement

feedback about this at the time of the inspection, the clinical manager had agreed this needed further review and had a plan to review this with staff and spend more time observing ward culture.

The involvement of people in the care they receive

The majority of patients we spoke with told us that they the service had a good admission process which included them being introduced to the ward. Both wards had detailed admission booklets which explained the service and the facilities available.

Staff told us that patients were actively encouraged to be involved in the planning of their care. Patients were involved in multi-disciplinary meetings and in planning goals for their care, treatment and discharge. Whilst the care plans we reviewed did not always reflect this or use the patient's own words, half of the patients we spoke with told us that they knew their care and discharge plans well and felt involved.

Five patients we spoke with told us that service had kept their families informed appropriately and involved them in their care where necessary. However, of the three carers we spoke with, two told us that communication with them from Branwell ward (the acute mental health wards) was poor and that they always had to chase staff for updates and information. One carer we spoke with told us that they had witnessed staff being rude to their relative and that they would not recommend the service.

All patients had access to the support of advocates, who visited the ward weekly to speak with patients.

Patients were able to give feedback about the care they received via complaints and comments boxes located on the wards, and via weekly community meetings on each ward. Branwell ward also had a comments wall on which discharged patients left positive and inspiring feedback about their care. Each ward had a daily morning meeting between staff and patients where they made plans together for the day to ensure patients were involved and able to make choices. Staff also gave each patient a weekly involvement plan of leave, therapy and activity groups. Both wards had detailed 'you said we did boards' and we saw that the service had made changes in response to feedback. For example due to patients' dislike of the smoke-free environment, the hospital had begun to provide electronic cigarettes.

The service used the 'friends and family' test to ascertain feedback about care and treatment. Between 1 May 2017 and 30 December 2017 there had been no responses to the survey for this service. The service had an action plan in place to increase the poor return rate for the service which included the use of information technology to allow visitors to leave feedback and allow more detailed review of the service.

The provider had also conducted an annual service user satisfaction survey with patients. The survey asked for feedback on the environment, care and treatment, and therapies and information and rights. In the 2017 survey we reviewed during the inspection, there was only one response on Branwell ward which was wholly positive and no response on Austen ward. The service had an action plan in place to improve the response rate.

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

Good

Access and discharge

At the time of the inspection there were 10 patients admitted to Austen ward (the acute words for adults of working age with mental health problems) which had 14 available beds. There were 18 patients admitted to Branwell ward (the psychiatric intensive care unit) which had 19 available beds.

Between 1 May 2017 and 31 October 2017, the average bed occupancy rate was 77% on Austen ward and 99% on Branwell ward. The Royal College of Psychiatry states that optimum bed occupancy to deliver high standards of care in acute settings should not exceed 85%. However, we did not see an impact of this on patients.

Where patients had pre-arranged leave to other settings, for example for an overnight stay, the wards did not use these beds for other patients until the service had fully discharged the patient.

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

Requires improvement

The service admitted patients from across the country and therefore cared for some patients who were from outside of the local area. However, there remained beds available for patients in the local catchment area. The service kept some beds as commissioned beds with NHS trusts.

Where patients required more intensive treatment, there was a flexibility of admission between the acute ward and psychiatric intensive care unit to provide consistency and support to patients. Staff did not move patients between wards without justified clinical grounds.

The service had not reported any delayed discharges of patients to other settings. However, staff said there could be difficulties in moving patients on to more appropriate settings, particularly those who had restrictions with the Ministry of Justice.

Between 1 March 2017 and 1 February 2018 Austen ward (the psychiatric intensive care unit) had admitted 122 patients and discharged 120. Branwell ward (the acute ward for working age adults with mental health problems) had admitted 247 patients and discharged 251. This demonstrated an ongoing focus on discharge and recovery.

There had been a small number of patients who the service had readmitted within ninety days of discharge. Between 1 November 2016 and 31 October 2017 there had been three re-admissions to Branwell ward and three to Austen ward within 90 days of discharge.

The facilities promote recovery, comfort, dignity and confidentiality

Patients on Austen ward had access to a variety of facilities, rooms and equipment which included a dining room, lounge, quiet lounge, activities of daily living kitchen and games room. On Branwell ward patients had access to a dining room, lounges, activities of daily living kitchen and visitors lounge. All rooms were unlocked and accessible to patients. Patients also had access to laundry facilities which they could use independently according to their individual risk assessment.

Patients could use a gym, therapy room and visitor's room in the communal areas of the hospital either independently or with staff escorts depending on their individual risk assessments.

Patients on both wards had access to outside space and the hospital was in the process of providing outdoor gym equipment.

Patients were able to make a phone call in private either using the ward telephone or their own mobile telephone.

Patients on both wards had access to hot and cold drinks and snacks throughout the day and night. Patients told us that food was of good quality and they also had a choice to order takeaway food to the ward.

Patients had their own bedrooms and were able to personalise them should they wish too. Each bedroom contained secure storage and patients told us that they felt their possessions were safe. Patients had access to their own bedroom keys and this was appropriately risk assessed.

Staff gave patients a weekly timetable of activities which included therapy sessions, leave and on ward activities. On Branwell ward staff organised pool competitions which the patients enjoyed, and where risk assessment was appropriate patients from other wards were encouraged to join them.

Meeting the needs of all people who use the service

Branwell ward was accessible to patients with mobility needs because it was located on the ground floor of the hospital. Austen ward was located on the first floor of the hospital, but had an accessible lift for patients with mobility needs.

Both wards had a detailed patient information boards with information about patient rights, how to make complaints, treatments, health conditions and medications. Patients had weekly access to advocacy support and were encouraged to use this support to make complaints or raise concerns about care and treatment. Staff had access to interpreters who they could invite to the ward to support patients where English was not their first language. Staff had access to information for patients in languages other than English.

Catering staff were able to meet the needs of individual patients. Menu's had vegetarian options and staff cooked food on site so they could meet individual needs and preferences including cultural and religious needs.

The hospital had a spiritual room available to patients. Staff would organise appropriate external spiritual support as required.

Listening to and learning from concerns and complaints

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

Requires improvement

Between 6 November 2016 and 1 September 2017 the whole core service had received 20 complaints.

Thirteen of these complaints related to Austen ward (psychiatric intensive care unit). In the same time period Austen ward received two compliments.

Seven complaints and seven compliments were received by Branwell ward (acute ward for adults of working age) in the same time period.

We reviewed five compliments during the inspection and saw that patients and carers had described staff as "great, engaging, happy to listen to problems, professional and caring". A visitor to the hospital described staff as "friendly, welcoming, and described the hospital as having "supportive and driven" leadership.

On Austen ward one complaint was upheld, 10 complaints were not upheld, and two were partially upheld. Of these complaints, six related to concerns raised by patients and their relatives or advocates about the behaviour or attitude of staff, one related to the hospital smoke-free environment, one related to access to laundry and newspapers, and five related to generic concerns about care.

On Branwell ward two complaints were upheld and five complaints were not upheld. Four complaints related to concerns about staff attitudes or behaviour, one related to religious needs not being met and one related to generic concerns about care.

We reviewed seven complaints, three from Branwell ward and four from Austen ward. All concerns were resolved at a local level and none were referred to the Ombudsman. Staff completed complaints investigations within the provider's timescales. Complaints investigations were thorough. Complainants received a detailed response to their complaint which outlined how the service would improve.

In four complaints we found that whilst the service had accepted that action was required to improve, these complaints had not been categorised as upheld. This meant that the service was not accurately recording the number of upheld complaints. The low recognised number of upheld complaints meant that complaints were not used to inform quality improvement objectives within the service's governance processes.

Ward level staff knew the complaints procedures and referred to senior staff as appropriate. Patients and carers we spoke with told us that they knew how to make complaints. Advocates also supported patients to voice concerns and complaints. Both wards had clear information for patients about how to make complaints.

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

Requires improvement

Vision and values

Cygnet Health Care Ltd had an overall vision to be the 'provider of choice'. The local hospital strategy was 'to provide superior quality healthcare that; service users recommend to family and friends, clinicians prefer for those in their care, commissioners first choice for their service users and employees are proud to work for".

The values of the provider were:

- Helpful
- Respectful
- Honest
- Empathetic
- Responsible

The service displayed the values throughout the hospital. The majority of staff we spoke with were able to describe the values.

At a ward level staff were encouraged to discuss the values of the organisation in supervision, team meetings, and through the appraisals process.

Staff knew who the most senior managers in the organisation were because they visited the hospital on a six monthly basis for governance meetings and often visited the wards.

Good governance

The hospital had a clear governance structure in place. On a monthly basis, all senior staff from ward manager level met for clinical governance meetings. A standardised

agenda was discussed which included areas such as; medication management, compliance with the Mental Health Act, risk management, serious incidents, restraint, and safeguarding.

Since August 2017, the hospital had begun to focus governance into ward level. On a monthly basis each ward manager received a data pack. This included information regarding areas such as incidents, restraints, prone restraints and complaints and compliments. There was an expectation that each ward manager would present this information to the governance meeting and discuss actions for example in regards to reducing incidents of restraints. We were able to see that this was taking place.

On a six monthly basis the senior leadership team met with the board and corporate managers. Meetings took place on site and followed the same format as local governance to ensure the meeting followed up issues and concerns from a local level.

There were areas of governance which we found were effective and well established. Most clinical staff were appraised and supervised and had opportunities for additional training and development. The service planned and managed staffing well, and ward managers ensured wards ran with safe levels of staffing. The service managed the use of temporary staff well, to provide consistency for patients.

The provider actively sought feedback from patients, carers and staff about the services the hospital provided. There was a thorough and detailed plan of ward level and hospital wide audits to monitor and improve safety. There were thorough and detailed processes in place in relation to the management of the Mental Health Act.

At ward level there were opportunities for staff to learn from incidents and because team meetings, supervision and debrief were taking place and staff told us that they felt supported.

The service worked to several key performance indicators to measure safety and quality, these included areas such as; sickness, training, and complaints. The service measured their performance against other Cygnet hospitals to indicate any areas in which the hospital was an outlier.

The hospital had a local risk register in place which fed into the corporate level risk register. There were two risks on the local risk register which included the recruitment of qualified nurses and physical healthcare GP provision for patients. The hospital manager updated the risk register on a monthly basis with notes of actions taken each month. Managers could escalate concerns to the corporate risk register after discussion with the corporate risk manager. There were no local concerns from the hospital entered on the corporate risk register. Although the corporate risk register contained items which would be a risk for the hospital such as; staff recruitment and retention, high dependency on agency workers, competitors, suicide and self-harm, failure to manage staff stress, high use of restrictive practices, and primary healthcare.

However, we identified some concerns relating to the governance structure and systems used.

Local managers agreed that the use of planned prone restraint for the administration of intra-muscular medication was not always appropriate. The corporate management of violence and aggression lead felt that this was the safest route. We could not see evidence of where senior managers were holding these ongoing discussions, or how they had highlighted them to corporate level governance. There was no evidence of a local action plan to address the concern.

Staff did not always use the governance systems and processes in place effectively to ensure improvements in quality and safety. For example managers had not completed the local overarching action plan to include quality improvement plans from complaints and not all serious incidents which required action (such as serious injuries to staff) were included on the action plan meaning that senior managers did not discuss them in governance meetings.

We had concerns about the culture and behaviour of staff. In the twelve months prior to the inspection there had been six allegations of abuse, five relating to Austen ward and one relating to Branwell against staff. The wards had also received ten complaints (six on Austen ward and four on Branwell ward) relating to the attitude and behaviour of staff. There was also an incident on Branwell ward where a patient made a complaint about staff being heavy handed in restraint and the investigator did not make a safeguarding referral. Although not all of these complaints and safeguarding concerns were upheld or substantiated it raised questions about the culture and behaviour of staff. The hospital's senior leadership team had not investigated this high level of concern. However, in response to our

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

Requires improvement

feedback about this at the time of the inspection, the clinical manager had agreed this needed further review and had a plan to review this with staff and spend more time observing ward culture.

Staff did not always record the level of holds used during restraint. This meant that the service could not assure themselves that staff were using the appropriate level of holds with patients in restraint in line with their management of aggression and violence training and whether staff had used pain compliance techniques with patients. However the clinical manager and management of violence and aggression lead had created an action plan which included the continuation of these audits on a monthly basis, the findings fed back to ward managers and individual staff, changes made to the recording forms, and additional staff training.

Leadership, morale and staff engagement

The organisation valued its staff and had a number of methods in place to reward them, such as staff awards and opportunities for training and development.

The provider had conducted a hospital-wide staff survey in November 2017. Whilst results were not broken down and specific to Austen and Branwell wards, the service had 79% positive responses with the most positive responses being in relation to enjoying working for Cygnet Health Care Ltd, feeling supported by managers, feeling valued, feeling encouraged to report incidents, accidents and near misses. Ninety-three percent of staff felt that they understood Cygnet's values and 71% of staff would recommend the hospital as a place to work.

Negative responses included that 56% of staff have felt unwell in the last twelve months due to work related stress, 29% of staff said there were not enough staff on their ward to help them to do their job properly. In response to the staff survey the management team had created an action plan which they would complete by May 2018. At the time of the inspection the service had completed all areas other than two, which were longer term projects relating to estates and the information technology infrastructure.

Although there had been a high turnover of staff in the last twelve months, the service were able to explain that staff had left the service for a variety of reasons such as; career changes, promotions and transferring to become temporary staff. The service had dismissed four staff members who they did not feel practised within the values of the service.

During the inspection, staff we spoke with talked of feeling supported, happy in their jobs. They felt that they had time to take part in supervision and team meetings where they were encouraged to make suggestions to improve and develop the service.

Commitment to quality improvement and innovation

Austen ward (the psychiatric intensive care unit) had received accreditation from the quality network of psychiatric intensive care units in 2014; the quality network had reviewed and upheld this in December 2017.

The hospital and corporate provider had a clear strategy for reducing restrictive practice. A large part of this strategy was to introduce 'Safewards'.

Branwell ward had been using Safewards methodology since November 2016 and Austen since August 2017. Branwell was further along in their journey; we saw evidence that this implementation was having a positive impact. There was a calm, positive and therapeutic atmosphere this brought to the ward with the introduction of the interventions such as 'soft words', 'calm down methods' and an inspiring discharge message board used by patients. Staff had also introduced an allocations board on the ward whereby staff described each patient by one word chosen by staff, words used were 'genuine, calm, valued and brave'.

Requires improvement

Wards for older people with mental health problems

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

Are wards for older people with mental health problems safe?

Requires improvement

Safe and clean environment

Fairfax ward is located at Cygnet Hospital Wyke and provides care for up to 22 older male patients with mental health problems which may be functional (such as schizophrenia) and patients with a secondary organic diagnosis (such as dementia) or long term health conditions.

We checked the whole of the environment to check whether it was safe and clean.

The ward had a 'T' shaped layout, which did not allow staff a clear line of sight to observe patients. The service mitigated this risk by having staff allocated to observe patients at intervals throughout the day and night. Staff discussed each patient's observation levels in multi-disciplinary team meetings and at ward handover meetings; observation levels differed according to the risk identified by individual patients.

All areas of the ward contained ligature points including; communal lounges, patient bedrooms and corridors. A ligature point is something that a patient intent on self-harm could use to tie something to in order to strangle themselves.

The ward manager and estates manager had completed a ligature audit of the ward in January 2018. The audit identified all the ligature points and noted the highest risk areas to be in patient bedrooms and bathrooms. Ligature maps were located in staff only areas, which highlighted ligature risks to staff as a visual reminder on an ongoing basis. Staff mitigated the risk through observation levels determined by patient's individual risk assessment.

Staff had updated the ligature audit since the time of our last visit in November 2017, when we had concerns about the safety of patients due to the ligature points on the ward. The service had made improvements, such as the removal of blinds which were unsafe in communal lounges. Staff had also removed televisions from the walls in the communal lounges to reduce risk, although staff had placed these at floor height, there remained a risk from trailing wires. The ward manager was aware of this and we saw that a plan was in place to attach the televisions within cabinets to the wall and conceal cables within two weeks of our inspection. In the interim staff managed the risk with patient observations and risk assessment.

The ward was available to male patients only and was compliant with the Mental Health Act Code of Practice and Department of Health guidance on eliminating mixed sex accommodation.

Fairfax ward had a fully equipped clinic room with equipment for staff to monitor patient's physical health needs. It contained an adjustable examination couch with privacy screen, a blood pressure monitor, an electro-cardiograph machine, and weighing scales. All equipment had been marked as clean by staff and staff had ensured they had correctly calibrated it. The ward also had an emergency grab bag. The nurse in charge checked the bag each night to ensure the emergency equipment was in order. The bag also contained a hyper-glycaemia treatment box and an anaphylaxis kit. Staff also had access to an automated external defibrillator.

Requires improvement

Wards for older people with mental health problems

The ward did not have its own seclusion room. Patients were able to access the seclusion room which was located within another area of the hospital outside Branwell acute ward. This required a walk around the outside of the hospital, and was difficult for patients with limited mobility. It was only used by the ward in emergency situations and only twice within the last twelve months. Staff told us that it took approximately five minutes to walk from Fairfax ward to the seclusion room. Whilst we saw no evidence that this practice had resulted in an incident, it was unclear whether the service had considered the potential risk to patients and staff when staff escorted patients from Fairfax ward to the seclusion room.

The seclusion room met with guidance contained within the Mental Health Act Code of Practice. There were two clear areas for staff to observe patients and a two-way intercom to aid communication between patients and staff. The room contained a clock which was visible to patients so that they were able to orientate themselves to the time of day, and an en-suite bathroom area. There were no visible ligature points within the room and staff were able to provide patients with ligature proof clothing should this be required.

Furnishings throughout the ward were in good condition, and the main ward areas were clean. Carers told us that ward was clean when they visited. Domestic staff cleaned the main areas of the ward and patient bedrooms during our visit. Staff made use of handwashing facilities and wore personal protective equipment such as aprons and gloves when delivering personal care and providing meals to patients. However, we did observe several staff members wearing nail varnish which is against infection control guidance.

Staff had undertaken an infection control audit on 15 February 2018. The audit undertaken by staff rated 14 areas of the ward. Staff had rated seven of these areas as amber (below 95% compliance) or red (below 80% compliance). The lowest areas of concern were the ward kitchen at 59%, domestic room at 72% and the laundry room at 75%. There was no action plan available to address the concerns raised by the audit.

At the time of the inspection there remained ongoing concerns, particularly in the laundry room. The law requires that the registered person of an organisation must have regard to the Code Of Practice on the prevention and control of infections (2015). Staff did not follow the Code of Practice or Department of Health guidance regarding the decontamination of linen (HTM 01-04), or the provider's own policy. Laundry was not all washed at the required temperature to ensure it was disinfected, clean bed linen was kept on the laundry room floor, soiled linen was stored in the laundry room in soluble bags without outer protection, and staff working in the laundry did not wear protective clothing.

The design of the laundry facility did not allow for effective management of infection control. The Code of Practice states that services should separate laundry facilities. This was not the case because the laundry room was the only through route into the domestic storage room. We also saw that staff stored inappropriate items in the laundry room such as their own belongings, and a basket of old and soiled slippers and shoes. The room also contained a bin for disposable gloves which did not have a covering.

We had concerns that moving and handling equipment which was not visibly clean and awaiting disposal was stored next to clean and in use equipment.

We also found that staff washed and re-used medication administration pots and oral syringes used by patients and disinfected them in a cold water solution rather than using their stock of re-usable ones. Following the inspection, the provider told us that this practice had been stopped immediately.

We shared these concerns with the ward manager at the time of the inspection. The ward manager was aware of the concerns and particularly because the ward had one patient recently diagnosed with methicillin-resistant staphylococcus aureus which meant that patients required additional protection from infection. The ward manager confirmed that they had invited an external contractor into the ward to support a renewed infection control audit and procedures.

Staff cleaned other areas of the ward regularly and the ward smelt fresh.

The estates manager undertook regular environmental risk assessments alongside the ward manager and the hospital manager. These were available to staff on the wards. In response to our concerns about the environmental safety of the ward at our inspection in November 2017 the service had made changes to the environment to make this safer for patients and reduce risk of significant harm. This

included the addition of new handrails, the movement of beds closer to nurse call alarms, highlighting of light switches to orientate patients and making the ward flooring safer to reduce the risk of falls.

The hospital had a fire risk assessment in place which managers reviewed every six months, and the local fire service had visited and provided a report to the service. The hospital had gas safety, electrical wiring and portable appliance testing certificates. Fire system and equipment checks were also in place. During the inspection a fire alarm sounded and we saw that staff followed procedures to move patients into the communal lounge behind fire doors to await further instruction as per their policy. Patients had personal evacuation plans stored in the fire box on the ward.

All ward staff carried personal alarms and patients had access to nurse call alarms in their bedrooms. We saw that alarms were in good working order during the inspection, and that they were regularly tested.

Safe staffing

Prior to the inspection, the service submitted data regarding their staffing levels. The hospital had 129 substantive staff including clinical, managerial, administrative and ancillary staff. On Fairfax ward there were 10 whole time equivalent nursing posts, and 26 whole time equivalent health care support worker posts. At the time of the inspection eight of these posts were vacant; four qualified nursing and four healthcare support worker posts. The hospital had the qualified staff vacancies on their local risk register as they continued to have difficulty recruiting to these posts. The provider had an overall vacancy target of less than 35%.

The ward had experienced a high turnover of staff. Between 1 February 2017 and 31 January 2018 ten staff had left the service. These were nine healthcare support workers and one qualified nurse. The service were able to explain that staff had left the service for a variety of reasons such as; career changes, promotions and transferring to become temporary staff. The service had dismissed one staff member who they did not feel practised within the values of the service.

In the same time period the ward had a 4% staff sickness rate.

Staff worked two shifts from 7.15am to 7.45pm or 7:15pm to 7:45am, this allowed for a 30 minute handover between shifts.

The hospital used an internal staffing ladder tool to estimate the number of staff required per shift. Minimum staffing levels on the ward were two qualified nurses and four healthcare support workers during the day and night. The ward manager explained that this level would increase by one staff member for every two patients admitted to the ward. This staffing matrix was the same for Fairfax ward as it was for the other wards within the hospital. The ward manager told us that they were able to bring in additional staffing according to the needs of the patients admitted to the ward. The ward manager used Cygnet Health Care Ltd bank qualified nurses and healthcare support workers and agency qualified nurses and healthcare support workers.

Within the three month period between 1 September 2017 and 30 November 2017 the service had used bank staff 131 times. Based on baseline staffing this was 12% of available shifts. The service had used agency staff 587 times (54% of available shifts). This meant that in each 24 hour period there was an average of six agency staff working on the ward. This was due to the four qualified nurse vacancies and the acuity and complexities of the patient group. Data given by the provider stated that no shifts were unfilled or fell below safe staffing levels during the same time period. Although the use of agency staff was high, to ensure consistency for patients the service had contracted some agency nurses to work on the ward for a longer period of time or until the service had filled vacancies. The hospital manager told us that ward managers ensured that they balanced staffing to ensure that there were no shifts managed by a team of only temporary staff.

We reviewed the staffing rotas from 1 January 2018 to 4 February 2018. There were always two qualified nurses working on the ward during each day and night shift.

Qualified nursing staff were available and visible to patients on the ward throughout our visit. The two patients we spoke with told us that staff were visible and that they had not had experience of staff cancelling their leave or activities due to staffing shortages. The provider showed us data which they had collated confirming that staff had not cancelled any patient leave or activities between 1 October

2017 and 16 February 2018. The ward had two activity co-ordinators who conducted on ward activities with patients and therefore staff would not cancel these in response to staffing changes or shortages.

There was enough staff to carry out physical intervention with patients should they be required. The service had trained all staff in the management of violence and aggression and staff from other wards would also attend the ward for support as required.

There was adequate medical cover day and night. A consultant and specialty doctor supported staff during the day. At night there was an on-call doctor who would attend the ward as required within an adequate time period. Staff told us that doctors were always contactable and available for support.

Prior to the inspection we asked the service to provide us with evidence of staff training. Cygnet Health Care Ltd had a training compliance target of 95%. Staff carried out mandatory training in twenty areas which included; basic and intermediate life support, food hygiene, infection prevention and control, information governance, the Mental Capacity Act and Deprivation of Liberty Safeguards and the Mental Health Code of practice. Staff had undertaken training in dementia awareness, but this was not mandatory training. Eighty-five percent of training did not meet the provider's own target. Five areas were below 75% compliance including the Mental Health Act Code of Practice (33%), infection prevention and control (70%), information governance (70%) and the Mental Capacity Act and Deprivation of Liberty Safeguards (73%) and information governance (70%). We saw a direct impact on patient care in relation to some of these areas of training for example infection prevention and control and the Mental Capacity Act and Deprivation of Liberty Safeguards.

The provider told us that some areas of training were below 75% because of information technology issues lasting three months which had prevented staff from carrying out online training. Mental Health Act training was below 75% because the provider had recently moved from an online to face to face training package to provide more detailed training to staff.

Assessing and managing risk to patients and staff

Between 1 May 2017 and 31 Oct 2017 staff had used seclusion with two patients and long term segregation with one patient. We reviewed both records of seclusion and found them to be in good order. The use of this restrictive intervention was proportionate to the risk presented by the patient.

Between 1 January 2017 and 1 June 2017 there were 378 restraints with 55 patients, nine of them that taken place in the prone (face down) position.

The number of restraints had increased to 419 with 57 patients between 1 July 2017 and 1 December 2017, 12 of these had taken place in the prone (face down) position.

We reviewed the risk assessments of seven of the 11 patients admitted to the ward at the time of the inspection. Every patient had a thorough and detailed risk assessment completed within 24 hours of admission and staff updated these monthly or after any incident and in multi-disciplinary team meetings with the involvement of all professionals. Staff used a recognised risk assessment tool the 'short term assessment of risk and treatability'.

The service had several blanket restrictions in place. A blanket restriction is a rule which a provider puts into place for all patients regardless of their risk level or detention status. These blanket restrictions included locked doors to the kitchen, dining area and sensory room, patients limited to one bottle of fizzy drink per day, patients' fizzy drinks and snacks were locked away in the kitchen and they needed to ask staff permission to get them, and staff also counted the cutlery in and out before and after each meal time.

Staff told us that patient snacks and drinks were restricted for safety reasons because some patients on the ward were at risk of choking. They told us that staff locked doors to prevent access to areas where some patients may be at risk. The ward manager was aware of the restrictions and had conducted a blanket restriction audit but had not yet made changes due to time constraints of being new into their post. However, there was no confirmed timescales as to when the service would rectify these concerns.

At the time of the inspection there were no informal patients admitted to the ward, all patients were detained under the Mental Health Act. There was a visible Mental Health Act information board which informed informal patients of their rights to leave the ward. However, the service did not provided this in accessible formats to meet the needs of the patient group.

The provider had a search policy in place (2017) and staff practice was in line with the policy. Staff searched patient belongings on their arrival. Staff asked patients for consent before searches took place. Any further searches would only take place if there was an identified risk following an individual patient risk assessment.

Staff undertook differing observation levels dependent on the risk presented by the patient at the time, both in regard to their mental health, physical health and mobility. Patient observation levels varied from every 30 minutes to continual observation. Staff were able to increase observation levels should this be required, and staff discussed observation levels at twice daily handover meetings and weekly multi-disciplinary team meetings.

During the inspection, we reviewed more than 40 incidents of restraint which had taken place in the three months prior to the inspection. We found that staff used the majority of restraint with patients who were unable to manage personal care and needed some low level of restraint to enable staff to support them to manage this. Following our inspection in November 2017, staff recording of the use of de-escalation techniques had improved which meant that we were able to see that the use of low level restraint was proportionate to the needs of the patient involved. Staff told us that they always used restraint as a last resort. However, patient care plans did not always discuss what interventions staff could undertake prior to the use of restraint to reduce the need for physical interventions, such as by the use of positive behaviour support planning or by involving families in the planning of patient care. The clinical manager and ward manager were aware of this issue and had begun to interrogate the ward's restraint data. They had already identified three patients involved in the highest uses of restraint and had decided to introduce positive behaviour support planning with this patient. However this was not in place at the time of the inspection.

National Institute for Health and Care Excellence guidance (NG10) recommends avoiding prone restraint, and only using it for the shortest time possible. The Mental Health Act Code of Practice states that "unless there are cogent reasons for doing do, there must be no planned or intentional restraint of a person in a prone position". This is because there is an increased risk of patient asphyxiation when this method is used. During our inspections of this service in June 2015 and November 2017 we told the provider that they must reduce the amount of prone restraint used with patients.

Since the time of our last inspection in November 2017 staff had used prone restraint on two occasions. When we asked staff about the main reasons for the use of prone restraint they told us that if a patient refused oral medications and there was a clear need to give medication via an intra-muscular route, this would be performed by staff with the patient in a prone (face down) position. Care records we reviewed supported that staff used this approach without evidence that an alternate method was always offered. However, in the same time period, staff had given intra-muscular medication to patients four times, but only twice in the prone position. This evidenced that staff could use other methods of administration.

The use of planned prone restraint is against national guidance. This is also against the provider's own policy for medication management (2016) which states that staff should 'take full account of the need to avoid prone restraint' and the provider's own 'management of violence and aggression' policy (2017) which states that staff must avoid intentional prone restraint.

We reviewed the provider's staff training package for the management of violence and aggression. The provider used the 'West London mental health NHS Trust' manual for training staff across Cygnet Health Care Ltd. The on-site management of violence and aggression trainer had annual refresher training on this model and then used this teaching with staff. At our inspection of this service in November 2017 we told the provider that they must ensure the availability of training to staff in methods of restraint with patients who are older and those who have mobility problems because we had a number of concerns about patients with unexplained bruising at that time. The corporate lead for the management of violence and aggression and hospital management team had completed a training needs analysis for the ward and were working on a proposal with the provider to amend the training.

The training model included training staff in the use of pain compliance where there was a threat to life presented by a patient. Pain compliance is a method of using painful stimulus on a patient to gain compliance during restraint.

Requires improvement

Wards for older people with mental health problems

The Mental Health Act Code of Practice states that staff are able to use these methods in situations where a threat to life is apparent and they are designed for use as an 'immediate rescue'.

Staff confirmed that they had been taught pain compliance techniques but told us that they cannot recall using them, and that they would always be a last resort in a life threatening situation. We did not see evidence in the records reviewed during the inspection that any incidents of restraint had used restraint holds that would have met the threshold for pain compliance.

Due to our previous concerns regarding unexplained bruising suffered by patients we asked the provider if they were able to provide us with any data or monitoring relating to the use of pain compliance on the ward. The management of violence and aggression lead had conducted an initial audit. This audit had identified that six of the 797 restraint records (<1%) within the twelve months prior to the inspection where staff had not thoroughly recorded the types of holds used during the restraint. This meant that it remained unclear what holds staff had used during these cases. In response to the initial audit, the on-site management of violence and aggression lead and clinical manager had created an action plan which included; conducting monthly audits of restraint documentation to review any use of pain compliance in detail, and staff re-training forums. The clinical manager would share the outcomes at monthly governance meetings with team managers to disseminate to ward staff in team meetings.

Between 31 October 2017 and 20 February 2018 staff made seven notifications to the Care Quality Commission. Staff had raised six of these with the Local Authority as safeguarding alerts, as one notification did not require a safeguarding referral.

Four safeguarding alerts related to patient falls or unexplained injuries and two related to physical healthcare concerns. Of these concerns, one was not substantiated and the remaining five were ongoing investigations. Since the time of our last inspection in November 2017, the recording and acknowledgement of safeguarding concerns had improved. During the inspection we saw that staff reported incidents of safeguarding when necessary and had a good knowledge of safeguarding and how to report.

The service had a good system of working with the Local Authority. The clinical lead met regularly with the safeguarding lead from the Local Authority to discuss ongoing or open safeguarding concerns, and the quality of referrals. The Local Authority had commented that referrals to them, from the service had improved. The hospital also had a safeguarding tracker in place to log and monitor safeguarding concerns and responses which managers discussed at local governance meetings.

During the inspection we checked the arrangements for managing medicines on the ward. Medicines were stored securely and according to manufacturer's instructions in a locked medication room on the ward. Each day nursing staff checked the fridge and room temperatures to ensure the correct and safe storage of medicines to ensure they worked correctly, and reported any concerns to the maintenance staff and via incident reports, taking advice from pharmacists when they identified errors. Nurses also completed nightly medication stock checks and controlled drugs checks.

A pharmacist visited the ward weekly to conduct specific checks of medication cards and storage. They also completed a detailed monthly and quarterly pharmacy audit which included checks of the clinic rooms and emergency equipment and controlled drugs. The pharmacist provided reports to the ward manager and at monthly clinical governance meetings.

We reviewed medication audits for quarter two and quarter three and found that staff had taken action following audits and made changes to practice to improve results. There was a reduction in prescription writing errors from 0.5% to 0.2% and administration errors reduced from 2% to 1%.

We discussed prescribing practices with the lead consultant psychiatrist for the service. Doctors had prescribed some patients more than one anti-psychotic medication and doctors had prescribed some patients medication which was above recommended British national formulary limits. The consultant psychiatrist explained that all doctors within the hospital took part in an audit of prescribing practice to monitor this. They also said that the multi-disciplinary team meetings discussed the use of medication above limits to continually review the potential risks against the benefits of the medications prescribed. Doctors felt assured that staff had undertaken

regular physical health checks with these patients to monitor any potential impact on their physical health and staff undertook monitoring such as via the use of the Lester tool.

Due to the patient group admitted to the ward, patients had a variety of additional needs such as; long term physical health conditions, mobility issues, falls, nutritional risks and skin integrity concerns. Patients had care plans in place which addressed these needs, and there had been an improvement in their management since the time of our last inspection in November 2017.

Since the time of our last inspection the service had been responsive to our concerns about the number of falls taking place on the ward. They had delivered training to staff in correct moving and handling techniques and improved patient access to handrails and call alarms. Each patient now had an initial mobility assessment in place conducted on admission.

There had been 18 patient falls on Fairfax ward between 1 September 2017 and 11 November 2017, one of these resulted in a serious injury and two others in hospital admission. There were 20 further patient falls between 16 November 2017 and 9 January 2018. However none of these resulted in a serious injury to the patient, four resulted in minor cuts or abrasions and staff recorded the remainder of incidents as no harm. The ward manager had introduced a post falls assessment and staff were using this at the time of the inspection. All staff had also received in-house training in 'recognising and assessing medical problems in psychiatric settings' to improve staff response to illness and injuries in the patient group in response to a previous serious injury.

The occupational therapist had begun to conduct a falls audit since our last inspection and the service was aware that this continued to be a risk for this patient group. They had begun to interrogate their falls data in detail including the time of the fall, area of the ward and the staff on shift to enable them to complete a falls strategy for the ward. They were also in the early stages of working with a similar service within the Cygnet group to discuss ongoing falls strategies.

During the inspection we witnessed a patient fall on the ward. Staff responded appropriately and used correct moving and handling techniques and an immediate post fall assessment and the patient was able to mobilise independently.

Assessment of risk in relation to eating and drinking for each patient had improved since the time of our last inspection in November 2017. Staff followed an eating and drinking protocol and assessed patient needs. We saw that where staff had identified patients as being at risk of choking, this was clearly visible during meal and snack times.

The hospital's registered general nurse supported patients with long term physical health conditions. External agencies such as district nurses and speech and language therapists had attended the ward to support staff with patients with complex needs.

Track record on safety

The service reported that there had been four serious untoward incidents between 1 November 2016 and 30 November 2017.

Of these four incidents two related to patient on patient assault, one related to poor moving and handling techniques, and one was a serious injury caused by a patient fall. Staff had investigated and resolved all but one of these incidents.

There had been significant changes to processes and procedures on Fairfax ward in relation to the most recent serious incident where a patient had fallen and suffered a broken neck of femur. Staff were able to give examples of the improvements made following serious falls incidents, including the implementation of post fall reviews.

Reporting incidents and learning from when things go wrong

All staff were able to report incidents using a paper based system incident recording and reporting system. The ward manager and clinical manager reviewed all incidents.

If incidents met the provider's serious incident criteria, ward managers completed 24 hour and 72 hour reports. The corporate risk manager reviewed these and decided whether a full investigation and root cause analysis were required. An external case manager completed the investigation and root causes analysis within 20 days of the

date of the incident. The investigation manager shared the final serious incident reports at monthly governance meetings. The clinical manager oversaw any actions required from reports via the service's 'overarching local action plan'. However we reviewed the 'overarching local plan' during the inspection and found that a number of incidents and concerns raised since the time of our last inspection were not included in this plan. These included; falls incidents, changes to prevention and management of violence and aggression training, uses of pain compliance and infection control.

Since August 2017, the service had begun to re-focus their approach to governance to ensure closer involvement at ward level. Ward managers received monthly data packs with interrogation of incident data per ward. They presented this data at monthly clinical governance meetings to discuss action they would take to reduce identified risks. There was an expectation that team managers would then share learning via the local learning lessons log and in team meetings and supervision with ward level staff.

We saw little evidence of this taking place in practice. Staff told us that it was difficult to find time to review emails and learning logs, and that debrief following incidents was rare, we saw on restraint and incident reports that staff rarely recorded any debrief discussions. We reviewed team meeting minutes for the two months prior to the inspection and saw that there was no discussion of lessons learned from incidents within the ward, hospital or provider wide. However the ward manager had recognised this, and had recognised the importance of support to staff and an increase in morale. They had brought into place five minute staff de-brief sessions at the end of each shift for staff and reflective practice forms to increase learning and reduce staff stress levels. The clinical manager had a plan to change the format of team meetings to bring this into line with a structured agenda which matched the agenda used in clinical governance meetings; the revised supervision agenda also took the same format. The plan was to make these changes in March 2018.

Duty of Candour

The Duty of Candour regulation explains the need for providers to act in an open and transparent way with people who use services. It sets out specific requirements that providers must follow when things go wrong with care and treatment. The provider had a Duty of Candour policy in place and staff understood the need to be open and transparent when they had made mistakes and to make written apologies when they should. Staff had considered the use of the regulation when things had gone wrong with patient care and we saw evidence of this in incident recordings.

Are wards for older people with mental health problems effective?

(for example, treatment is effective)

Requires improvement

Assessment of needs and planning of care

We reviewed the care records of seven of the 11 patient admitted to the ward at the time of the inspection. All patients had thorough care plans in place which staff completed within 24 hours of their admission to the service.

Staff had a clear understanding of the importance of monitoring and managing the physical health needs of patients. All patients had a physical health examination completed by the admitting doctor on admission. Staff used the modified early warning scores system to record patient's physical health observations and the frequency of this was dependent on the needs of the patient.

Where patients had long term physical health conditions, they had a specific care plan to support these needs. Staff received support in meeting these needs from the registered general nurse based on site. The nurse was responsible for liaising with other professionals as required such as speech and language therapists and district nurses for patients requiring support with wound care. The ward specialty doctor was aware of the importance of these issues for the patient group and was clear about the importance of a parity of esteem between physical and mental health needs for the patient group.

Staff updated care plans monthly or more regularly if there had been a change in need. They also discussed care plans in weekly multi-disciplinary team meetings. Care plans were thorough and holistic and discussed areas including; safety planning, self-care, physical health needs, relationships, safeguarding and life skills. We saw little evidence of discharge or recovery plans in place in the

patient files we reviewed. However, staff told us that they would usually discuss this in multi-disciplinary team meetings. Without a specific care plan, individual goals for discharge are not clear for the patient or their family.

The patient care plans we reviewed did not contain positive behaviour support frameworks and planning. The provider told us that they used a method of 'my safety planning' with patients which was a model of positive behaviour support. However, this was not present in the care plans we reviewed. Care plans did not discuss patient's preferences, sensory needs or reasons for challenging behaviour and there was no evidence that staff had discussed with patients and their families.

Staff did not always complete care plans collaboratively with patients. Staff invited patients, their carers and advocates to multi-disciplinary meetings where they discussed the patient's progress. The involvement of family was clearer in the multi-disciplinary record; however this information did not transfer into the patient care plans. None of the patient care and treatment files we reviewed contained communication or sensory needs planning.

Information required to deliver care was stored in a paper file on the ward; all staff inputted into the same file which was contemporaneous and logical to follow and stored securely.

Best practice in treatment and care

All policy and procedures used by staff referenced current guidance such as the Mental Health Act Code of Practice and National Institute for Health and Care Excellence guidance on short term management of violence and aggression (2015). The service underpinned the management of medication with a range of guidance including the clinical guidelines on the management of schizophrenia (2009). The service ensured that they embedded this through regular audits of the storage and prescribing of patients' medication, and closely monitoring the physical health of patients prescribed anti-psychotic medications.

Patients had access to psychological and occupational therapies recommended by the National Institute for Health and Care Excellence. The service employed a clinical psychologist, a forensic psychologist and one assistant psychologist; there was a vacancy for a further assistant psychologist. Psychology staff would usually deliver therapy on a one to one basis on Fairfax ward due to the needs of the patient group rather than in group settings, they were able to offer cognitive behavioural therapy. Occupational therapists also followed best practice guidance with patients using the model of human occupation screening tool and community and life skills evaluations.

Access to and monitoring of physical healthcare for patients was a priority for the service due to the nature of the patients admitted to the service. A physical healthcare policy was in place and the service employed a registered general nurse to oversee the physical long term health care needs of patients. The registered general nurse attended all patient multi-disciplinary meetings to highlight risks and discuss the needs of patients with long term physical health conditions. They also maintained liaisons with professionals outside the service where patients need additional assistance such as district nurses. The service continued to struggle with access to GP services. However managers had entered this concern on the service risk registered and senior managers continued to work with local commissioner to resolve the concern.

Staff used recognised rating scales to assess and respond to patients' physical health needs including; the 'Lester' tool to assess the cardio-metabolic health of patients, as well as the modified early warning score system. The service also monitored the nutrition and hydration of patients. The service used a variety of other measurement and outcome tools to support treatment and care, including; mental health clustering scores, cognitive evaluation and completion of multi-agency public protection assessments.

The service undertook a variety of audits to monitor the quality and safety of the service. The hospital had an annual clinical audit programme which included audits of the following areas completed by senior staff:

- residential environmental impact scale
- restrictive practice, seclusion, restraint and prone restraint audit
- clinical file audit
- rapid tranquilisation audit
- physical health audit
- Fairfax ward outcome measures audit

Ward level staff also completed clinic room, and fire and environmental audits. The management team above ward manager level met monthly in a clinical audit meeting

where they discussed the outcomes of audits conducted each month and identified and reviewed action plans in response to concerns to make improvements. They identified learning to disseminate to ward level teams.

However we noted that outcomes from day to day audits such as infection control and environmental audits where not discussed in governance meetings. This meant that the important outcomes from these audits did not have specific action plans. It was difficult to see what action was taken when improvements where required and how this fed into governance and back to ward level.

Skilled staff to deliver care

The service had experienced and qualified staff from a range of different disciplines including; psychiatry, psychology, mental health nursing, general nursing, occupational therapy, healthcare support workers and substance misuse services to provide input into the ward. The service supported staff to complete the 'care certificate' and had also sponsored some staff to obtain nursing qualifications depending on their level of experience.

Staff received an appropriate local and corporate induction, and all temporary bank staff received the same induction as permanent staff. The service had an individual ward induction for new starters or agency staff.

The service provided us with data which stated that all clinical and therapy staff had received an appraisal within the last twelve months and 70% of non-clinical or ancillary staff had received an appraisal within the last twelve months.

All Doctors who needed to had completed re-validation within the last twelve months.

The provider had a clinical supervision target of 90%. The provider told us that in the twelve months prior to the inspection clinical supervision compliance was 74%. Between 1 June 2017 and 1 December 2017 monthly supervision compliance was between 96% and all staff had received monthly clinical supervision. However clinical supervision had fallen to 54% by January 2018. The ward manager explained that they were new to the ward (within three months), and they understood the importance of staff supervision and planned to roll out a new supervision format with all staff on the ward in March 2018. Staff had limited opportunities for reflective practice sessions, supervision, de-brief and team meetings. They told us that morale on the ward was low. Staff attributed limited opportunities for supervision, debrief and team meetings to pressures on the ward due to the acuity of the patient group.

Staff told us that they could access additional training to mandatory training staff, including dementia awareness, clozapine management, engagement and observations, prescription writing and security. The hospital manager had also arranged for staff from the ward to attend external falls prevention training in early March 2018.

Multi-disciplinary and inter-agency team work

There was a range of professional disciplines available at the service that made up the multi-disciplinary team, including; psychiatry, psychology, mental health nursing, general nursing, occupational therapy, and substance misuse.

We observed a multi-disciplinary team meeting during the inspection. The meeting included the consultant psychiatrist, specialty doctor, occupational therapist, clinical team leader and the patient's wife. The psychologist had also contributed to the meeting in a report format. Staff invited the patient to the meeting but they did not attend.

The meeting discussed the patient's progress, and any incidents. Staff updated risk assessments and care plans throughout the discussions. We saw that the doctor gave all parties the opportunity to contribute to action plans for the patient. Staff discussed the patient and their needs in a kind, dignified and respectful manner throughout the meeting.

There were twice daily handover meetings on the ward at the start of each shift. We observed a handover meeting of the late shift during the inspection. The nurse in charge of the day shift gave the handover to the incoming staff team. The handover was detailed and staff discussed each patient in turn including medication, mobility and falls, activities, pressure relief, risks and the outcome of leave. Staff knew patients and their needs well and there was good communication about the safety of patients and any changes to medications or equipment needed.

The service had effective working relationships with professionals outside of the service. Ward managers remained in contact with commissioners and bed

managers. Staff also worked closely with other professionals such as district nurses who came into the ward to treat patients. The hospital continued to work with local GP services to enable access for Fairfax patients to their services. This had been an ongoing issue for the patient group however it remained high on the agenda for the medical director and hospital manager who met regularly with commissioners in order to find a resolution for this issue.

Adherence to the MHA and the MHA Code of Practice

At the time of the inspection 33% of eligible staff had received training in the Mental Health Act. This training was mandatory for qualified staff and there was a plan in place to roll this out to remaining staff within twelve months. The hospital manager explained that the service had recently moved from an online training course to a more detailed and updated face to face training course which had caused a time delay in training compliance. Staff we spoke with had a sound understanding of the Act and knew who they could refer to for support with a complex issue.

The service had on on-site Mental Health Act administrator. Staff knew who this staff member was and told us that they were accessible and offered advice and guidance to staff.

The Mental Health Act administrator had oversight of admission paperwork, monitored the dates for patient's tribunal meetings and renewals, and provided reminders to psychiatrists when action was required. They also completed regular audits of paperwork to it was correct and complete and that staff were applying the Act appropriately. The administrator and their assistant were well qualified for their role and had robust systems and processes in place. The corporate lead for the Mental Health Act was based at the service and was also available to provide guidance and support.

We reviewed the provider's policy 'for the administration of the Mental Health Act' (2016). The Mental Health Act manual for staff sat alongside this policy. The policy referenced relevant legislation including the Mental Health Code of Practice (2015).

We reviewed the Mental Health Act paperwork of seven patients during the inspection. Paperwork was stored with patient files and in good order. All patients had valid consent to treatment assessments and treatment certificates were in place where these were required. All patients' records contained copies of their detention papers. Staff recorded that they explained patient's rights to them regularly as per the Act. Patients had access to section 17 leave as granted by the responsible clinician on the ward and doctors clearly recorded this in a file kept on the ward. However we did see in one record that one doctor had crossed out a section 17 leave date to renew it rather than complete a new form which was against good practice guidance.

The ward had a Mental Health Act information board visible on the ward for patients and their carers. The hospital gave information leaflets to patients and their carers throughout admission to explain rights, policies and procedures. Staff supported patients to access an independent mental health act advocate where they lacked capacity. However we did not see information provided in accessible formats for patients with limited understanding. However staff told us that they could easily access this information if it was required.

Our Mental Health Act reviewer last visited the ward in February 2017. They raised concerns that patients did not always have access to independent mental health act advocates, and that patients did not always sign their care plans. They also had concerns about the storage of expired certificates of treatment. Staff had rectified these concerns at the time of our visit.

Good practice in applying the MCA

At the time of the inspection 72% of eligible staff had received training in the Mental Capacity Act and Deprivation of Liberty Safeguards. This training was mandatory for all staff.

We reviewed the provider's policy for the Mental Capacity Act (2016). The policy was thorough and explained the principles of the Act and contained relevant guidance including updates from the 2014 supreme court judgement in relation to Deprivation of Liberty Safeguards.

Patients were able to access the support of independent mental capacity advocates if required.

However, staff had a limited understanding of the Act and its principles; particularly in regard to its interface with the Mental Health Act. In seven patient files we reviewed we did not see any examples of staff undertaking decision specific capacity assessments with patients, (other than consent to treatment under the Mental Health Act) or evidence of staff undertaking and documenting best interests discussions.

Requires improvement

Wards for older people with mental health problems

Staff relied on doctor's consent to treatment under the Mental Health Act capacity assessments and had a limited understanding of what areas of a patient's care and treatment this covered.

For example, we reviewed the file of one patient who doctors had prescribed medication for diabetes to. Staff delivered this medication covertly (hidden in food). As this was a physical healthcare condition for which the patient lacked capacity to consent to treatment, we would expect that staff undertake a two-stage capacity assessment with the patient, as their care plan stated that they were "completely unable to communicate needs". There was no discussion around the patient's capacity or their best interests in any of the multi-disciplinary meeting minutes we reviewed. There was also a time when a doctor prescribed anti-biotics to this patient and there was no assessment around this matter.

At the time of the inspection there were no patients on the ward under the authority of a Deprivation of Liberty Safeguard. The service had made one application within the last twelve months which they had withdrawn when the service discharged the patient.

There was no audit in place for adherence to the Act and no Mental Capacity Act lead at the service.

Are wards for older people with mental health problems caring?

Good

Kindness, dignity, respect and support

During the inspection we completed two 'short observational framework for inspection' observations. We used this tool to spend time observing patient and staff interaction during lunchtime and also in the afternoon in the communal area of the ward. All of the interactions we observed were kind, caring, and staff spoke with patients with encouragement, dignity and respect.

We observed staff talking with patients about their favourite things and giving them choices for example at lunchtime about what they would like to choose to eat.

In the handover and a multi-disciplinary team meeting we observed staff discussing patients in a kind and dignified manner. Staff knew patients well and were able to discuss their individual needs.

We gave opportunities to all patients admitted to the ward to speak with us during the inspection. However, due to the nature of their illnesses, only two patients wished to speak with us. One patient told us that staff 'were kind' and 'made me feel better'.

The involvement of people in the care they receive

The service had a robust admission process which included orientation to the ward and the support of a doctor and named nurse for every patient on admission. There was not an admission booklet available for patients or carers to support them to orientate to the ward at the time of the inspection. This was available for other wards at the hospital. The hospital manager told us that this was being re-designed and would soon be available on the wards.

Where patients were able to contribute to their care plans, staff asked them to make comment on them. Staff also worked collaboratively with patients, their carers and other professionals involved in their care in multi-disciplinary team meetings to ensure a holistic and multi-faceted approach to care. However, in the care plans we reviewed it was not possible to see how staff had documented the patient, or their families' views on care plans. Staff did not use this as a method to provide less restrictive care to patients, for example by asking families for needs, wishes and preferences for those unable to communicate these themselves. During the inspection clinical manager told us that evidencing service user involvement in care planning was a recognised area for improvement.

The service no longer had a patient involvement lead and had recognised in audits and governance meetings that this was a loss to the service and was restricting patient's opportunities to give feedback about their care. Many of the patients admitted to the ward had difficulties with verbal communication; however staff were able to listen patiently and meet their needs. None of the patient files we reviewed contained a communication plan for patients who had difficulties with verbal communication.

Advocates visited the wards regularly and supported patients to voice concerns or complaints. We spoke with

Requires improvement

Wards for older people with mental health problems

one of the advocates who told us that they visited the ward weekly and that the service invited them to monthly governance meetings to share feedback about their work with patients.

Staff told us that they encouraged patients and carers to give feedback about the service. The hospital provided examples of the formal routes for service users to provide feedback to the service including community meetings, service satisfaction surveys and family and friends surveys.

We spoke with two carers of patients admitted to the ward during the inspection; we attempted to contact other carers but they were unavailable. Both carers agreed that that staff were welcoming, friendly and approachable and kept in regular contact with families. They advised that staff invited them to meetings and discussions about the care of their relative. Both felt that they would feel comfortable raising concerns or complaints with staff.

The service used the 'friends and family' test to ascertain feedback about care and treatment. Between 1 May 2017 and 30 December 2017 there had been two responses about Fairfax ward both of which stated that would be 'extremely' likely to recommend the service. They described staff as friendly and helpful. The service had an action plan in place to increase the poor return rate for the service which included the use of information technology to allow visitors to leave feedback and allow more detailed review of the service.

The provider had also conducted a service user satisfaction survey with patients. The survey asked for feedback on; environment, care and treatment, and therapies and information and rights. There were fifteen responses, however only five patients answered the majority of questions. The most positive responses were that 100% of the patients who responded; knew how to make a complaint, felt that they had their rights explained, felt that staff had never discriminated against them, they felt treated with dignity and respect, had their confidentiality protected, and felt better than when they had been admitted to the service.

However, negative responses were that 50% of patients did not feel satisfied with their accommodation, 40% did not always feel safe and 60% felt that staff disturbed their sleep during the night. The service had an action plan in place which we reviewed during the inspection to address the areas of concern raised by patients in this survey.

Staff did hold community meetings with patients and there were no carers groups or forums available. This meant that there was limited opportunity for patients to give feedback about the service. Staff told us that this was because some of the patient group would be unable to participate. However we observed during the inspection that there were other patients with functional difficulties who would be able to contribute to meetings.

Are wards for older people with mental health problems responsive to people's needs?
(for example, to feedback?)

Requires improvement

Access and discharge

At the time of the inspection there were 11 patients admitted to Fairfax ward which had 22 available beds. Between 1 May 2017 and 31 October 2017, the average bed occupancy rate was 82%.

Where patients had pre-arranged leave to other settings, for example for an overnight stay, the service did not use these beds for other patients until the service had fully discharged the patient. We saw examples of patients leaving the ward for admission to acute hospitals for physical healthcare and being able to return to their allocated bed.

The service admitted patients from across the country and therefore cared for some patients who were from outside of the local area. However, there remained beds available for patients in the local catchment area. The service kept five beds for acutely unwell patients needing more emergency care, and the remaining beds were available for patients with longer term needs. Staff could provide care to end of life for some patients if required.

We did not see any examples of patients being transferred to acute or psychiatric intensive care wards. Should a patient's condition deteriorate, staff would increase their observations and staffing levels to safely manage them within the ward environment rather than consider transfer to another setting to support continuity of care and because staff on the ward had the specialist knowledge and experience to support the patient group.

Requires improvement

Wards for older people with mental health problems

Between 1 March 2017 and 1 February 2018 the service had admitted 41 patients and discharged 46. This demonstrated an ongoing focus on discharge and recovery to less restrictive settings.

Between 1 November 2016 and 31 October 2017 the service had not readmitted any patients to the service within 90 days of their discharge.

The facilities promote recovery, comfort, dignity and confidentiality

Patients had access to facilities on the ward which included a communal lounge (which contained a small open kitchenette) and two quiet lounges. There was a sensory room and dining area; however staff locked these rooms so they were not open access for patients. Patients also had access to outside space which was securely enclosed but there was open access throughout the day for patients.

Patients used the quiet lounges to meet with visitors, and for assessments or one to one activities. Patients were also able to access visitor's rooms, multi-faith rooms and meeting rooms in other areas of the hospital.

We observed patients having lunch during the inspection and the food was hot, appeared appetising, and was of good quality. Staff were able to cater for patient's individual needs and offered patients choices at each meal time.

Patients were able to use the small kitchenette area in the communal lounge to make hot drinks if they were able. However all patient's own snacks and fizzy drinks were locked away by staff and patients needed to request permission from staff to access them. Staff told us that this was to manage choking risks in the patient group. However this was not individually risk assessed and therefore a blanket restriction. It also reduced patients' autonomy and independence.

Patients were able to personalise their bedrooms. However, the bedrooms on the ward were in the process of a rolling programme refurbishment. Due to this saw that six patient bedrooms had no lockable storage to secure their possessions. Staff told us that this was because not all patients were able to manage a key or secure code to lock away their things. One patient we spoke with told us that he was disappointed he did not have anywhere in his bedroom to lock away his personal possessions. We also saw that six patient bedrooms had no wardrobe or space to hang clothing and therefore patients kept this in piles on their bedroom floors. This did not provide dignity and comfort for patients. Staff told us that they had removed hanging spaces to allow for renovation of these rooms.

Patients had access to a range of activities. The ward had two permanent activity workers who spent time with patients undertaking games and music sessions. During the inspection we saw lots of activity taking place with patients in the communal lounge such as bingo and card games. Staff told us that activities were also available during evenings and weekends.

Meeting the needs of all people who use the service

The ward was accessible to patients with mobility needs because it was located on the ground floor of the hospital. The ward had some bedrooms which the provider had designed to be accessible for those with mobility needs. They contained fixed ceiling hoist equipment.

The ward had a detailed patient information board with information about patient rights, treatments, health conditions and medications. However we could not see that any of the information was readily available in an accessible format to meet the needs of the patient group. However staff said that they could get this for patients who needed it. Patients also had limited access to information about making complaints because the ward contained only one small complaints poster which was small and not clearly visible to patients. However patients had weekly access to advocacy support and were encouraged to use this support to make complaints or raise concerns about care and treatment. Staff had access to interpreters who they could invite to the ward to support patients where English was not their first language.

Catering staff were able to meet the needs of individual patients. Menu's had vegetarian options and because staff cooked food on site they could meet individual needs and preferences including cultural and religious needs. Staff supported patients with additional eating and drinking needs during mealtimes.

The current statement of purpose for the service described the ward as 'older male's mental health'. It described the profile of patients admitted to the ward as those with a primary diagnosis of a functional mental health disorder such as schizophrenia, psychosis or bi-polar affective disorder. The profile also stated that the service was able to support patients with a secondary co-morbid diagnosis of

organic mental health disorders such as vascular dementia, Alzheimer's disease, or Korsakoff's syndrome and patients with long term physical health conditions. We saw that the majority of the patients admitted to the ward had a primary diagnosis of organic mental disorders such as dementia and Alzheimer's disease. Staff told us that approximately 70% of the patients admitted had organic rather than functional mental health disorders. The nature of diagnosis and acuity of patients had changed over time, meaning that the service model was attempting to provide care for a patient group, who had significantly different needs. For example, the majority of patients had dementia related illnesses but the service had not designed the ward in a dementia friendly manner. There was a lack of good lighting, contrasts of colour, sound absorption and pictorial signage. Conversely we spoke to one patient with a high functioning mental health condition during the inspection who felt unhappy that staff designed activities for patients with dementia and there was not much stimulation for him.

Listening to and learning from concerns and complaints

Between 1 November 2016 and 26 October 2017 the ward had received six complaints. Within the same time period, the ward had received nine compliments.

We reviewed compliments received by the service from relatives of patients between 27 December 2017 and 5 January 2018, which included feeling relieved about the care of their relative, staffing making significant improvement's to their relative's health, and described staff as 'brilliant'.

Of the six complaints received the service did not uphold three of them, one was upheld and two were partially upheld. Patient's relatives raising concerns about the quality of health and personal care had made The two partially upheld complaints included patients' relatives raising concerns about the quality of health and personal care, and the complaint which the service had upheld related to staff keeping a relative waiting during a visit.

We reviewed three complaints during the inspection; staff had resolved all three at a local level. There was a detailed complaints procedure in place which included staff sending an initial acknowledgement letter to the complainant, a further response within five working days and a more detailed response within 20 working days where this was required. The service managed complaints impartially by choosing an investigator from a different service within the hospital. Staff were aware of the complaints procedure and less senior staff would seek advice from more qualified staff. Patients had the support of advocates who supported them to raise concerns; however there was limited access to complaints information and opportunities to complain due to a lack of community meetings.

Staff had responded to two of the complaints within the timescale outlined by the provider's policy. In one complaint staff did not meet the timescale because they did not send a final letter of reply to the complainant until four months after the initial complaint due to staff sickness.

All three complaints investigations were thorough and contained clear actions for improvement.

Staff were not able to tell us about how the service had made changes and improvements following complaints. This was because managers did not share improvements in quality and learning from complaints according to the hospital's own processes. In order to monitor quality and improvements, the complaints process involved the investigator creating a quality improvement plan for each complaint received. Senior managers told us that they reviewed these action plans via the 'overarching local action plan' in governance meetings and managers then disseminated learning to staff at ward level. Managers were not following this process because the overarching local action plan noted 'complainant satisfaction' with no further actions for every complaint (even where quality improvement plans were present).

Ward level staff knew the complaints procedures and referred to senior staff as appropriate. Patients and carers we spoke with told us that they knew how to make complaints. Advocates also supported patients to voice concerns and complaints.

Are wards for older people with mental health problems well-led?

Requires improvement

Vision and values

Requires improvement

Wards for older people with mental health problems

Cygnet Health Care Ltd had an overall vision to be the 'provider of choice'. The local hospital strategy was 'to provide superior quality healthcare that; service users recommend to family and friends, clinicians prefer for those in their care, commissioners first choice for their service users and employees are proud to work for".

The values of the provider were:

- Helpful
- Respectful
- Honest
- Empathetic
- Responsible

The values were displayed throughout the hospital and available to staff on the ward. The majority of staff we spoke with were able to describe the values. During the inspection we found that the behaviour of staff across the service displayed these values in their direct work with patients.

At a ward level staff were encouraged to discuss the values of the organisation in supervision, team meetings, and through the appraisals process. However there was limited opportunity for this at the time of the inspection. The ward manager and clinical manager had recognised this had had designed a new supervision and team meeting structure which would incorporate this from March 2018.

Staff knew who the most senior managers in the organisation were because they visited the hospital on a six monthly basis for governance meetings.

Good governance

The hospital had a clear governance structure in place. On a monthly basis all senior staff from ward manager level met for clinical governance meetings. A standardised agenda was discussed which included; actions from the previous meeting, an advocacy presentation, medication management, compliance with the Mental Health Act, risk management, serious incidents, restraint, seclusion, safeguarding, serious incidents, audit outcomes, areas of concern, compliance and regulation, quality assurance updates, therapies, physical health, complaints and compliments.

Since August 2017 the hospital had begun to focus governance into ward level. On a monthly basis each ward manager received a data pack. This included information regarding areas such as; incidents, restraints, prone restraints and complaints and compliments. There was an expectation that each ward manager would present this information to the governance meeting and discuss actions for example in regards to reducing incidents of restraints. We were able to see that this was taking place.

On a six monthly basis the senior leadership team met with the board and corporate managers. Meetings took place on site and followed the same format as local governance to ensure the meeting followed up issues and concerns from a local level.

There were areas of governance which we found were effective and well established. Staff were appraised and supervised and had opportunities for additional training and development. The service planned staffing well, and ward managers ensured wards ran with safe levels of staffing. The service managed the use of temporary staff well, to provide consistency for patients.

We felt assured about the ability of the governance of the services to rectify our concerns because of the evidence in the significant work the service had completed since our last inspection in response to our concerns about the safety of patients on the ward. There was a positive influence on these changes from the hospital manager, newly appointed clinical manager and ward manager. The new clinical manager had plans in place to address concerns within the service about team meetings, debrief and supervision with the planning implementation of a new supervision and team meeting structure from March 2018.

The service worked to several key performance indicators to measure safety and quality, these included sickness, training, supervision and appraisal, complaints, safeguarding, serious incident reports, restraint and compliance. The service measured their performance against other Cygnet hospitals to indicate any areas in which the hospital was an outlier.

The hospital had a local risk register in place which fed into the corporate level risk register; there were two risks on the local risk register which were the recruitment of qualified nurses and physical healthcare GP provision for patients. The hospital manager updated the risk register on a monthly basis with notes of actions taken each month. Managers could escalate concerns to the corporate risk register after discussion with the corporate risk manager. The corporate risk register contained items which would be

a risk for the hospital such as; staff recruitment and retention, high dependency on agency workers, competitors, suicide and self-harm, failure to manage staff stress, high use of restrictive practices, and primary healthcare.

However, we identified some concerns relating to the governance structure and systems used.

Local managers agreed that the use of planned prone restraint for the administration of intra-muscular medication was not always appropriate. The corporate management of violence and aggression lead felt that this was the safest route. We could not see evidence of where managers had held these ongoing discussions, and how they highlighted this to corporate level governance. There was no evidence of a local action plan to address the concern.

In our inspection in November 2017 we told the provider that they must make changes to ensure they trained staff in the use of restraint with older people. At the time of the inspection the provider had completed a training needs analysis for the ward and the hospital manager and the managing aggression and violence lead were working on a proposal with the provider to amend the training. However at the time of the inspection no local or corporate changes had been made and there was no evidence of a local or corporate action plan to address the concern.

Staff did not always use the governance systems and processes in place effectively to ensure improvements in quality and safety. For example managers had not completed the local overarching action plan to include quality improvement plans from complaints and ward level audits. Staff were not always learning lessons from incidents or complaints because there were gaps in supervision, team meetings, and team de-briefs at the time of the inspection.

Staff did not always record the level of holds used during restraint. This meant that the service could not assure themselves that staff were using the appropriate level of holds with patients in restraint in line with their management of aggression and violence training and whether staff had used pain compliance techniques with patients. However the clinical manager and management of violence and aggression lead had created an action plan which included the continuation of these audits on a monthly basis, the findings fed back to ward managers and individual staff, changes made to the recording forms, and additional staff training.

Leadership, morale and staff engagement

The organisation valued its staff and had a number of methods in place to reward them, such as staff awards and opportunities for training and development.

The provider had conducted a hospital-wide staff survey in November 2017. Whilst results were not broken down and specific to Fairfax ward, the service had 79% of positive responses with the most positive responses being in relation to enjoying working for Cygnet Healthcare Ltd, feeling supported by managers, feeling valued, feeling encouraged to report incidents, accidents and near misses. Ninety-three percent of staff felt that they understood Cygnet's values and 71% of staff would recommend the hospital as a place to work.

Negative responses included that 56% of staff have felt unwell in the last twelve months due to work related stress, 29% of staff said there were not enough staff on their ward to help them to do their job properly. In response to the staff survey the management team had created an action plan for them to complete by May 2018. At the time of the inspection the service had completed all areas other than two, which were longer term projects relating to estates and information technology infrastructure.

During the inspection staff we spoke with talked of difficulties with low morale on the ward, but that this had begun to improve in the last two to three months. Staff felt it was difficult to take breaks and undertake de-briefs after incidents due to the acuity of the patients on the ward. The ward manager had plans to increase morale and had introduce compliments for staff, reflective practice sheets, debriefs at the end of shifts and planned a new supervision and team meeting structure for March 2018.

Although there had been a high turnover of staff in the last twelve months, the service were able to explain that staff had left the service for a variety of reasons such as; career changes, promotions and transferring to become temporary staff. The service had dismissed one staff member who they did not feel practised within the values of the service. The provider also managed sickness by rag rating sickness levels into green, amber and red ranges. A

Requires improvement

Wards for older people with mental health problems

green target was 2%, amber 2 to 5% and red above 5%. Managers reviewed this in governance meetings and created action plans for staffing levels reaching amber or red.

Commitment to quality improvement and innovation

The service was not currently part of accreditation or peer review schemes.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that staff plan care in a person centred manner by using the provider's 'my shared pathway' tool, to ensure positive behavioural support planning is implemented to reduce aggression and communication and sensory plans to aid communication with patients.
- The provider must ensure that care plans reflect the patient's voice and reflect the involvement of family and carers.
- The provider must ensure that staff provide care with dignity in respect on Fairfax ward, and that there are not blanket restrictions in place which reduce patient's opportunities for autonomy and independence.
- The provider must ensure that the statement of purpose for Fairfax ward is clear and ensures care and treatment is designed to meet the needs and preferences of all patients. There must be a dementia friendly environment to meet patients' needs. Staff must be trained in the care of patients with dementia.
- The provider must ensure that care and treatment of service users on Fairfax ward takes place with the consent of the relevant person and in accordance with the principles of the Mental Capacity Act.
- The provider must ensure that staff follow infection control procedures on Fairfax ward and that the service prevents, detects and controls the spread of infections.
- The provider must ensure that acts to control or restrain service users are proportionate to the risk presented and that staff always follow national guidance regarding the use of prone restraint.
- The provider must ensure that the governance systems in place assess, monitor and improve the quality of service provided are embedded, including restraint techniques with older people, recording of restraint holds, ward level audits, and complaints.
- The provider must ensure that they respond and take action regarding all complaints about the behaviour of staff and that managers address concerns about the culture of the acute and psychiatric intensive care wards in a timely manner. Patients on Fairfax ward must be able to give feedback about the service.
- The provider must ensure that records of patient restraint are clear, thorough and detail what method of restraint was used, including identifying the level of holds.
- The provider must ensure that staff undertake all mandatory training.

Action the provider SHOULD take to improve

- The provider should continue with plans to manage the recruitment of qualified staff.
- The provider should continue to scrutinise falls data on Fairfax ward and improve practice and focus on this area.
- The provider should continue with plans to re-introduce supervision and team meetings in line with the renewed structure.
- The provider should ensure that patients have opportunities to complain and that complaints information is clear on Fairfax ward.
- The provider should ensure that they have taken all risks, and issues of dignity, into account for patients who staff escort from Fairfax ward to the seclusion room.
- The provider should ensure that staff on Branwell ward are aware of fire procedures and the sound emitted by the alarm.
- The provider should ensure that staff undertake all seclusion reviews on time and in line with the Mental Health Act Code of Practice.
- The provider should ensure that staff carry out night time checks of patients in a manner which is comfortable for patients.
- The provider should ensure that all non-clinical staff receive an annual appraisal.
- The provider should ensure that discharge plans are clear and accessible to patients on Fairfax ward.

Outstanding practice and areas for improvement

- The provider should ensure that all patients on Fairfax ward have somewhere to hang their clothing and that all patients have somewhere secure to store their possessions in their own rooms.
- The provider should ensure that staff communicate effectively with carers and relatives.

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 9 HSCA (RA) Regulations 2014 Person-centred care **How the regulation was not being met:** On Fairfax ward the care and treatment of patients did not always meet their needs and reflect their preferences. This was because staff did not use the provider's own method of care planning in positive behaviour support or use communication and sensory plans to reduce the need for restrictive interventions. Fairfax ward was not designed in a dementia friendly manner. The statement of purpose for Fairfax ward did not reflect the diverse needs of the patient group to ensure that care and treatment was designed to achieve preferences and ensure patient's needs could be met. **This was a breach of regulation 9 (1) (b) (c) (3) (b)**

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect **How the regulation was not being met:** Patients were not always treated with dignity and respect on Fairfax ward because there were blanket restrictions in place which did not support the autonomy, independence and involvement of patients. **This was a breach of regulation 10 (1) (2) (b)**

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent **How the regulation was not being met:** Care and treatment of patients on Fairfax ward was not always provided with consent of the relevant person and staff did not always act in accordance with the provisions of the Mental Capacity Act. **This was a breach of regulation 11 (1) (2) (3) (4)**

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 **How the regulation was not being met:** Care and treatment was not always provided in a safe way for service users on Fairfax ward because there was not proper assessment of the risk of preventing, detecting and controlling the spread of infections due to the conditions of the laundry room. Staff sterilised but re-used patient medication pots and syringes. **This was a breach of regulation 12 (1) (2) (h)**

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment **How the regulation was not being met:** Patients were not always protected from abuse and improper treatment because acts to control or restrain service users were not always proportionate to the risk presented because staff used planned prone restraint for the administration of intra-muscular medication on all wards.

This section is primarily information for the provider

Requirement notices

This was a breach of regulation 13 (1) (4) (b)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **How the regulation was not being met:** Governance systems did not ensure that the service assessed, monitored and mitigated risks and improved the quality and safety of services. This was because there were a number of areas where risks were highlighted and the service had not always followed their own governance structure by implementing and reviewing time limited, measurable actions plans in response to concerns in relation to areas including complaints and ward level audits. This reduced the ability for staff to learn lessons and for the service to make improvements. The provider had not undertaken local action in accordance with previous concerns relating to the provision of training to staff working with older adults (restraint) in a timely and monitored way, although a training needs analysis had taken place there was no local or corporate action plans in place. There had been several complaints regarding the culture and behaviour of staff on the acute and psychiatric intensive care wards. The service had not taken action in response to these concerns to investigate the culture and make improvements to quality and safety. Staff did not always clearly record the levels of restraint holds they used. **This was a breach of regulation 17 (1) (2) (a) (b) (c)**

Regulated activity	Regulation

This section is primarily information for the provider

Requirement notices

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

Treatment of disease, disorder or injury

Regulation 18 HSCA (RA) Regulations 2014 Staffing

How the regulation was not being met:

Sufficient numbers of suitably qualified, competent, skilled and experienced persons were not deployed because not all staff completed the required levels of mandatory training as is necessary to enable them to carry out their duties across all three wards.

This was a breach of regulation 18 (1) (2) (a)