Cygnet Hospital Bierley

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?	**Good**
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 Bierley as **'requires improvement'** because:

- The hospital did not always provide safe care and treatment. We had concerns about the safety of the environment. Not all ligature risks had been appropriately risk assessed and those risks mitigated. The ground floor seclusion room had a viewing panel that could be obscured from the inside to prevent the use of staff viewing points, which could compromise patient and staff safety. Staff sometimes transported patients in restraint holds whilst using stairs, and there was no risk assessment for staff to follow for this procedure. On the psychiatric intensive care unit, the use of planned prone restraint was not always in line with national guidance. On the specialist personality ward patients did not have risk assessments, which staff regularly updated following every incident. There were some blanket restrictions in place on the specialist personality disorder ward and low secure forensic wards which were not included in the blanket restriction audits undertaken.
- The hospital was not always providing effective care. The monitoring of patient's physical health did not always take place according to best practice guidance or the provider's own policy. This included patients who the service had newly admitted to the psychiatric intensive care unit, patients who had received rapid tranquilisation and patients with long term physical health needs. Staff did not always monitor patients' potential side effects when they prescribed medication to patients. Staff did not always ensure patients gave consent and that staff recorded this in line with the Mental Health Act. When patients lacked capacity to make specific decisions, staff did not act in accordance with the Mental Capacity Act. Staff told us that they did not always receive monthly formal supervision.
- The service was not always responsive to the privacy and dignity of patients on the psychiatric intensive care unit, because staff brought patients through communal areas of the hospital when they were admitted to the unit. The ward was on the first floor of the hospital and did not have a separate entrance.
- There were elements of the governance processes across the whole service, which were not entirely effective. Audits taking place such as in physical health monitoring, ligature risk assessments and blanket restrictions audits did not ensure that all areas of risk and concern were monitored to ensure the senior managers were aware of all areas of concern. The service did not have written protocols or risk assessments in place for staff to follow when transferring patients to seclusion using stairs, or for admitting patients through communal areas, and using stairs to the psychiatric intensive care unit.

However:

- The hospital provided care, which was compassionate, and empowered patients to be active partners in their care. Patients described staff as kind and caring and we witnessed this behaviour during our inspection. Patients had access to advocates, and were able to make complaints and give feedback about the service they received. The service was routed in patient involvement and the feedback of patients was important to the leaders of the service.
- The hospital had a high quality therapy service, which encompassed a focus on patient recovery. The therapy service had received national recognition, and staff were proud and passionate about its achievements.
- Patients had access to therapies and activities, which were high quality, and met their emotional, spiritual and cultural needs. The services were discharge focussed and the length of patient admissions was appropriate to their needs. The service had made adjustments to meet the needs of patients with mobility needs, and was able to ensure person centred care for patients with specific cultural and religious needs.
- The senior leadership team were knowledgeable, qualified and experienced. They were passionate about improving the quality of care and treatment at the service. Staff felt valued and supported by managers and the service continued to request feedback from staff.

Summary of findings

- The service was committed to quality improvement and innovation and had been involved in a number of projects and awards all of which involved the support of patients.

Summary of findings

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Services we looked at:
Acute wards for adults of working age and psychiatric intensive care units; Forensic inpatient/secure wards; Personality disorder services.

Summary of this inspection

Background to Cygnet Hospital Bierley

Cygnet Hospital Bierley is an independent mental health hospital provided by Cygnet Health Care Ltd. The hospital provides care for 63 male and female patients across four different wards:

- Bronte ward is a 12 bed forensic low secure service for women
- Shelley ward is a 16 bed forensic low secure service for men
- Denholme ward is a 15 bed psychiatric intensive care unit for women
- Bowling ward is a 20 bed specialist personality disorder service for women

The hospital has been registered with the Care Quality Commission since April 2009 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 'requires improvement' overall, with a rating of 'inadequate' in the safe key question. At this inspection the hospital was in breach of six regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014:

- Regulation 9; person centred care, because the search policy in place did not meet with current guidance.
- Regulation 10; dignity and respect, because patients on Bowling ward did not have personal space.
- Regulation 12; safe care and treatment, because there were issues across all four wards in relation to the management, storage, administration and recording of medicines, and not all staff on Bowling ward had received appropriate training.
- 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.
- Regulation 17; good governance, because the systems in place did not ensure that staff recognised and learned from incidents, and information collated from ward level was not always consistent with information at board level.

We re-visited the hospital in August 2016 to check that the services were now compliant with the above regulations. At this inspection we re-rated the provider as 'good' overall, with a rating of requires improvement in the 'safe' domain. The provider had taken action to address our concerns from the previous inspection. However, the provider continued to be breach of Regulation's 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014; premises and equipment, and safe care and treatment because areas of Bowling ward smelt unpleasant and there were ligature points on Bowling and Bronte wards, which were not on the ligature risk assessment.

We re-visited the hospital in May 2017 to carry out a focussed inspection of the 'safe' domain. The rating of 'requires improvement' in the safe domain was upheld, and previous ratings of good in the effective and well led domains were suspended as we found some breaches of regulation at this inspection. 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 staff not carrying out appropriate physical health checks following the use of restrictive interventions.
- Regulation 17; good governance because managers were not aware of all the risks presented to patients.

We reviewed all these breaches of regulation at this inspection, we found that the provider had made improvements to their governance structures and were no longer in breach of Regulation 17. At this inspection, the provider remained in breach of some areas of regulation 12.

Our Mental Health Act Reviewers visited:

Summary of this inspection

- Bowling ward (specialist personality disorder service) in January 2018
- Denholme ward (the psychiatric intensive care unit) in January 2017
- Bronte ward (the low secure forensic female ward) in December 2017
- Shelley ward (the low secure forensic male ward) in October 2015

At these visits, the reviewers raised concerns including vague timescales for discharge, little involvement of patients in care plans, a lack of reference to discharge planning in patients' care plans, cold temperatures on Bronte ward, patients' section 17 leave forms did not always indicate that staff had given them copies. We also reviewed these concerns during this inspection.

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

The service had an accountable officer. The accountable officer is a senior manager who is

responsible and accountable for the supervision, management and use of controlled drugs. Without an accountable officer, a service cannot ensure the safety of medication processes and procedures.

Our inspection team

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

Why we carried out this inspection

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

How we carried out this inspection

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

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

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

During the inspection visit, the inspection team:

- visited all four wards at the service, looked at the quality of the ward environments and observed how staff were caring for patients
- spoke with 24 patients
- spoke with six relatives or carers of patients
- collected feedback from two patients using comment cards
- spoke with the hospital manager, clinical manager, general manager, quality lead, the medical director, the hospital's expert by experience and service user involvement lead, and all four ward managers
- spoke with 37 staff members including nurses, doctors, healthcare support workers, therapy staff and domestic, estates and ancillary staff

Summary of this inspection

- looked at the care and treatment records of 24 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 patient community meetings, handovers, a governance meeting and multi-disciplinary team meeting
- looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the service say

During the inspection, we spoke with 24 patients in one to one interviews and a patient focus group. We offered all patients the opportunity to speak with us during the inspection. We also collected feedback from two patients using comment cards. All patients we spoke with told us that they had access to advocacy and knew how to make a complaint.

Patients from the forensic low secure service made positive comments that the wards were clean, and that they felt staff cared about them, were interested in their wellbeing, and were visible and available to help them on the wards.

Three patients from Bronte ward, the female, forensic, low secure ward, made negative comments about their care; one told us that they felt staff did not care about them, and two patients said they sometimes felt unsafe due to aggression from other patients on the ward. Two patients on Shelley ward, the male, forensic, low secure ward, said there were not enough staff to allow patients to do things off the ward, including going out on leave or participating in off-ward activities. Patients from both wards felt the environment was too restrictive and it took a long time for patients to get escorted leave.

Patients from the specialist personality disorder service on Bowling ward were mainly positive in their feedback. They said that they felt safe on the ward, and that staff were caring and respectful towards them. Patients felt that access to spiritual support was good, with staff facilitating external visits and support if a patient required this. However, negative comments related to the variety of activities on offer and the management of aggression by agency staff due to a lack of detailed understanding of the patients' needs. One patient stated that they felt there were not enough staff on the ward to talk to, whilst another commented that their escorted leave had been cancelled due to a lack of staff. We provided a box for patients to leave comments cards about the service, however the hospital had misplaced this box and therefore we did not know if any comments had been made.

Patients from the psychiatric intensive care unit told us that staff were and respectful and polite, except one patient who told us that staff did not knock before entering their room. Most patients, apart from one, told us that leave and therapy were not cancelled and there was good access to therapies and activities. Patients we spoke with confirmed that staff talked to them about their rights and gave them information leaflets.

Patients said that their family and carers were informed and involved with their care and could telephone the service and attend ward meetings. They said they were offered opportunities to give feedback about the service and able to attend daily morning meetings. All patients told us that they liked the food provided. However, three patients we spoke with had experienced some aggression towards them from other patients.

We also spoke with six carers during the inspection to obtain their feedback on the service their relative had received.

Carers of patients from the low secure ward told us that overall, they were happy with the care and treatment their relative received from the hospital and they knew how to make a complaint if needed. Three carers told us they thought escorted leave was sometimes cancelled because of too few staff. One carer thought staff could improve communication by letting family members know about their relative's mental state prior to home visits.

Carers of patients admitted to Bowling ward were positive about care and treatment overall. They stated that staff were polite and caring. However, one carer felt that staff had previously been hostile and rude to them when they had attempted to gather information about

Summary of this inspection

the care of their relative. Two carers also told us that communication from the ward was poor and that they had found it difficult to arrange visits; one carer said that they had experienced distress due to lack of information sharing from staff relating to the physical presentation of a relative following an incident.

We were unable to speak with carers of patients admitted to the psychiatric intensive care unit. Due to the short stay nature of the ward the service was only able to provide us with contact details of one carer who was not available to speak with us during the inspection.

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:

- The seclusion room on the ground floor of the hospital was used by patients from all wards. The room had a viewing panel could be obscured by patients moving the mattress which could compromise the safety of patients and staff.
- The provider did not have a protocol or risk assessment in place for staff to follow regarding how staff could safely transfer patients down stairs to the seclusion room.
- On the psychiatric intensive care unit, care and treatment records reviewed showed that staff had used planned prone restraint to give intra-muscular medication to patients and to safely exit seclusion. This is against national guidance because it involves the planned used of prone restraint which should only be used as a last resort.
- On Bowling (specialist personality disorder ward), there were ligature points on the ward which had not been risk assessed and therefore staff had not mitigated against the potential risk.
- On Bowling (specialist personality disorder ward), patient's risk assessments were not always reviewed in a timely manner after each incident and according to the provider's own policy.
- Oxygen cylinders stored in emergency resuscitation bags on Bowling (specialist personality disorder ward) and Denholme (psychiatric intensive care unit) were out of date or did not have a date recorded on them, despite staff stating that these were audited on a weekly basis.
- Not all staff on Denholme ward had completed mandatory training. Training compliance in risk assessment and security awareness was below 75%.

However:

- There had been a reduction in the use of restrictive practices. Recordings of the reasons for using restrictive interventions had improved in response to the service putting enhanced audits in place and providing staff with additional training.
- The hospital was clean and well presented.
- The prescribing of medicines practices at the service were good and pharmacists completed thorough medication audits.

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- Managers had responded well to the fire safety concerns raised and had a time limited action plan in place to address concerns.
- The process for reporting incidents was clear and all incidents were reviewed by senior managers. Staff were aware of changes and learning as a result of incidents from within the hospital and in other services.
- The majority of staff had undertaken mandatory training in areas important to their role. Mandatory training across the hospital had reached an average of above 80% in most areas.

Are services effective?

Requires improvement

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

- On Denholme (psychiatric intensive care unit), and Bowling (specialist personality disorder ward) staff did not always follow the processes for consent to treatment under the Mental Health Act.
- Where patients lacked capacity to consent to specific decisions staff did not always follow the correct processes. The service did not audit adherence to the Act and some staff lacked understanding its principles and processes.
- On Bowling (specialist personality ward) two out of four staff members told us that monthly formal supervision did not always take place. Allied health professionals who worked across the service told us that they did not always have recorded monthly supervision, which was not in line with the provider's own policy.
- Patient care plans on Bowling (specialist personality disorder ward) and Denholme (psychiatric intensive care unit) wards did not always include recordings of the patient's own words and choices, for example about family involvement or restraint. Staff had discussed this in detail throughout patient meetings and therapies but they did not always transfer this into care planning.
- Patient care plans on Bowling (specialist personality disorder ward) and Denholme (psychiatric intensive care unit) were not always person centred and did not contain information about the involvement of family's in patient's care.
- On Denholme (psychiatric intensive care unit) and Bowling (specialist personality disorder ward) staff did not always undertake observations and physical health checks of patients following the use of rapid tranquilisation as per national guidance and the provider's own policy.

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- On all four wards, staff did not always complete appropriate monitoring of patient's physical healthcare when they were prescribed medications with serious side effects, as per national guidance and the provider's own policy.
- On Denholme (psychiatric intensive care unit) staff did not always carry out appropriate and timely physical health checks with newly admitted patients. When patients refused health checks there was no assessment of risk and documented follow up with an adequate time period.
- Staff did not always monitor the long-term physical health conditions of patients on Bronte and Shelley (forensic inpatient wards), or ensure that patients received timely reviews and monitoring of the conditions with professionals.

However:

- Patients had access to a highly skilled on site multi-disciplinary team. Multi-disciplinary team meetings were effective, inclusive and informative for patients and staff.
- The therapy and recovery opportunities available to patients at the hospital was high quality and had received national recognition.
- Staff used recognised rating scales to measure patient outcomes and ensure treatment was effective.
- All patients had care plans, which were completed in a timely manner and regularly updated. Members of the multi-disciplinary team all input into patient care plans to ensure a fully collaborative plan of care.

Are services caring?

Good

We rated caring as **good** because:

- We witnessed care on all wards, which was respectful, compassionate, kind and responsive.
- Patients used words such as 'respectful' and 'polite' to describe staff and almost all patients said that staff always had time to listen to them.
- Feedback from patients was almost entirely positive about the way staff treated them.
- Patients had the support of advocates who visited each ward weekly.
- The service was rooted in patient involvement, they employed an expert by experience and service user involvement lead to support and encourage patients to give feedback about the care they received.

Summary of this inspection

- Patients were involved in media projects and involved in designing policies and procedures in the running of the service.

However:

- Carers from Bowling ward did not feel that staff communicated with them well.

Are services responsive?

Requires improvement

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

- Patients being admitted to the psychiatric intensive care unit had to transfer through the communal areas of the hospital to reach the ward, as there was not a separate entrance. This was not dignified for patients because they were visible to patients, visitors and staff.
- On Bowling ward, patient care plans did not always include patient's detailed plans for discharge. Staff discussed these in detail via patient meetings and multi-disciplinary meetings, but they did not always transfer into patient's care plans.

However:

- Patients and carers knew how to complain and the service managed complaints well.
- Patients had access to facilities and activities on all wards, which were of high quality and able to meet their recovery needs and emotional and spiritual needs.
- Patients and their carers had access to a variety of information regarding the service, the treatment offered and information about complaints. The admission information to aid orientation to the wards was high quality.
- The service was discharged focussed and continued to discharge patients to less restrictive settings.
- Patients had access to drinks and snacks throughout the day and night and told us that the food offered was high quality and there was choice available. Catering at the hospital was able to provide for patients with religious or cultural needs as all food was prepared on site.
- There were adjustments in place to ensure access to the hospital for people with mobility difficulties. Staff had access to interpreter's and information in languages in order to support patients.

Are services well-led?

Requires improvement

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

Summary of this inspection

- The audit systems in place were not always effective and had not identified the issues we found during the inspection for example in relation to; consent to treatment records, blanket restrictions, compliance with the Mental Capacity Act and physical health checks.
- There was not a written protocol or risk assessment in place for staff to follow in relation to transferring patients using stairs to seclusion rooms.
- There was not a written protocol or risk assessment in place for staff to follow in relation to admitting patients to the psychiatric intensive care using the stairs and through communal areas of the hospital.

However:

- The management team were suitably qualified and experienced and were passionate about the service they delivered.
- Staff knew and agreed with the values and vision of the organisation; staff practice modelled the values and behaviour of the organisation throughout our inspection.
- All managers at the service were involved in the governance process to ensure changes and improvements began at ward level.
- Staff spoke highly of the management team and overall felt supported and effectively managed and supervised.
- Staff had high quality training and development opportunities and the management team had been built from within the service.
- The service were committed to quality improvement and innovation and had been involved in a number of projects, which had received national recognition.

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.

Staff participated in mandatory training in the Mental Health Act. Seventy-nine percent of staff on Shelley ward (low secure male forensic inpatient ward), all staff on Bronte ward (low secure, female forensic inpatient ward), 88% of staff on Bowling (specialist personality disorder ward), and 87% on Denholme (psychiatric intensive care unit), had completed this training.

The service had systems in place to ensure the proper implementation and administration of the Mental Health Act. They carried out regular audits of compliance with the provisions of the Act.

Care records across all services 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 responsible clinicians and staff clearly and correctly documented this.

On all wards, staff informed patients about their eligibility for an independent mental health advocate, who visited the unit once a week to speak to patients.

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

On all wards other than Denholme ward, all patients had consent to treatment forms stored with their care and treatment files. On Denholme ward (psychiatric intensive care unit) and Bowling ward (specialist personality disorder ward), we had concerns about consent to treatment documentation. Medicines were not always prescribed in accordance with the Act and did not always ensure that appropriate legal authorisation was in place to continue treatment after changes were made.

Mental Capacity Act and Deprivation of Liberty Safeguards

Staff participated in mandatory training in the Mental Capacity Act and Deprivation of Liberty Safeguards. All staff on Shelley ward (low secure, male forensic inpatient ward), 94% of staff on Bronte ward (low secure, female forensic inpatient ward), 91% of staff on Bowling (specialist personality disorder ward), and 76% on Denholme (psychiatric intensive care unit), had completed this training.

The provider had a Mental Capacity Act policy in line with the associated Code of Practice. The policy contained appendices with forms for recording capacity assessments and best interest decisions.

Despite high levels of compliance with this mandatory and the policy, staff had only a basic knowledge of the Mental Capacity Act and its principles. Staff across all wards had a misunderstanding between consent to treatment under the Mental Health Act and the assessment of capacity under the Mental Capacity Act.

Staff across all three services told us that they were reliant on senior staff members such as doctors and social workers to undertake capacity assessments and make best interests decisions where a patient lacked capacity to make specific decisions. Although staff were able to give us some examples of very complex decisions following the principles of the Act, staff often made less complex decisions on behalf of patients with little evidence of an assessment of their capacity to make decisions independently.

The service did not conduct audits of adherence to the Mental Capacity Act, and the service did not have a designated person who could support staff and provide advice, updates and education on changes to this legislation.

At the time of the inspection, no patients were being cared for at the service under a Deprivation of Liberty Safeguard.

Detailed findings from this inspection

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	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Forensic inpatient/ secure wards	Requires improvement	Requires improvement	Good	Good	Requires improvement	Requires improvement
Personality disorder services	N/A	N/A	N/A	N/A	N/A	N/A
Overall	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement

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

Requires improvement

Safe	Requires improvement
Effective	Requires improvement
Caring	Good
Responsive	Requires improvement
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 Bierley provides a psychiatric intensive care unit for adults of working age (Denholme ward) which had 15 beds for female patients over the age of 18.

At the time of the inspection, the service had admitted 12 patients to Denholme ward. All patients were detained under the Mental Health Act.

Denholme ward had an 'L' shaped layout, which did not allow staff a clear line of sight to observe all patients. The ward mitigated this risk by having staff allocated to observe patients at intervals throughout the day and night and through the placement of mirrors on corridors. Staff discussed patients' observation levels in multi-disciplinary team meetings and at handover meetings and these differed according to the risk presented by each individual patient.

Some areas of the ward contained ligature points (a ligature point is a place to which patients intent on self-harm might tie something to strangle themselves). A ligature audit of the ward commenced in March 2018 in order to identify and reduce risk. This ligature audit noted the highest risk areas, and action taken to reduce and mitigate the risks, including work on the estate, and observation of patients, the level of which was determined by patients' individual risk assessments. The addition of ligature maps in staff only areas supported staff to be aware of ligature points. Ligature cutters were available to staff and kept in the main ward office and easily accessible.

As a female patients only ward it was compliant with the Mental Health Act Code of Practice and the Department of Health guidance on eliminating mixed sex accommodation.

Denholme ward had a fully equipped clinic room, which staff used to store equipment to support patients with their physical healthcare needs. All equipment, including a blood pressure monitor and scales had been marked as clean by staff, and correctly calibrated.

The ward had an emergency grab bag stored in the main ward office that staff used to support patients in an emergency and a defibrillator. A clinical team leader checked the bag and defibrillator (24 hour diagnostic check and weekly in depth check) to ensure the equipment was in order. However, the date on the oxygen cylinder had expired; the clinical team leader changed this immediately.

The seclusion room on Denholme ward closed on 17 March 2018 for planned refurbishment. The seclusion room had also been out of use at the point of our Mental Health Act review visit in January 2017, but had re-opened. Further incidents during 2017, which included a serious incident whereby a patient was able to gain access to furnishings and create a weapon. resulted in the service planning to upgrade the room. However, there had been unforeseen delays to the refurbishment schedule. We saw that the refurbishment of the seclusion room included upgrades to the room, such as a sliding panel door.

During this refurbishment, staff had escorted patients to another seclusion room on the ground floor of the hospital

outside Shelley ward (the male, forensic, low secure ward). It was not exclusively used for Shelley ward's patients. Staff and patients from Denholme ward accessed this seclusion room via a set of stairs, because Denholme ward was located on the first floor of the building. We had concerns that the provider had not carried out an assessment to determine the risks of transporting patients down the stairs to seclusion when in restraint. Since the time of the closure of the first floor seclusion room, staff had moved nine patients to the ground floor seclusion room using restraint. One member of staff told us that staff had been injured while moving a patient down the stairs, however we did not see any incident reports relating to injuries of staff or patients and senior managers at the service did not think that incidents had occurred.

The seclusion room on the ground floor complied with guidance in the Mental Health Act Code of Practice because it had a viewing panel allowing staff to observe patients, a working clock, natural light and toilet facilities. Patients could communicate with staff via an intercom. However, we were concerned that patients could use the mattress (which was not fixed at any point) to restrict staff observation.

The ward and the communal areas of the hospital looked clean and patients confirmed this. Furnishings throughout the ward were clean and in good condition and we saw domestic staff regularly cleaning the main areas of the ward during our visit. The ward carried out an infection control audit in March 2018 that showed an overall infection control compliance of 96%. We also observed that staff made use of hand gel and clear handwashing techniques were evident.

The hospital's general manager was responsible for overseeing environmental, health and safety and fire risk assessments. Health and safety representatives from each ward met with the general manager each month to discuss environmental risks and actions. The estates lead and general manager completed regular environmental audits of the entire hospital site, which included weekly ward tours to monitor and manage environmental concerns. Staff confirmed they were able to request support from the maintenance team where they identified repairs required on the wards.

The hospital had implemented a number of actions to improve the management of fire risks because of a serious incident on the Denholme ward in October 2017, where staff identified an issue with the fire repeater panel. These actions included regular maintenance checks of the fire repeater panel, employing an independent fire risk assessor to visit the hospital, and the hospital had delivered additional fire training to reception and administration staff.

In February 2018, the hospital received a fire enforcement notice from the West Yorkshire fire brigade, because the fire brigade had a number of concerns about risk following completion of a fire assessment. The hospital had responded to this via the completion of a time limited action plan. We reviewed this action plan during the inspection and found the service had completed most areas, other than those tasks, which required long-term building work. The fire brigade will re-visit the hospital to check on compliance in May 2018. The general manager told us that the hospital had been supported by the corporate provider to make the required changes and become compliant.

We reviewed fire policies, procedures and safety during the inspection and found that the estates team had undertaken tests of emergency lighting, fire extinguishers, lift safety, gas safety and electrical equipment within the last twelve months.

All staff carried an alarm that when activated showed up on a central panel to indicate the location where the alarm had been pressed. All ward staff were observed to carry personal alarms, and nurse call alarm buttons were present in patient's bedrooms. Staff checked alarms were working each morning when they collected them from reception. Each day the shift leader allocated a staff member to respond first if an alarm sounded. Staff told us colleagues responded promptly when they needed assistance. Patients had access to alarm call points in their bedrooms and communal areas including bathrooms.

Safe staffing

Prior to inspection the provider submitted data regarding their staffing levels. The total number of substantive staff on Denholme ward 1 January 2017 to 31 December 2018 was 35. From 1 November 2017 and 31 January 2018 there was 9.5 qualified nurses and 21.7 healthcare support workers with two qualified nurse vacancies and four healthcare support worker vacancies.

The staff team on Denholme ward was made up of preceptorship nurses, registered mental health nurses,

clinical team leaders and healthcare support workers. In addition, patients had access to the support of a multi-disciplinary team. This included a consultant psychiatrist, specialty doctor, occupational therapists, psychology, healthy living coordinator and social workers employed by the hospital.

The hospital used a staffing matrix based on 'hours per patient day' to determine appropriate nurse and healthcare support worker staffing levels per shift, there was a minimum of four staff on shift including two nurses. Staff worked a day or night shift and crossover of these shifts allowed for a 30-minute handover. The ward manager explained that staffing levels changed regularly dependent on the number of patients admitted to the ward, the level of observations for patients and staffing increased if patients' escorted leave took a member of staff out of the hospital for a lengthy period.

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. Internal Cygnet Health Care Ltd bank nurses and healthcare support workers, agency nurses and healthcare support workers provided shift cover. The ward manager told us that they used regular agency workers who were familiar with the ward, which ensured consistency for patients.

Between 1 November 2017 and 31 January 2018 Denholme ward used bank staff to cover 137 shifts and agency staff to cover 157 shifts, which was 29% of all shifts during this period. This usage was due to the acuity and complexities of the patient group and current vacancies on the ward.

Between 1 January 2017 and 31 December 2017, the service had a 6% sickness rate, and had four staff leavers. The ward manager informed us that vacancies had been filled recently.

Data given by the provider stated that no shifts were unfilled or fell below safe staffing levels during the same period. We reviewed the staffing rotas from 1 January 2018 to 01 April 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. We spoke with five patients from the ward who told us that staff were visible; four had not had experience of leave or activities being cancelled but one patient had. The ward manager informed us that staffing shortages did not result in cancelled leave but an emergency on the ward could delay or postpone leave or an activity. The provider informed us that they had not had to cancel any patient leave or activities.

There was enough staff on duty to safely carry out physical intervention with patients should they be required. Training in the prevention and management of violence and aggression was mandatory for staff and 95% of staff on Denholme ward had completed this training.

There was adequate medical cover day and night. We saw consultants and specialty doctors supported staff on the ward during the day and there was an on-call doctor who would attend the ward as required during the night and had attended incidents we reviewed within thirty minutes.

Staff carried out mandatory training in 26 areas including basic and intermediate life support, safeguarding, medicines management, infection control, information governance, the Mental Capacity Act and Deprivation of Liberty Safeguards, and the Mental Health Code of Practice. Cygnet Health Care Ltd had a training compliance target of 95% but only two of the mandatory training met this target for Denholme ward.

Data provided showed that two areas of training were below 75% compliance on Denholme ward; risk management and assessment (53%) and security awareness (69%). The ward manager informed us that letters were sent to all staff to indicate what training required completing, training days had been allocated and there were some issues with online training access that were being resolved.

Assessing and managing risk to patients and staff

Between 1 July 2017 and 31 December 2017, staff had used seclusion on 35 occasions on Denholme ward and had not used long-term segregation with patients. Staff told us that they initiated seclusion as a last resort, increasing observations levels were possible and if it was used it would be for the shortest time possible. We reviewed six patient's care plans and one indicated what interventions staff could use with the patient to reduce the need for physical interventions. For example, the use of grounding techniques (these help to keep someone in the present) such as vapour rub or vinegar when the patient was experiencing flashbacks and the use of when required intramuscular injection instead of oral medication.

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

Requires improvement

We reviewed four records of the seclusion of patients from Denholme ward and found them to be in good order. The use of this restrictive intervention was proportionate to the risk presented by the patient.

On Denholme ward there were six seclusion audits between October and November 2017, which showed a clear improvement in compliance with seclusion paperwork standards.

We reviewed care records of six of the 12 patients admitted to Denholme ward. 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'.

Denholme ward operated with some blanket restrictions. For example; patients had supervisory access to the outside area, staff removed items from patients such as razors, glass, smoking paraphilia and cans. Staff continually monitored these rules, and included them in the ward's quarterly blanket restriction audit. These blanket restrictions were justified, as it was a necessary and proportionate response to the risk identified for this patient group, and was therefore in line with the Mental Health Act Code of Practice. Patients had access to their own mobile phones within their rooms as long as they signed a mobile phone contract. Staff never locked communal areas such as the lounge and dining area and patients were individually risk assessed for use of other items including hair dryers and straighteners.

All patients admitted to Denholme ward were detained under the Mental Health Act. Staff told us that informal patients were not usually admitted to this type of service, but would offer this advice and had access to information for patients if necessary.

The provider had a search policy in place 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 and the ward manager told us that if patients refused a body search then a wand could be used and if they refused this or refused to hand over prohibited items then they would be placed on observation. Any further searches would only take place if a risk was identified.

Staff undertook differing observation levels dependent on the risk presented by the patient at the time. Patient observation levels varied from every 60 minutes to continual observation. Nursing staff were able to increase or decrease observation levels should this be required, and staff discussed observation levels at handover meetings and in weekly multi-disciplinary team meetings.

During inspection, we reviewed 10 incidents of restraint, which had taken place between 1 January 2018 and 31 March 2018 on Denholme ward. Staff made clear recordings of the actions they had taken to de-escalate situations prior to the use of restraint. In five of the 10 incidents reviewed we found that the restraint used by staff was low-level restraint and for an average of three and a half minutes in length. In the remaining five records staff had recorded the use of prone (chest down) restraint.

At our last comprehensive inspection of this service in June 2015, we told the provider that they must reduce the numbers of prone restraint. At our last comprehensive inspection of this service in 2015, we found that on Denholme ward between 47% and 63% of incidents of violence and aggression resulted in restraint between February and April 2015. The longest period of prone restraint we found recorded was for 50 minutes in April 2015. There was evidence of a reduction in the use of, and time spent in prone restraint.

Comparatively, the provider told us that between July 2017 and December 2017 had used restraint 129 times, 31 of these incidents had taken place in prone restraint, which was 24% of the overall restraint use. In response to our findings at the previous in the previous inspection, the provider told us that they continued to work on the reduction in the use of prone restraint. The provider told us that from January to March 2018 the use of prone restraint had reduced to 20 uses of prone restraint within 154 restraints, which was 13% of prone use in overall restraint. In recent visits by the expert by experience, Cygnet Bierley had been rated (using an internal tool) as the best Cygnet hospital in terms of their least restrictive approach to care.

The service were aware, from their own reviews and audits that some use of prone restraint on this ward was against national guidance. Staff had been taught to use prone restraint to give intra-muscular medication and to allow them safe exit from seclusion. We saw evidence of this because in three of the five restraint records we reviewed during the inspection, staff had noted the reason for prone

restaint as 'for intra-muscular medication'. We reviewed the march 2018 ward manager's governance pack, which stated that five prone restraints had been used that month, two as exit from seclusion and three for intra-muscular medication. This evidenced the use of a planned approach to prone restraint, which is against national guidance. 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. As well as not being in line with national guidance, 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.

However, the senior leadership team had recognised this concern prior to our inspection and had taken action. They had an ongoing project in place to look at staff re-training for alternative injection sites to further reduce the use of prone restraint across the service.

On Denholme ward we reviewed 12 rapid tranquillisation records between 1 January 2018 and 31 March 2018. The National Institute for Health and Care Excellent describes rapid tranquilisation as 'use of medication by the parenteral route (usually intramuscular or, exceptionally, intravenous) if oral medication is not possible or appropriate and urgent sedation with medication is needed'. We found observations had not been recorded in accordance with national guidance and the hospital policy in four cases. There were no observations recorded at all for one episode and nursing staff had not recorded any reasoning for this.

We reviewed the provider's staff training package for the management of violence and aggression. The training model included training staff in the use of pain compliance holds 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 these methods but were clear that they were last resort methods. The provider was aware of the need to monitor and measure the use of these types of restraint holds and had conducted an audit of their use. This audit had identified one incident where staff had recorded the use of holds that could be described as pain compliance. We reviewed this incident and found that it was proportionate to the level of risk presented by the patient.

Safeguarding adults and safeguarding children training was mandatory, and 86% and 90% of staff respectively had completed this training on Denholme ward. Care records demonstrated that staff reported incidents of safeguarding when necessary and had a good knowledge of safeguarding and how to report. Monthly ward manager reports were completed which included the number of concerns reported to the local authority safeguarding team.

A range of policies supported medicines management. They were regularly reviewed and available electronically to all staff on the ward computers.

During the inspection we checked the arrangements for managing medicines on Denholme ward. Medicines were stored securely on the ward and according to manufacturer's instructions in a locked medication room. Each day nursing staff checked fridge and room temperatures to ensure safe storage of medicines and reported any concerns to maintenance staff.

A pharmacist visited the ward weekly to conduct an audit of medication cards and storage. The monthly ward manager reports included a medicines management audit, which looked at Mental Health Act compliance and administration errors. The reports detailed action taken to reduce the errors and considered changes to practice to improve results.

There were safe procedures for children that visit the ward. The ward manager told us that no visitors under the age of 18 came onto the ward. Two visitors' rooms in the communal corridor had toys and games available. The ward manager told us that risk assessments were carried out and staff supervision increased during visits if required. During inspection, we observed one patient on Denholme ward having regular visits with an infant in line with their risk assessment and care plan.

Track record on safety

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

Requires improvement

Between 8 February 2017 and 16 February 2018, Denholme ward had reported four serious incidents. These related to a fire, one incidence of incorrect mental health paperwork due to the medical recommendation not being made within the required time, which contravenes the Mental Health Act, one allegation of abuse from a patient towards staff and one disclosure of abuse from a family member. For the incident of fire setting, the hospital had liaised closely with the police and clinical commissioning groups to ensure the safety of the patient. Staff identified an issue with the fire repeater panel on the ward stating it was not obvious that the fire was on Denholme ward. There was an action plan in place and the hospital had taken appropriate action.

Senior leaders within the organisation had liaised with other stakeholders where required to ensure the safety of the patients, investigated all incidents, root cause analyses were completed where appropriate, and action plans were in place to address any issues identified.

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 the 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' that was regularly reviewed during monthly governance meetings to track progress.

Staff received feedback from investigation of incidents, both internal and external to the service. The service had a corporate and local lessons learned log that they disseminated to all staff, and we saw these present on the wards and in staff areas during the inspection. Managers disseminated lessons learned to staff via a monthly quality newsletter.

Staff told us about incidents at a local level and in other Cygnet Health Care locations where they had made changes to local processes to reduce risk. Following a serious incident involving boiling water, the water provided for patients to make drinks was kept at a safe temperature to reduce the impact and severity if a similar incident occurred.

The service had re-focussed their approach to governance to ensure closer involvement at ward level since August 2017. Ward managers received monthly data packs including the incident data for each ward. They presented this data at monthly clinical governance meetings to discuss the action they would take to reduce identified risks. Team managers shared learning via the local learning lessons log and in team meetings and supervision with ward level staff.

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 required. Nursing staff on Denholme ward told us that they were aware of the policy and understood their responsibilities in relation to it, but we did not see any examples of its use at the time of the inspection as none of the serious incidents which had taken place warranted its use.

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

(for example, treatment is effective)

Requires improvement

Assessment of needs and planning of care

We reviewed care records for six of the 12 patients admitted to Denholme ward. All six patients had a care plan completed within 24 hours of admission, which included an 'understanding my mental health and physical health' care plan. We also saw that one patient had a further care

plan created which related to Clozapine treatment (this antipsychotic medication is subject to strict monitoring requirements because it is associated with serious side effects).

The majority of the care plans reviewed were standardised and this meant it was difficult to evidence the patient's own voice. The provider explained that care plans were written in this format for new patients whilst they settled into the ward and staff developed a deeper understanding of their needs. However, staff updated care plans monthly or more regularly if there had been a change in need. One patient had written their own care plan and the care plans in place for this patient were thorough and holistic. Staff we spoke with confirmed that this was an option to all patients. Staff worked with patients and sought out their needs and wishes in multi-disciplinary meetings, which was clear in the notes we reviewed. Staff invited patients, their carers and advocates to these meetings and they were person centred. However, this did not always transfer into patient care plans.

The hospital was in the process of transferring all patient records to an electronic patient record system. Staff told us this would be done in stages but they could not tell us what the timescale was for this. The service had an overarching action plan for the transference of the systems. All patients had a paper record that included physical health assessments and care plans and staff kept handover and daily notes on the electronic system. They also kept electronic records of Mental Health Act paperwork and capacity assessments. Staff told us they knew where records were stored and had not encountered any problems with the two systems.

The hospital controlled access to electronic records by ensuring staff had individual passwords, which kept them secure. However, on Denholme ward, some patient paper records were kept in the nursing office, which was locked with continual staff presence, however these were not in a locked cabinet.

The hospital had appropriate information sharing policies in place and we saw how staff protected patient information by having agreements in place with patients about who they wanted staff to share their information with. Staff also protected patient information by having secure procedures for the access and storage of confidential information.

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 the 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).

Staff carried out regular audits to ensure medicines were stored and prescribed effectively. Staff used a standardised side effect assessment tool with patients to check if they were experiencing any side effects from their medication.

We found that there were occasions when the monitoring of the physical health of patients prescribed anti-psychotic medications had not taken place according to national guidance. One out of four patients prescribed antipsychotic medicines had no monitoring recorded at all. However, the service attempted to ensure that best practice was embedded on the ward through regular audits of the storage and prescribing of patients' medication, and two patients prescribed high dose antipsychotic treatment had appropriate monitoring undertaken and recorded in accordance with guidance and the hospital policy.

Staff did not always ensure that the physical health needs of patients were assessed adequately. In four of the six patient records we reviewed, the physical healthcare forms were not completed and staff had recorded that the patient had declined or was unwell. One patient had been admitted for 72 hours and their physical healthcare checks had not been undertaken in accordance with the hospital policy. Where patients had declined physical health checks staff had not recorded in three of the four patient records when this would be reattempted.

Staff did not always ensure they supported patients with long-term physical health needs. One patient had not had a review of their long-term health condition with an appropriate practitioner. Patient access to being able to register with a GP practice was an ongoing challenge. However, access to GP services was via a long-standing service level agreement with a local GP practice who provided a weekly dedicated clinic for patients. Managers had entered this concern on the service risk register and senior managers continued to work with local commissioners to resolve the concern. A physical

healthcare policy was in place and the service had advertised to employ a registered general nurse to oversee the physical long-term health care needs of patients. The ward manager told us that prior to admission Denholme ward would receive a full physical health history and risk assessment prior to accepting a referral.

The hospital did not have a policy in place to guide staff to support a patient who was admitted within the post-partum period (within six weeks of childbirth) and referred us to the generic physical health policy. It is essential that these patients have specific care and treatment to ensure their physical health and welfare is maintained. Royal College of Psychiatry Quality Network standards for psychiatric intensive care units states that "the ward/organisation has a care pathway for the care of women in the perinatal period (pregnancy and 12 months post-partum) that includes: assessment; care and treatment (particularly relating to prescribing psychotropic medication)".

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

The service had an in-house psychology team who conducted psychology assessments with patients to identify a psychology treatment pathway specific to their individual needs. They delivered psychological therapies such as dialectical behaviour therapy, cognitive behaviour therapy and acceptance and commitment therapy substance misuse programmes. Interventions were provided in a group or one to one basis dependent on the assessment. On Denholme ward, 75% of patients accessed in-house psychological therapies within one week from admission. This had increased from 70% in 2016.

On Denholme ward, patients were offered daily bite size recovery skills sessions. We observed a dialectical behaviour support bite size group and a recovery skills group. Both groups were well planned and structured. The group facilitators ensured and encouraged the involvement of all patients. We observed respectful questioning and good suggestions for skills to develop further in the dialectical behaviour support group. We observed staff suggesting good distraction techniques in the recovery skills group. Staff sought feedback from patients to plan for the future sessions.

The psychology team monitored and measured patient outcomes after therapy by mapping reductions in symptoms and measuring patient satisfaction to improve the quality of therapy offered.

The team were aware of the newly published (January 2018) 'power, threat, meaning' framework developed by the British psychological society, and plans in place for implementing this framework within the service.

Occupational therapists also followed best practice guidance. Staff completed assessments and outcomes monitoring with patients using the model of human occupation screening tool, the occupational self-assessment, and the occupational circumstances assessment. These assessments were used to create care plans with patients to develop life and independence skills. The occupational therapy team saw all patients within 72 hours of admission. Occupational therapists worked on a one to one and a group basis with patients.

The hospital had an onsite accredited recovery college where patients from Denholme ward were able to undertake a variety of courses, for example in baking and multimedia.

Patients we spoke with told us that there was good access to therapies and activities.

Senior staff undertook a variety of audits, following an annual audit programme to monitor the quality and safety of the service. These included:

- Adhering to Cygnet discharge standards on Denholme ward
- Infection control
- Psychology outcomes
- Prevention and Management of Violence and Aggression
- Complaints
- Patient notes
- Blanket rules audit
- Restrictive practice audits; seclusion, restraint, prone restraint, blanket rules, rapid tranquilisation

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 the audits conducted each month, identified and reviewed action plans in response to concerns or to make improvements, and identified learning to disseminate to teams.

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

Requires improvement

Skilled staff to deliver care

The service had experienced and qualified staff from a range of different disciplines including psychiatry, psychology, mental health nursing, occupational therapy, healthcare support workers and social workers.

All staff including temporary and bank staff received an appropriate local and corporate induction. Temporary staff had access to the same mandatory training as permanent staff. Doctors had completed re-validation where required within the previous 12 months.

The provider had a thorough recruitment policy. We reviewed staff files for managers, nurses, health care support workers, doctors and temporary staff. All staff had the appropriate paperwork in place to ensure safe recruitment including disclosure and barring checks, references, and copies of qualifications and professional registration.

The provider had a clinical supervision target of 90%. As at 31 January 2018, all staff on Denholme ward had received clinical supervision every four weeks as per Cygnet Health Care Ltd.'s own policy. Managerial supervision took place alongside clinical supervision where required. Staff we spoke with told us that they had regular supervision and felt that supervision was an ongoing process as they could flag up issues straight away.

Staff from social work and occupational therapy departments told us that supervision was not always formalised and that it took place on an ad hoc basis. The providers own policy stated that "all health professionals must have monthly supervision".

Staff we spoke with told us they had received a recent appraisal of their performance. On Denholme ward, 81% of staff had received an appraisal within the last 12 months. Appraisal compliance was 100% by the time of the inspection.

Staff had access to monthly team meetings and printed minutes were kept in a folder on the ward and covered agenda items such as governance, data packs, ward audits, and quality issues, incidents and complaints.

Staff we spoke with told us that they could discuss any training needs that they had and felt supported to access external qualifications. One member of staff was currently on secondment (a temporary transfer of a worker to another position) to lecture at a university and one healthcare support worker was working part time whilst completing a degree in nursing. The psychology team have also completed considerable in-house training with staff. All staff have undertaken 'an induction to psychologically informed care' training and staff across the service have received Dialectical behaviour therapy skills training. There has also been two days training on Denholme ward for 'working psychologically' and 'validation strategies' (a method of communicating with and helping disoriented people).

Managers told us they had access to human resources support for dealing with poor staff performance. The supervision records we reviewed demonstrated that the manager addressed poor performance and responded to the outcomes of investigations.

Multi-disciplinary and inter-agency team work

The multi-disciplinary team at the hospital included psychiatrists, psychologists, mental health nurses, occupational therapists and social workers.

There was involvement from various members of the multi-disciplinary team within separate patient care plans, for example social worker, occupational therapy and psychology input. Regular face-to-face multi-disciplinary team meetings also took place with professionals, patients and their families. In addition to one to one work with patients, the psychology team supported the multi-disciplinary team to ensure patients had access to psychologically informed care. They did this by offering monthly case consultations on all wards, monthly reflective practice sessions with staff on Denholme, and supported staff de-brief sessions following incidents.

The hospital had a dedicated social work service that supported patients with housing, benefits, contact with their families, and supported capacity and best interests processes with individual patients. Social workers completed a specific care plan, which was evident in the six care records that we viewed.

In addition to social workers, occupational and psychological therapy, patients had the support of a healthy lifestyles co-ordinator and service user involvement lead.

We examined multi-disciplinary team meeting notes, which evidenced patient and family or carer involvement. The multi-disciplinary team meeting followed a structure

including background history, assessment of current presentation, patient (and family or carer views), risk assessment and action plan that included medication changes, therapy, section 17 leave and discharge planning.

During multidisciplinary meetings, the patient was able to put forward their own views regarding treatment and discharge and one patient gave positive feedback regarding learning new skills in psychology sessions. Staff felt that they were listened to during ward rounds and multidisciplinary team meetings when discussing the treatment of individual patients.

As part of our inspection, we observed one morning handover meeting. In the handover meeting, we observed how staff on the night shift shared detailed information with the day shift about each patient and any concerns they had. Staff discussed any incidents from the previous night and confirmed observation levels of the patients. Staff also highlighted any actions within the communication book such as a family visit for one patient and supported another patient to do some online shopping. Staff recorded handover notes electronically so other staff including members of the multidisciplinary team could refer to them.

The ward manager told us that the service worked to maintain relationships with professionals outside of the service area and the commissioners. The ward manager compiled individual patient reports for some commissioners. Patient access to being able to register with a GP practice was an ongoing challenge. However, access to GP services was via a long-standing service level agreement with a local GP practice who provided a weekly dedicated clinic for patients. Managers had entered this concern on the service risk register and senior managers continued to work with local commissioners to resolve the concern.

Adherence to the MHA and the MHA Code of Practice

At the time of inspection, 87% of staff on Denholme ward had completed mandatory training in the Mental Health Act. Staff we spoke with had a good understanding of the Mental Health Act.

The service had on on-site Mental Health Act administrator who was available to give advice and to support to staff. Staff knew who the administrator was and how to access them.

The Mental Health Act administrator told us that they oversaw admission paperwork, ensured accuracy of section papers, monitored dates for patients' tribunal meetings and renewals, and gave reminders to staff when action was required. They regularly audited paperwork to ensure it was correct and complete, and that staff were applying the Act appropriately. The Mental Health Act administrator also had the opportunity to feedback to senior hospital managers on a monthly basis; raising any concerns or problems in relation to the application of the Mental Health Act to ensure compliance hospital-wide. A Mental Health Act audit was completed on Denholme ward on 23 March 2018 and the paperwork was 100% compliant for each patient including paperwork such as capacity assessments, consent to share information, and section 17 paperwork, where appropriate.

The corporate lead for the Mental Health Act also provided guidance and support where required.

Section 17 leave records were signed by the relevant clinicians and were stored within individual patient's files on the ward and uploaded on to the electronic system. If a patient took allocated leave staff would clearly document on a form kept within the paper file to ensure staff knew what leave patients had remaining.

One patient on Denholme ward had been prescribed a medicine that was not included on the relevant consent to treatment certificate. We raised this with the nurse in charge who contacted the responsible clinician to review the prescription. For another patient on Denholme ward, we saw capacity and consent for treatment had changed. The relevant certificates and capacity assessments had not been updated correctly or in a timely manner to ensure a legal authorisation was in place to continue treatment. We also reviewed six patient care records and found that the capacity and consent to treatment form was missing in three of the files. We spoke to the ward manager regarding this who told us that the responsible clinician would complete consent to treatment during the first ward round and upload onto the electronic system before the ward clerk files the paper copy. We reviewed 16 consent to treatment documents and found medicines were not always prescribed in accordance with the provisions of the Mental Health Act.

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

Requires improvement

Staff recorded on a two weekly basis that they explained patient's rights to them regularly as per the requirements of the Act. Patients we spoke with confirmed that staff talked to them about their rights and gave them information leaflets.

Patients had access to an Independent Mental Health Advocate who visited the ward on a weekly basis. Information boards on the ward also documented how patients could access the advocacy service at any time. Staff stated that they supported patients to access an Independent Mental Health Advocate where there may be concerns regarding capacity. However, we did not see information provided in formats that are more accessible, for example different languages or easy read. The ward manager told us that they could contact the information analyst for the hospital who could translate and print leaflets in different languages and formats if required.

Our Mental Health Act reviewer last visited Denholme ward in January 2017. They raised concerns that there was little evidence of patients contributing to the formulation of their care plans, patients' own views were largely unrecorded, and there was a lack of reference to discharge planning in patients' care plans. We saw improvements with patient engagement in some care plans.

Good practice in applying the MCA

Mental Capacity Act and Deprivation of Liberty Safeguards training was mandatory and 76% of staff on Denholme ward were compliant with this training.

The Mental Capacity Act is a piece of legislation, which maximises individual's potential to make decisions for themselves wherever possible. The Act and associated code of practice provides guidance and processes to follow where someone is unable to make their own decisions.

The provider had a Mental Capacity Act policy in line with the Mental Capacity Act code of practice. The policy contained appendices with forms for recording capacity assessments and best interest decisions.

However, staff had limited knowledge of the practicalities of recording capacity assessments, and best interest decision making, and told us that they always referred to the responsible clinician or social work staff, where they had doubts about a patient's capacity to make decisions. Patient records contained some evidence of capacity assessments but we did not see evidence that staff consistently documented best interest decisions where they assessed that a patient lacked capacity to make a specific decision. According to the Mental Capacity Act 2005 Code of Practice, staff should make sure a record is kept detailing the process of working out the best interests of a person who lacks capacity.

Social work staff or the responsible clinician carried out all capacity assessments and best interest decision-making processes within the hospital. This meant staff on the ward did not always identify when capacity assessments were needed, or should be reviewed and they did not always identify what constituted a best interest decision and how to document this in the patient's record.

When we spoke to social work staff about this, they agreed that implementation of the Mental Capacity Act and best interest decision-making process was patchy across the hospital.

The provider did not carry out any audits or monitoring staff adherence to the Mental Capacity Act and the associated code of practice other than monitoring staff compliance with specific training. We could not see an embedded culture of assessing capacity and best interest decision making across the hospital because most staff thought it was the responsibility of the responsible clinician or social work team.

All the patients on the psychiatric intensive care unit were detained under the Mental Health Act. This meant that staff did not provide care and treatment to patients under Deprivation of Liberty Safeguards.

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

Good

Kindness, dignity, respect and support

We observed staff caring for patients in the ward environment. They were responsive to patients' needs and treated patients respectfully.

Staff demonstrated a caring approach and had detailed knowledge of the individual needs of patients on Denholme ward, including any advance decisions

regarding their care. All patients had a named nurse and an associate nurse, as well as a support worker assigned to all patients daily. Patients could request a one to one with any member of the team in the morning meeting. Staff had placed a welcome board on the ward so patients knew which staff were on duty.

We spoke to staff on Denholme ward about equality for patients and person-centred care for equality groups. We were told that support mechanisms had been considered and we saw good practice and support offered to one patient.

We spoke with five patients from Denholme ward and the feedback we received was mainly positive. Patients told us that the staff were very supportive and helpful. One patient said staff were "very caring, they treat you like a human being" and another patient said "they encourage me to distract myself, they are helpful". However, one patient told us that staff did not knock before they entered the room and that they never spoke with them.

The involvement of people in the care they receive

Denholme ward had a welcome pack to give patients on admission, including information about the local area and the ward environment, support staff, visitors, meetings, therapies and groups, mobile phones and how to complain.

During inspection, we observed an admission to Denholme ward. Staff greeted the patient and introduced themselves. The patient was escorted to their room on the ward and a consented search was undertaken, which maintained the patient's dignity. The patient was orientated to the ward and introduced to other patients. The patients requests for footwear and a snack was immediately actioned.

Staff invited patients, their carers and advocates to multi-disciplinary meetings, we saw evidence in files of invites to manager's hearings, and evidence of staff giving patients their medical notes prior to the meeting. We saw evidence in the files that patients could have a copy of their care plan and that copies were provided to carers if the patient consented.

Patients had access to an Independent Mental Health Advocate who visited the ward of a weekly basis. Information posters on the ward also documented how patients could access the advocacy service at any time and a picture of the advocate was included. The Independent Mental Health Advocate would also attend multidisciplinary meetings, which patients that we spoke to confirmed and all were aware of the advocacy service.

During the inspection, a carer was present during a meeting with their family member but they were unable to speak to us. The hospital provided us with one carer telephone number but we were unable to reach the carer to obtain feedback. However, we observed staff speaking to family members on the telephone and during admission to the ward the healthcare support worker offered to contact the family of the patient. Denholme ward had a family, friends and carer's pack containing relevant information about the hospital, ward, therapies and information about carers assessments and support. The hospital was hosting a carers event and a poster was visible on the ward advertising this event.

Denholme ward held a morning meeting Monday to Friday, a community meeting every Monday, and an involvement meeting every month. A list of dates were on a patient notice board for the next four involvement meetings. Patients we spoke to said they attended morning meetings and one patient told us she had completed a feedback form.

Staff had placed a 'you said, we did' board on the ward following feedback and requests from patients. For example a request for a reading group activity and for therapy leave in addition to any agreed daily leave, had been actioned.

Staff told us that patients could feedback to the occupational therapy team regarding improvements to the activities provided and the ward environment. Recent feedback from patients requested changes to the communal lounge on Denholme ward. This feedback had led to a repainted wall, beanbag area, the television moving onto the wall, and the purchase of an artificial aquarium.

The service used the 'friends and family' test as a means of gaining feedback about care and treatment. Between 3 March 2018 and 31 March 2018 there had been no responses to the survey on this ward, due to the shorter stay nature of the service.

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

Requires improvement

Cygnet Health Care Ltd employed an expert by experience lead for the north region. During the inspection, we talked to the expert by experience to obtain their views about the service.

They told us that the leaders and managers at Bierley had a strong focus on an ethos of service user involvement and on reducing restrictive practice across the hospital.

We saw that the role of expert by experience had been valuable to patients and to the service. They visited regularly and talked to patients about their care and treatment. They reported the feedback from service users to the governance meetings and project boards to ensure the patient's voice could be heard across the organisation. The expert by experience reported that the service users had told them that they felt 'empowered' by being involved in projects and from learning when things had gone wrong.

Locally, Cygnet Hospital Bierley also employed a service user involvement lead, which confirmed the hospital's ethos of ensuring patients were involved and directive in the care provided at the service. The role of this staff member was to 'create a voice for service users'. The involvement lead held a monthly meeting with patients from each ward. Patients took the minutes of these meetings and were encouraged to be creative about ideas to improve the service, including projects and activities. This meeting also devolved into working groups of patients to resolve issues around changes to policy and practices and ensure the patient voice was part of any changes to the service, for example, to ensure the new policy for the use of e-cigarettes met the needs of patients. The involvement lead also supported patients to take part in the 'recovery college' and in various other involvement projects via the use of media.

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

Requires improvement

Access and discharge

At the time of the inspection there were 12 patients admitted to Denholme ward, which had 15 available beds.

Between 1 July 2017 and 31 December 2017, the average bed occupancy was 79% and between 1 January 2017 and 31 December 2017 the average length of stay was 38 days. National guidance states that the optimum level of the provision of good quality care is 85%.

It was rare for patients to have any overnight leave from Denholme ward. The ward manager informed us that this might happen prior to discharge to test a stepdown placement or for an overnight home visit. The ward did not use these beds for other patients during any patient leave.

Denholme ward admitted patients from across the country and cared for a number of patients from outside of the local area. However, there remained beds available for patients in the local catchment area.

When patients became ready for discharge they would typically step down to a ward within the patients' local area. Staff did not move patients between wards without justified clinical grounds.

Between 1 January 2017 and 31 March 2018 Denholme ward had admitted 168 patients and discharged 166, which evidenced an ongoing focus on discharge. There was a discharge planning section within all patients care plans we reviewed. Patients told us about the plans for their discharge which had been discussed during the multi-disciplinary meetings. Denholme ward had not reported any delayed discharges of patients. Staff spoke of difficulties in moving patients on to more appropriate settings, particularly those who required a specialist service.

The facilities promote recovery, comfort, dignity and confidentiality

We were concerned about how the service protected the privacy and dignity of patients being admitted to the ward. Denholme ward was situated on the first floor meaning that patients coming in for admission, were admitted via the hospital's main entrance and reception, and then had to move through communal areas of the hospital to access the ward. These patients often arrived via ambulance or secure transport. The national association of psychiatric intensive care and low secure units guidance sets out the national minimum standards for psychiatric intensive care in general adult services. The guidance states that psychiatric intensive care unit should be on the ground

floor and if the psychiatric intensive care unit is part of a hospital, an entrance to the unit that does not necessitate travelling through the rest of the hospital should be provided.

The service had attempted to mitigate this risk by closing corridor access to all other patients and staff when the patient was moving through the hospital on their arrival. We observed this process during the inspection and it was not always followed by all staff and patients. Senior managers told us that if a patient was unsettled on arrival they would be placed in the ground floor seclusion room until the risk of moving through the hospital was lower. This was not dignified for patients who were visible on admission to other patients, staff and visitors to the hospital.

Denholme ward was welcoming, with staff names of those on shift clearly displayed, as well as the activities for the day shown on the notice board.

The ward had a quiet room. Music was playing and the staff controlled this from the main ward office. Patients had access to a large communal room with a television and a number of chairs and sofas, and a dining area where a flask of hot water enabled patients to make a drink. In addition to these rooms was a meeting room used for communal activities and one to one sessions. The ward manager told us that visitors could also use this room if the patient was too unwell to use the visitor's rooms off the ward. The ward also had a kitchen, which was not accessible to patients but where food and drinks could be stored and staff would get this for them. A laundry room was available for patients who had been risk assessed to use the equipment with supervision.

Thornton therapy department was located off Denholme ward and staff would escort patients to range of therapeutic activities and interventions. The rooms on this corridor included a sensory room that was entirely padded and contained a television, music system, lights, mirror balls and projectors and was popular with patients as a relaxing space. A fully equipped kitchen for planning, preparing and cooking meals, a well-equipped gym and a multi-activity room with a pool table, games console and a computer area, catered for patients with a mixture of planned and pre-booked sessions. The multi-activity room also ran a tuck shop Monday to Friday, 1 – 1.30pm, which was led by patients. Meetings, recovery college courses and therapy sessions were facilitated in a further group room.

There were two visitors' rooms and a multi-faith room on the ground floor. Two of the visitor's rooms off the ward also included toys and activities for family and friends visiting with children.

On Denholme ward patients could have access to their mobile phones at all times, as long as they were kept in their bedrooms and a mobile phone contract was completed on admission to the ward. The ward also had a phone in a private room that patients could use to make free outgoing calls.

On the ground floor, there was a secure courtyard, which patients could access with a member of staff. Staff told us that there were no restrictions to patients going outside but they had to ask a member of staff who would escort them. Within the courtyard, there was plenty of outdoor seating and some outdoor gym equipment. The staff told us that they would have BBQs in the summer and outdoor activities.

Drinks and snacks were available 24 hours a day and staff told us that patients could buy their own food. Staff supported them to complete online shopping if they chose to. We spoke to five patients and they told us that they liked the food provided. One patient said the "food is great. I love that you have options you can choose from a menu. No complaints. Usually a great menu".

Individual bedrooms could be personalised and we saw a room that had pictures and quotes on the walls. All rooms had a safe for the patient to use to store their possessions and staff on the ward kept any prohibited items securely. Patients could have their own key to their rooms. This was individually risk assessed. Where patients were not able to have a key, staff unlocked these rooms on request.

A range of activities was available seven days per week and led five days of the week by the occupational therapist team or ward psychologist. Staff told us that on a weekend patients often used their section 17 leave, engaged in one to one time, and participated in a number of activities such as arts and crafts, board games and books.

Meeting the needs of all people who use the service

A lift ensured people who could not manage the stairs could access Denholme ward. The ward had wheelchair access to rooms and a larger bedroom for disability access. Access to a communal bathroom was available for all patients.

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

Requires improvement

During the inspection, we saw that numerous posters and notice boards were on the walls informing patients about the:

- recovery college
- complaints procedure
- independent mental health advocate
- daily activities
- food menus
- you said, we did – improvements
- patient involvement, for example involvement meeting dates

The ward manager told us that they had access to interpreters and recently had a patient who spoke polish on the ward. The staff used the interpreter service during ward rounds, to read the rights of the Mental Health Act, and for a general conversation. The ward manager also told us that the information analyst provided information leaflets printed in different languages or formats.

Food choice was good and the kitchen catered for different dietary and cultural requirements, such as halal meat. Patient feedback had previously been negative regarding the quality and variety of food so this was an objective for the head chef to ensure culinary improvements and ensure catering for personal preferences.

Listening to and learning from concerns and complaints

The complaints process was available on the general notice board and within the welcome pack. Patients told us that they knew how to complain. An advocate was also available to support patients to complain or raise concerns.

From January 2017 to December 2017, staff recorded 25 complaints on Denholme ward; five upheld, nine partially upheld, seven not upheld and four withdrawn. No complaints had been referred to the ombudsman.

Complaint themes included loss of property and staff attitude on Denholme ward. The hospital reviewed closed circuit television footage where possible and offered a financial settlement were evidence could not prove or disprove the complaint regarding property loss. Staff attitude had been addressed using coaching, supervision and in more formal cases with the application of the disciplinary policy.

Staff confirmed managers provided feedback following complaints and we saw evidence of discussions in individual supervision sessions regarding the outcome of complaints and investigations.

From January 2017 to December 2017 Denholme ward received 26 compliments. One written compliment came from a carer who was very happy with the care his family member had received whilst on Denholme ward.

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 values of the provider were:

• Helpful

• Respectful

• Honest

• Empathetic

Staff we spoke with had a good awareness of the vision and values of the provider. The values were displayed throughout the hospital and were available to staff on the ward. During the inspection, we found that the conduct and performance of staff on Denholme ward displayed these values in their direct work with patients.

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

Managers were present on the ward, in particular the hospital, clinical and general managers. Staff we spoke with were also aware of the other senior managers who attended the hospital for six monthly governance meetings.

Good governance

The hospital had a clear governance structure in place. Every six months the senior leadership team from Cygnet Hospital Bierley met with the board and corporate managers for corporate governance meetings. Ward managers, senior staff, and senior members of the

multidisciplinary team attended a local Cygnet Hospital Bierley, monthly governance meeting. This meeting was structured and followed the same format as the corporate governance meetings and discussions included advocacy, medicines 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. The ward managers were responsible for reviewing and presenting a monthly data pack of this ward level information to the local governance meeting, and then for feeding back to staff and completing the key actions to improve quality and address any shortfalls discussed in the local governance meetings.

The service had a number of key performance indicators in place 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 service had made improvements in establishing their governance systems since the time of our last inspection. Clinical staff were appraised and supervised and had opportunities for specialist training and development. The service planned and managed staffing well and we saw evidence that poor performance was effectively dealt with by managers. The service employed a service user involvement lead, healthy lifestyle lead and an expert by experience to ensure patient's voices were heard and that patient involvement in care was high on the agenda.

Staffing was thoroughly monitored by the service. Between 1 January 2017 and 31 December 2017 the service had a 6% sickness rate, and had four staff leavers. The ward manager informed us that vacancies had been filled recently, and we reviewed staffing to find that no shifts were left unfilled.

At ward level there were opportunities for staff to learn from incidents. Staff felt supported because team meetings, supervision and debriefs were taking place. Staff were able to give us clear examples of how important information was shared across the service and across all hospitals managed by the provider.

Senior managers were aware of the risks and priorities for the service. For example, they were aware that some of the staff current practices in relation to the use of planned prone restraint were against national guidance. The clinical lead had made regular contact with the corporate managers to rectify this is and had made plans for a new method of staff training, and was awaiting training dates in order to create an action plan. Alongside this, the provider continued to work on reducing the use of prone restraint and had developed audits of its use to provide oversight and feedback to staff.

The hospital had a local risk register, which fed into the corporate risk register. Ward staff told us they could submit items to the local risk register via their ward managers. Senior managers could escalate concerns to the corporate risk register after discussion with the corporate risk manager. They told us that they felt confident and encouraged to do so, and had developed sound corporate relationships which allowed them to raise concerns at a corporate level and obtain additional support at service level as required, for example in response to the fire enforcement notice.

The hospital had ten current risks on their local risk register, which they monitored through the monthly governance meetings. These risks included staffing vacancies, a patient death, access to primary health care, heating systems, seclusion rooms, anti-barricade locks, structural concerns and fire safety deficiencies.

Minutes from the local governance meetings showed that staff conducted regular audits to ensure they were improving quality and safety on Denholme ward. Managers had recognised issues relating to the recording of rapid tranquilisation and seclusion, and had taken action to improve this, including the introduction of training sessions.

However, governance systems and processes were not entirely effective. Despite the service's approach to audit, we found concerns on Denholme ward in relation to the recording of physical health checks on admission, the monitoring of anti-psychotic medication side effects and monitoring of patients following the use of rapid tranquilisation. Also, the supervision of allied health professionals was not in line with Cygnet policy. Senior managers were not of aware of all of these concerns at the time of the inspection.

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

Requires improvement

There was a lack of oversight at senior management level regarding the application of the Mental Capacity Act. Although staff were trained, they lacked confidence to understand the interface between the Mental Capacity Act and the Mental Health Act. This had developed into an incorrect culture of staff understanding what decisions they could make on behalf of detained patients and at ward level, we saw that staff were reliant on others to assess capacity.

Despite Mental Health Act audits taking place and noting compliance we found errors in patient's consent to treatment paperwork.

The senior management team were aware of the risks of moving patients using stairs to the ground floor seclusion room, and moving patients admitted to the psychiatric intensive care unit using stairs. However, there was not a risk assessment or protocol for staff to follow in order to manage this risk.

There was not a protocol in place for staff to follow in relation to admitting patients through communal areas of the hospital to the psychiatric intensive care unit. The psychiatric intensive care unit was on the first floor of the hospital and did not have a separate entrance. The service had carried out an analysis of whether they should follow recommendations in national best practice guidance in relation to the first-floor location of the psychiatric intensive care unit in 2016. This was in response to a recommendation following the death of a patient. The service had made the decision not to re-locate the ward, there had not been a further review of this decision since this time.

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. Patients could nominate staff members to receive an employee of the month award.

The ward had four staff leavers between 1 January 2017 and 31 December 2017. This included one qualified nurse and three healthcare support workers. The service explained that staff had left the service for different reasons such as career changes and relocation.

The provider reported a 5.9% sickness rate for 2017 for both clinical and non-clinical staff hospital wide. The sickness absence related to physical health and reportable injuries. Sickness reports and monthly monitoring by exception highlighted support for staff and adherence to policy triggers for management of sickness absence. One member of staff we spoke with on Denholme ward told us that managers had supported a move to another ward on their return to work following a work related injury in order to support them to stay in work.

The provider had conducted a hospital-wide staff survey in November 2017. There were 64 respondents to the survey. The results of the survey were not broken down to ward level to protect staff anonymity. The overall staff survey 'positive score' was 78%. Eighty-three percent of respondents stated that they enjoyed working for the provider and 69% stated that they were proud to work for the provider. The staff survey showed lower levels of satisfaction with staffing levels, stress at work, staff benefits and pay, and staff experiencing bullying, harassment or abuse from service users. The provider continued to work these responses as part of the hospital's overarching local action plan.

Staff told they enjoyed their job roles, staff morale was positive, and relationships between staff and mangers on the wards were good. In the staff survey 91% of respondents agreed their manager treated them with respect and staff had respect for their immediate line managers. They felt supported by their managers and thought they did a good job. Staff told us the hospital encouraged leadership development opportunities and staff on Denholme ward told us that the hospital would support and fund people to go to university to undertake their nurse training.

Staff told us they felt able to raise concerns without fear of victimisation and confirmed they knew the whistleblowing processes. They felt they could contribute with ideas for developing the service. and

Commitment to quality improvement and innovation

The ward participated in national quality improvement programmes. Denholme ward had received 'accreditation of inpatient mental health services. This is an initiative linked to the Royal College of Psychiatrists. To achieve accreditation, a psychiatric intensive care service has to demonstrate the quality of care they provide to service users meets or exceeds the national guidelines and standards.

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

Requires improvement

During the inspection, we found a number of innovative projects in delivering therapy to patients, and ensuring that outcomes were met. Many of these projects were routed in patient involvement and the hospital strived to ensure patient involvement was an integral part of their work with the employment of their own expert by experience and service user involvement lead.

Some of these projects included;

- In March 2018, the hospital celebrated their Recovery College being awarded accreditation by the Assessment and Qualifications Alliance (AQA).
- The hospital have also won awards for their dialectical behavioural therapy programme with The Association of Psychological Therapies (APT) awarding the staff for their 'demonstrable commitment to deliver all five functions and corresponding modes of dialectical behavioural therapy, and to do so consistently and to a high standard' in April 2017.
- The hospital's psychology team have introduced bit size recovery skills sessions on Denholme ward to ensure that despite sometimes short stays on the ward, patients have access to therapy where they can learn skills and coping mechanisms.

The therapy teams had undertaken several media projects with patients such as producing an 'understanding borderline personality disorder film, a mental health stigma film. The hospital were also shortlisted for a national service user award for the development of a Dialectical behaviour therapy recovery inspiration group. Patients had entered a Cygnet wide dragon's den competition to raise funds for audio and information technology equipment.

Requires improvement

Forensic inpatient/secure wards

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

Are forensic inpatient/secure wards safe?

Requires improvement

Safe and clean environment

Cygnet Hospital Bierley had two low secure forensic inpatient wards, which provided care for patients over the age of 18. Shelley ward provided care for up to 16 male patients and Bronte ward provided care for up to 12 female patients.

Staff controlled entry and exit to both wards with electronic fobs and keys via an 'air-lock' system. Both wards had a 'T' shaped layout, which did not allow staff a clear line of sight to observe patients. Staff mitigated this risk through patient observations and some rooms contained curved mirrors, which helped mitigate blind spots.

Some areas of both wards contained ligature points. A ligature point is something that a patient intent on self-harm could tie something to in order to strangle themselves. The ward managers had completed a ligature audit on both wards within the last twelve months. These ligature audits identified all the ligature points and colour coded high risk areas in red, no areas were noted as high risk at the time of the inspection.

Staff told us that they mitigated the risk of ligature points through staff awareness and observation. The managers had placed a visual display in the staff office on both wards, containing the ligature points on the ward. Only staff could see the display and it increased their awareness of the ligature points and therefore increased staff vigilance during observations in these areas of the wards. Staff demonstrated knowledge of all the ligature risks. In addition, they could observe patients in the activity rooms from the staff office, which had a large window overlooking the area. The provider confirmed that in the three months prior to this inspection, they had not had any incidents on either ward with patients attempting to ligature.

However, we identified some ligature points during the inspection which staff had not entered onto the ligature audit or map on Bronte ward, for example; the service had fitted blinds in the activity rooms and there was a bookcase in the corner of the room but we could not see these identified on the ligature risk map. We raised our concerns with the hospital and they responded immediately, supplying supplied the ward with an up-to-date copy of the ligature audit and risk map, which contained all of the ligatures present on Bronte ward.

Both wards were compliant with the Mental Health Act Code of Practice and Department of Health guidance on eliminating mixed sex accommodation. Bronte ward only accommodated female patients and Shelley ward only male patients.

The clinic rooms on both wards were clean and well organised. There was an examination couch, blood pressure machine and weighing scales to allow staff to undertake patient examinations, including physical health checks. The equipment was clean and staff had calibrated it to ensure it worked properly. Staff recorded the temperature of the clinic rooms and medicines refrigerators on a daily basis and took appropriate action where temperatures fell outside the recommended ranges. At the time of our inspection, there were no controlled drugs on either ward, which the controlled drugs registers confirmed.

Forensic inpatient/secure wards

Staff had access to an emergency resuscitation bag, kept in the staff office. It contained oxygen, medication to treat patients with serious allergic reactions, a defibrillator, ligature cutters, a first

aid kit and other equipment required for resuscitation. Staff checked the bag on a weekly basis to ensure the contents were in good order.

There was a seclusion room on the ground floor of the hospital outside Shelley ward. It was not exclusively used for Shelley ward patients. Staff and patients from Bronte ward accessed the seclusion room via a set of stairs, because Bronte ward was located on the first floor of the building, and the first floor seclusion room had been closed for an upgrade since 17 March 2018. We had concerns that the provider had not carried out an assessment to determine the risks of transporting patients down the stairs to seclusion when in restraint. However, in the three months prior to our inspection, the provider told us they had not secluded any patients on Bronte ward.

The seclusion room on Shelley ward complied with guidance in the Mental Health Act code of practice because it had a viewing panel allowing staff to observe patients, a working clock, natural light and toilet facilities. Patients could communicate with staff via an intercom. However, we were concerned that patients could use the mattress, which was not fixed at any point, to restrict staff observation.

Both wards and the communal areas of the hospital looked clean and when we spoke with patients, they confirmed this. We checked cleaning records for the ward and found that in-house domestic staff cleaned the ward daily, including patient bedrooms and en-suite facilities. Staff told us that at weekends, they cleaned the wards because domestic staff only worked Monday to Friday. The décor was well- maintained and contained good furnishings. Each ward had an infection control audit but some of the items in the action plan were ongoing. For example, on Bronte ward, some minor repairs were needed in the kitchen area and on Shelley ward, the furniture coverings in the lounge area had not been cleaned though they had been replaced in the previous two years. The infection control audit specified that staff should complete all the actions by 1 May 2018.

Staff had access to hand gel cleansers, which were available on the entrance to both wards and in clinic rooms, kitchens, and toilets. We saw posters next to hand basins advising staff of correct hand-washing techniques. Both wards had an infection control lead. The lead on Bronte ward told us they encouraged patients to wash their hands before eating meals and taking medication.

The hospital's general manager was responsible for overseeing environmental, health and safety and fire risk assessments. Health and safety representatives from each ward met with the general manager each month to discuss environmental risks and actions. The estates lead and general manager completed regular environmental audits of the entire hospital site, which included weekly ward tours to monitor and manage environmental concerns. Staff confirmed they were able to request support from the maintenance team where they identified repairs required on the wards.

The hospital had developed a process to improve the management of fire risks. This included employing an independent fire risk assessor to visit the hospital, and planning enhanced face to face training for staff.

In February 2018, the hospital received a fire enforcement notice from the West Yorkshire fire brigade, because the fire brigade had a number of concerns about risk following completion of a fire assessment. The hospital had responded to this via the completion of a time limited action plan. We reviewed this action plan during the inspection and found the service had completed most areas, other than those tasks, which required long-term building work. The fire brigade will re-visit the hospital to check on compliance in May 2018. The general manager told us that the hospital had been supported by the corporate provider to make the required changes and become compliant.

We reviewed fire policies, procedures and safety during the inspection and found that the estates team had undertaken tests of emergency lighting, fire extinguishers, lift safety, gas safety and electrical equipment within the last twelve months.

All staff carried an alarm that when activated showed up on a central panel to indicate the location where the alarm had been pressed. All ward staff were observed to carry personal alarms, and nurse call alarm buttons were present in patient's bedrooms. Staff checked alarms were working each morning when they collected them from reception. Each day the shift leader allocated a staff

member to respond first if an alarm sounded. Staff told us colleagues responded promptly when they needed assistance. Patients had access to alarm call points in their bedrooms and communal areas including bathrooms.

Safe staffing

Both wards used an in-house staffing tool to identify staffing requirements, which was based on the acuity of patients admitted to the wards. On Bronte ward, the establishment levels were 7.1 whole time equivalent qualified nurses and 11.1 nursing assistants. On Shelley ward, the establishment levels were 7 whole time equivalent qualified nurses and 11 nursing assistants. At 1 November 2017, the provider told us there was one vacancy on Bronte ward and one vacancy on Shelley ward for a qualified nurse and one vacancy for a nursing assistant on Bronte ward. There were no vacancies for nursing assistants on Shelley ward.

The provider told us that from 1 November 2017 to 31 January 2018, the number of shifts filled by bank staff on Bronte ward was 137 and 132 on Shelley ward. In the same period, the number of shifts filled by agency staff on Bronte ward was 24 and on Shelley ward, it was 157. Staff told us the reason the use of agency staff was higher on Shelley ward was because they required slightly higher staffing levels to take account of greater numbers of patients. On Shelly ward, there were 16 patients whereas on Bronte ward, there were twelve. The provider reported that there were no unfilled shifts by bank or agency staff in the three months from November 2017 to January 2018. When we checked staffing rotas, we found that in the three months prior to our inspection, there was a minimum of four staff on shift including at least two nurses on Bronte ward during the day, and three staff including at least one nurse at night. On Shelley ward, there was a minimum of five staff including at least two nurses during the day, and three staff at night including one nurse.

In the 12 month period prior to this inspection, the provider told us the sickness rate for the hospital was 5.9% which was slightly higher than reported at the last inspection in 2017. The provider told us the staff turnover rate for Bronte ward was 21% and for Shelley ward it was 5.5%. These figures were lower than the figures reported at a hospital wide level in the last inspection in 2017.

Both ward managers confirmed they could adjust staffing levels daily according to patient need and occupancy within agreed parameters. Each morning, the ward managers met with other hospital managers to identify staffing needs for the coming day and night. Staff we spoke with confirmed they cooperated with each other across wards to move staff around as necessary to meet patient need. Several patients on Shelley ward told us they thought there should be more staff to facilitate patient leave. Both staff and patients confirmed that sometimes, not all patients could have escorted leave on the same day and some had to wait until the following day. The hospital told us that following the last inspection in May 2017, they had started to monitor any activities they cancelled. They told us that since the monitoring had been in place, they had not cancelled any patient leave or activity on either of the wards because of staff shortages.

The hospital had on-call arrangements to meet the needs of patients. Out of hours, there was always one nurse on call, and a clinical team leader or manager. Patients and staff had access to an on-call speciality doctor and psychiatric consultant. Patients and staff told us the on-call staff responded quickly when needed within thirty minutes.

Staff on both wards confirmed they completed mandatory training. Prior to the inspection, the provider told us the target for training compliance was 95% and staff participated in 26 mandatory training modules. These including basic and intermediate life support, infection control, information governance, medicines management, risk assessment and risk management, the prevention and management of violence and aggression, the Mental Capacity Act and Deprivation of Liberty Safeguards, and the Mental Health Code of practice. Staff compliance with mandatory training had improved on both wards since the last inspection but on Shelly ward, staff compliance with mandatory training was below the provider's target of 95% in eight training courses, and on Bronte ward, compliance was below target for ten courses. However, training compliance for all courses on both wards was above 75% which is the minimum standard expected by the Care Quality Commission. Staff told us agency and bank staff had access to the same mandatory training as other staff.

Assessing and managing risk to patients and staff

From July to December 2017, the provider told us that on Bronte ward there had been one incident of seclusion and no incidents of long-term segregation. On Shelley ward, there were three incidents of seclusion and no incidents of

long-term segregation. However, when we checked the seclusion records, we saw that there was one episode of seclusion on Bronte ward in the six months from July to December 2017.

We reviewed five seclusion records. Overall, we saw that seclusion was used appropriately and was proportionate the risks presented, Nurses carried out appropriate reviews and staff observed patients at appropriate intervals in line with the provider's policy. However, on Bronte ward, one seclusion record did not identify whether a medical review had been completed within the required timescale or what fluids or medication had been provided to the patient.

Between 1 July 2017 and 31 December 2017, staff on Bronte ward used restraint on 12 occasions with three patients. Two of these restraints were in the prone position. On Shelley ward, staff used restraint on 11 occasions with six patients and three of these were in the prone (chest down) position.

We reviewed seven restraint records which showed that most periods of restraint were of short duration and involved no more than three staff. Two incidents of restraint lasted for five minutes and one of those involved four members of staff. Staff told us they used restraint only as a last resort when verbal de-escalation techniques had failed to calm the patient sufficiently.

We reviewed five care records on Bronte ward and five on Shelley ward. On admission, staff completed a risk assessment called the short-term assessment of risk and treatability, and the historical clinical risk management tool. All the records we looked at contained an up-to-date assessment, which staff had reviewed as a minimum within the previous three months. Staff updated risk assessments following patient incidents and used a traffic light system to identify on-going risks.

Bronte and Shelley wards operated with some blanket restrictions. For example on Bronte ward, patients had supervised access to outside space. Staff removed items from patients such as razors, glass, smoking paraphilia and cans. Patients had access to hospital supplied basic mobile phones, staff never locked communal areas such as the lounge and dining area and patients were individually risk assessed for use of other items including hair dryers and straighteners. The laundry room was locked because this operated on a shared basis to allow all patients access to complete their own laundry, the ward kitchen was locked due to the high risk items stored, but patients had access to a beverage bay and also to a patient kitchen. Staff continually monitored these rules, and included them in the ward's quarterly blanket restriction audit. These blanket restrictions were justified, as it was a necessary and proportionate response to the risk identified for this patient group, and was therefore in line with the Mental Health Act Code of Practice.

However, several patients told us that staff did not allow them to have two-litre bottles of fizzy drinks on the wards. Patients had also raised this at the community meeting on Shelley ward in March 2018. Staff told us that this measure was in place to encourage patients as part of a healthier lifestyle and there was limited space on the wards to store large bottles. When we raised this with the hospital, they told us they would review this.

At the time of inspection, all patients on both wards were detained under the Mental Health Act but there was a notice displayed on each ward to tell informal patients that they could leave at any time by asking a member of staff to unlock the doors from the ward.

Staff adjusted levels of observation for patients based on their individual risks. They knew the observation levels required for each patient because they were on a board in the staff office. The provider had installed closed circuit television in the communal areas of both wards and specially designed anti-ligature vision panels were fitted on all patient bedrooms. The staff we spoke with were clear about what was expected of them when undertaking observations of patients. Nursing staff assessed the competence of support workers prior to them undertaking observations on their own. The clinical lead carried out monthly audits of observations to ensure these took place on the wards, and they reviewed observation charts against close circuit television.

The service had a search policy, which staff adhered to. Searches were only carried out with patients with their consent and where there was an identified risk, for example for some patients when returning from unescorted leave.

At our last comprehensive inspection of this service in June 2015 we told the provider that they must reduce the numbers of prone restraints. In response, the provider had continued to work on reducing the use of prone restraint and between January and March 2018; there were nine uses of restraint on Bronte ward with one use of prone

restraint, and two episodes on Shelley ward with no uses of prone restraint, which showed a reduction in its use. In the records we reviewed, we saw that staff had not used prone restraint to deliver any intra-muscular medication. Staff used prone restraint on one occasion to exit seclusion in November 2017 and had not used this method since this time.

We reviewed the provider's staff training package for the management of violence and aggression. The training model included training staff in the use of pain compliance holds 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 these methods but were clear that they were last resort methods. The provider was aware of the need to monitor and measure the use of these types of restraint holds and had conducted an audit of their use. This audit had identified no incidents where staff had recorded the use of holds that could be described as pain compliance, which evidenced that staff had a good understanding of the application of their training.

Between 1 July 2017 and 31 December 2017, Bronte ward had four episodes, (three oral and one intramuscular administration), where staff administered rapid tranquilisation to patients. Shelley had seven episodes, which were all oral administrations). This was lower than the 14 episodes reported at the last inspection. The National Institute for Health and Care Excellence defines rapid tranquilisation as 'use of medication by the parenteral route (usually intramuscular or, exceptionally, intravenous) if oral medication is not possible or appropriate and urgent sedation with medication is needed'. However, the hospital's own policy classed both oral and intramuscular administration as rapid tranquilisation. We reviewed six records where patients had been administered rapid tranquilisation. All records followed national guidance, except one where staff had not recorded the respiratory rate for one patient on Bronte ward.

All the staff on both wards had completed their mandatory training in safeguarding adults and children. The hospital had social work staff with a dedicated safeguarding lead. Staff on the wards were knowledgeable about safeguarding procedures and could describe different types of abuse and potential indicators of abuse. Support workers told us they would discuss any safeguarding concerns with the nurse in charge and could seek advice from the social work team. The hospital had up-to-date policies on adult and child safeguarding which contained safe procedures for children to visit patients off the ward in dedicated visiting rooms.

The provider had an appropriate medicines management policy, which incorporated ordering, storing, administering and destroying medicines. The hospital had an agreement with a local pharmacy that provided advice and support to staff to manage medicines safely. We reviewed the medicines administration charts for all patients on both wards. We found staff kept accurate records of the treatment patients received. Prescriptions for medicines to be given as or when required contained sufficient information to enable staff to administer them safely.

The pharmacy provider carried out monthly prescription card audits and fed results back to senior managers. We reviewed medication audits for December 2017 to February 2018 for both wards. Both wards had a low level of errors and we were able to see improvement month on month. For example Bronte had a 0.4 error rate in December 2017 and then no errors in January and February 2018. Shelley ward had improved from 0.5 administration errors to no errors between January and February 2018.

Track record on safety

From January to December 2017, there were eight serious incidents relating to Shelley and Bronte wards. The four incidents on Bronte ward related to two allegations against staff members and two episodes of patients absconding from leave. The four incidents on Shelley ward related to one incident of incorrect Mental Health Act paperwork, two incidents of allegations against staff, and one incident of a serious injury caused to a member of staff. Senior staff in the hospital had investigated all the incidents and carried out a root cause analysis where necessary.

Staff told us that in relation to the serious assault on a member of staff, the hospital had replaced the hot water dispensers in the kitchens with flasks. This minimised the risk to staff and patients from scalding water. Staff had taken action on all other wards not just the ward where the incident had happened. Staff told us the hospital had plans to replace the hot water dispensers with ones where staff

could control the water temperature. We saw evidence that maintenance staff had started to replace the hot water dispensers throughout the hospital to improve staff and patient safety.

Reporting incidents and learning from when things go wrong

When we spoke with staff, they had a good knowledge of the ward's reporting procedures and could describe the type of incidents to report. This included agency staff, students, and therapy assistants. Each ward had an incident reporting logbook, which they submitted to the ward manager after each incident. Ward managers kept records of incidents including safeguarding alerts, which they discussed at the morning meetings, which involved senior managers and the hospital's clinical lead. All ward managers were present at this meeting and staff told us this allowed them to share lessons learned from incidents, which happened on other wards.

Staff received feedback from incident investigations, both internal and external to the service. The service had a corporate and local lessons learned log, which they disseminated to all staff. We saw these present on the wards and in staff areas during the inspection. Managers discussed incidents at regular governance meetings and disseminated lessons learned to staff via a monthly quality newsletter.

We could see from the incident log that staff had carried out appropriate investigations and actions in relation to serious incidents. Staff discussed incidents in team meetings and at handovers. When we attended a ward handover where staff discussed a recent incident involving two patients. Staff gave examples of changes made following incident, for example managers advised staff to use the stable door facility in the team office if patients were obviously agitated. This allowed staff more opportunity to use verbal de-escalation and assess the behaviour of the patient before opening the door fully.

Most staff confirmed that they had the opportunity for debrief and support following incidents. Staff gave examples where they had been offered support and a de-brief following minor assaults by patients on the ward. Staff told us they offered patients support and debrief following serious incidents and we saw evidence of this in some of the patient records we reviewed.

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 confirmed they knew the provider had a duty to be open and honest when things went wrong. We did not see any examples of its use at the time of the inspection as none of the incidents which had taken place warranted its use.

Are forensic inpatient/secure wards effective?

(for example, treatment is effective)

Requires improvement

Assessment of needs and planning of care

We reviewed six patient records on Bronte ward and six on Shelley ward. All patients received a comprehensive and timely assessment either at admission or shortly after.

All the care records we reviewed contained a variety of different care plans, which staff updated regularly. Patients had different care plans according to their individual needs; for example, some patients had a substance misuse care plan because they had previous problems with drugs and alcohol. Some patients had health care plans in place to address weight issues and other lifestyle related behaviours. Care plans contained goals but were not always recovery oriented. This meant they were not always strengths based, which the Department of Health says is essential to promoting hope, well-being, and a sense of determination for people with mental illness.

The hospital was in the process of transferring all patient records to an electronic based system. All patients had two paper files, a main file with details of treatment and care including care plans and a physical health file with details of on-going physical healthcare monitoring. Staff kept handover and daily notes on the electronic system. They also kept electronic records of capacity assessments. Staff told us they knew where records were stored and many

documents were on both systems. However, it sometimes took them a long time to find notes, for example, capacity assessments, because they were not always duplicated in the paper notes.

Staff kept paper records securely in a lockable cupboard in the staff office. The hospital controlled access to electronic records by ensuring staff had individual passwords.

The hospital had appropriate information sharing policies in place and we saw how staff protected patient information by having agreements in place with patients about who they wanted staff to share their information with. Staff also protected patient information by having secure procedures for the access and storage of confidential information.

Best practice in treatment and care

The provider ensured that care and treatment policies contained reference to appropriate national guidance such as the Mental Health Act Code of Practice and National Institute for Health and Care Excellence. They produced medicines management policies underpinned by a range of relevant guidance including the clinical guidelines on the management of schizophrenia (2009).

Staff carried out regular audits to ensure medicines were stored and prescribed effectively. Staff told us that they carried out and recorded antipsychotic physical health and therapeutic drug monitoring when needed. Doctors told us that those patients taking high doses of anti-psychotic medications were discussed in two weekly multi-disciplinary meetings as per the benefits and risks of continuing the medications. National guidance states that monitoring is important to ensure people prescribed anti-psychotics are physically well, receive the most benefit from their medicines and are not affected by side effects of the medications prescribed. We reviewed the records for eight patients' prescribed antipsychotic medication and found that checks and reviews were not always taking place. For one patient prescribed high-dose antipsychotic medication, staff had completed all the necessary monitoring. However, in four records, staff did not complete physical health monitoring in line with national guidance. For example, in two of these four records the patient's electrocardiogram monitoring was overdue.

Staff supported patients with access to physical healthcare. We saw examples in patient records where staff referred patients for appropriate health screening, for example, they referred a diabetic patient for eye screening. Where necessary, staff supported patients to attend opticians, dentists, and chiropodists. Staff used a validated tool to give each patient a score for predicting their likelihood of them developing cardiovascular disease based on their individual risk factors.

The provider had a physical healthcare policy and intended to employ a registered general nurse to oversee the physical health care needs of patients. Patient access to being able to register with a GP practice was an ongoing challenge. However, access to GP services was via a long-standing service level agreement with a local GP practice who provided a weekly dedicated clinic for patients. Managers had entered this concern on the service risk register and senior managers continued to work with local commissioners to resolve the concern.

As part of the admission assessment, all patients received a physical health check followed by on-going physical health monitoring. Each patient had a separate physical health file with details of their weight, blood pressure, temperature, blood sugar levels, their waist measurement, and their body mass index. Staff monitored these on a weekly basis with patient consent. However, we found that two patients with long-term physical health conditions, such as asthma and diabetes had not had a recent review of their health condition with an appropriate practitioner. Staff had not recorded reviews of patients' long-term health conditions monthly in accordance with the hospital's physical healthcare policy.

Patients had access to psychological and other therapies recommended by the National Institute for Health and Care Excellence. The service had an in-house psychology team who worked with patients across both wards conducting psychological assessments and delivering psychological treatment tailored to the needs of individual patients. The team provided patients with access to cognitive and dialectical behaviour therapy and cognitive based substance misuse treatment programmes. They delivered interventions in group settings and on a one-to-one basis. Staff were aware of the newly published guidance developed by the British Psychological Society. Staff told us the provider had plans to put the new guidance into practice. Most patients we spoke with who had experienced

therapy told us they valued the psychological treatments on offer. Waiting times for patients on both wards to access in-house psychological therapy had improved from 51% of patients seen within six weeks in 2016 to 65% in 2017

Occupational therapists followed best practice guidance with patients completing assessments and outcomes monitoring with patients using the Model of Human Occupation Screening Tool, the occupational self-assessment, and the occupational circumstances assessment. Clinical staff used the Health of the Nation Outcome Scales, to measure patients' health and social functioning and the Mental Health Clustering Tool, to support effective care planning with patients. Psychology staff measured patient outcomes after therapy by mapping reductions in symptoms. Staff used the "Recovery Star" at regular intervals to measure patients' progress with their recovery goals. The star covered the main aspects of patients' lives including living skills, relationships, work, identity and self-esteem, and social networks.

The therapy teams had carried out several media projects with patients such as producing a film aimed at promoting an understanding of borderline personality disorder. The hospital was shortlisted for a national service user award for the development of a recovery inspiration group. Patients had entered a Cygnet wide 'dragon's den' style competition to raise funds for audio and information technology equipment.

Senior staff followed an annual audit programme to monitor the quality and safety of the service. Examples of audits included infection control, psychology outcomes, the prevention and management of violence and aggression, complaints, patient notes, restrictive practices, seclusion, restraint and rapid tranquilisation. Ward level staff also completed regular audits including infection control, clinic rooms and environmental audits. Each month, staff participated in a clinical audit meeting to discuss audit outcomes and review associated action plans.

Skilled staff to deliver care

Patients had access to a range of experienced and qualified staff including, doctors, nurses, psychologists, social workers, occupational therapists, and support workers. Social work teams supported patients with access to housing, benefits, and contact with families, and assessments of capacity. The hospital had a dedicated worker providing patients with healthy lifestyle advice and information. Patients also had access to a service user involvement lead who helped facilitate community meetings and ensured patients had opportunities to be involved in their care and treatment.

All staff including temporary and bank staff received an appropriate local and corporate induction. Temporary staff had access to the same mandatory training as permanent staff. Doctors had completed re-validation where required within the previous 12 months.

The provider had a thorough recruitment policy. We reviewed staff files for managers, nurses, health care support workers, doctors and temporary staff. All staff had the appropriate paperwork in place to ensure safe recruitment, including disclosure and barring checks, references, and copies of qualifications and professional registration.

The provider had a clinical supervision target of 90%, and, at 31 January 2018, the provider told us that all staff on the low secure forensic wards had received clinical supervision every four weeks as per the provider's policy. When we spoke with ward staff, they told us they received regular supervision. As part of the inspection, we checked some dates that staff including nursing staff and healthcare support workers had been supervised. Records kept by supervisors showed that nursing and healthcare support staff had access to clinical supervision in line with the provider's policy. Staff told us that they could talk to their supervisor about any concerns or stresses they might have.

However, staff from social work and occupational therapy departments told us that supervision was not always formalised and took place on an ad hoc basis. The provider's own policy stated all health professionals should have monthly supervision. Senior managers were not aware that supervision with this staff group did not always take place in line with the policy.

Staff, they told us they had received a recent appraisal of their performance. All staff on Shelley ward and 94% of staff on Bronte ward had completed an appraisal in the last 12 months. Both wards were 100% compliant with appraisal by the time of the inspection. Staff had access to regular team meetings and some staff participated in safeguarding supervision facilitated by social work staff. Staff confirmed they had access to minutes from meetings if they were unable to attend.

Forensic inpatient/secure wards

Staff from both wards told us they had access to specialist training for their role. Psychology staff provided training for staff including a two-day course in dialectical behaviour therapy and psychological formulation training. Members of the multidisciplinary team also had access to training in psychological approaches. The psychology team facilitated monthly sessions with staff to allow them to reflect on their practice and develop their treatment approach.

Managers told us they had access to human resources support for dealing with poor staff performance. Supervision records demonstrated that managers addressed poor performance including sickness and lateness.

Multi-disciplinary and inter-agency team work

We observed one multidisciplinary meeting and one handover meeting.

Staff and patients attended multidisciplinary meetings on each ward to discuss patients' care and treatment. Members of the multidisciplinary team worked effectively together to review patient care and formulate plans. The team knew the patients well and had a good rapport with them.

In the handover meeting, we observed how staff on the night shift shared detailed information with the day shift about each patient and any concerns they had. Staff discussed any incidents from the previous night and any on-going monitoring which they thought day staff needed to know. Staff recorded handover notes electronically so other staff including members of the multidisciplinary team could refer to them.

Staff had effective working relationships with external services to support patients' needs, for example working with commissioners and community teams to support patients' plans for discharge.

Adherence to the MHA and the MHA Code of Practice

At the time of our inspection, all the patients on both wards were detained under the Mental Health Act. There were notices on both wards indicating that informal patients could leave by asking a member of staff to open the doors. The hospital ensured that all staff received training in the Mental Health Act and the Code of Practice. On Bronte ward, all staff had undertaken this training and on Shelley ward, 79% of staff had undertaken it.

Staff had support from Mental Health Act administrators based within the hospital. They provided training, guidance and advice to staff. A clinical manager carried out monthly audits and ensured they fed back the results through the governance structures to other managers. The provider sent us copies of the most recent audits they had carried out in March 2018. As part of the audit, staff looked at T2 and T3 paperwork, whether patients had been reminded of their rights, whether section 17 leave forms were in order, and whether there was evidence of consent to treatment and consent to share information. Both Bronte and Shelley wards were 100% compliant with the requirements of this audit and there were no issues identified on their action plan.

When we looked at care and treatment records, we found that in all cases, staff had completed and reviewed the patient's consent and capacity to receive medical treatment. Staff regularly explained their rights to patients, which, they recorded and dated. We saw that staff assessed patients' understanding of their rights as part of the process and recorded each patient's consent to carer and family involvement.

Patients we spoke with told us they received copies of section 17 leave forms and when we looked at a sample of records, we could see that staff provided patients with copies of their leave authorisation forms. This was a previous issue on Shelley ward when they last had a Mental Health Act review in October 2015, which the ward had addressed.

On both wards, staff informed patients about their eligibility for an independent mental health advocate, who visited the unit once a week to speak to patients. Staff displayed posters advising patients about the service offered.

When we spoke with patients, they told us they were generally satisfied with their treatment except on Shelley ward where some patients told us there was not enough staff to ensure they could always take escorted leave every day. No patients raised any concerns regarding their care treatment or human rights, except for on one patient who thought their discharge from the ward had been delayed. When we spoke with staff about this, they told us they had difficulty locating a suitable placement but were working with other stakeholders to address this issue.

Good practice in applying the MCA

Requires improvement

Forensic inpatient/secure wards

Staff participated in mandatory training in the Mental Capacity Act and Deprivation of Liberty Safeguards. The provider told us that all of staff on Shelley ward and 94% of staff on Bronte ward were up-to-date with this training.

The Mental Capacity Act is a piece of legislation, which maximises an individual's potential to make decisions for themselves wherever possible. The Act and associated Code of Practice provides guidance and processes to follow where someone is unable to make their own decisions.

The provider had a Mental Capacity Act policy in line with the associated code of practice. The policy contained appendices with forms for recording capacity assessments and best interest decisions.

Not all staff demonstrated and understanding of the principles of the Mental Capacity Act, despite the high training compliance and the policy being in place. Some staff had limited knowledge of best interest decision making and told us that they always referred to social work staff, where they had doubts about a patient's capacity to make decisions. Social work staff or, in some cases, the responsible clinician carried out all capacity assessments and best interest decision making processes within the hospital. This meant staff on the ward did not always identify when capacity assessments needed to be reviewed and they did not always identify what constituted a best interest decision and how this should be documented in the patient's record.

Patient records contained some evidence of capacity assessments but we did not see evidence that staff consistently documented best interest decisions where they assessed that a patient lacked capacity to make a specific decision. We saw an example in the care record of a patient on the low secure forensic service who lacked capacity to make financial decisions. Staff gave the patient an allowance each day but there was no evidence they had carried out a best interest decision regarding the amount of the allowance. Staff had discretion to increase the amount but there was no documented evidence they acted in the patient's best interest, recognising the importance of the patient's wishes. According to the Mental Capacity Act 2005 Code of Practice, staff should make sure a record is kept detailing the process of working out the best interests of a person who lacks capacity. When we looked at the patient's records, staff had documented that the multidisciplinary team would review the patient's capacity every two weeks but we could find no evidence that this had happened. The Mental Capacity Act code of practice states that peoples' capacity should be reviewed as people can improve their decision-making capabilities.

When we spoke to social work staff about this, they agreed that implementation of the Mental Capacity Act and best interest decision-making process was patchy across the hospital. They told us the provider did not carry out any audits or monitoring staff adherence to the Mental Capacity Act and the code of practice other than monitoring staff compliance with specific training.

All the patients in the forensic wards were detained under the Mental Health Act. This meant that staff did not provide care and treatment to patients under Deprivation of Liberty Safeguards.

Are forensic inpatient/secure wards caring?

Good

Kindness, dignity, respect and support

We observed staff caring for patients within and outside the ward environment. They treated patients respectfully and professionally. Staff provided appropriate emotional support to patients when they were upset or anxious. They provided practical support, for example, by attending external appointments with patients. Staff were discrete and we saw they knocked on patient's bedroom doors to ask permission before entering. Staff demonstrated a caring approach and had detailed knowledge of the individual needs of patients on their ward. Staff had placed welcome boards in the hospital corridor so patients knew which staff were on duty.

The hospital had appropriate information sharing policies in place and we saw how staff protected patient information by having agreements in place with patients about who they wanted staff to share their information with. Staff also protected patient information by having secure procedures for the access and storage of confidential information.

Requires improvement

Forensic inpatient/secure wards

We spoke with five patients on Bronte ward and five patients on Shelley ward. Nine patients told us staff had a caring approach, treated them kindly, and were interested in their well-being.

The involvement of people in the care they receive

Each ward had a welcome pack with information to enable patients to orientate themselves on the ward. The packs contained up-to-date information about the facilities, staff, and ward routines. Ward managers told us new patients had a named member of staff to act as a first point of contact during the first few hours of admission. Their role was to show them round the ward and introduce them to other staff and patients. Staff also allocated new patients a 'buddy', another patient who helped them settle in.

As part of our inspection, we looked in detail at care plans for twelve patients across Bronte and Shelley wards. We found evidence that staff attempted to ascertain if patients had made or wanted to make advance statements of wishes and feelings about their future care and treatment.

Each record contained a plan, which staff developed in conjunction with patients. The plan contained information about how patients wished staff to treat them, for example, when they were emotionally unwell or displayed agitated behaviour.

We saw evidence that staff encouraged patients to be involved in the care plans and asked them to sign them and take copies. Care plans contained evidence of psychological input aimed at encouraging patients to maintain independence. The psychology team supported staff to complete patient risk assessments and they had a plan to enhance service user involvement in these risk assessments to ensure they were more meaningful for patients. Patients told us they felt involved in their treatment but in five of the records we looked at, patients had declined to sign their care plans. One member of staff told us they thought care plans were long and wordy and did not always encourage patient involvement. Some staff had developed care plans with pictures, which patients could relate to, and feel more involved.

Patients told us they felt involved in their treatment through attending community meetings and through multidisciplinary reviews. The hospital employed a service user involvement worker who facilitated daily meetings with patients to identify activities they wanted to get involved in. We attended community meetings on both wards. Patients were able to give feedback on the service and had opportunities to be involved in decisions about the running of the hospital. For example, the hospital had a plan to introduce electronic cigarettes, which patients could use on the ward. Staff consulted with patients about how they should implement this, including the price and how many electronic cigarettes patients should have each day.

Each ward had a display board containing patient suggestions and staff responses. For example, on Shelley ward, patients had asked for more one-to-one sessions so staff had increased the sessions provided by occupational therapy staff. On Shelley ward, patients wanted more weekend activities. Staff said they would facilitate some activities and trips at weekends. Psychology staff also took feedback from patients to improve the quality of therapy on offer.

Patients we spoke with confirmed they had access to appropriate advocacy services. The provider had an advocacy policy and both wards displayed information about how patients could contact the advocacy service. Where patients gave consent, we saw that staff involved patients' families in treatment including attendance at care reviews. Where appropriate, staff encouraged patients to keep in touch with people who mattered to them. Most carers we spoke with told us they had been invited to meetings. Each ward had a family involvement lead and staff told us the hospital was applying to become a member of the Triangle of Care. This is a scheme developed by the Carers' Trust to help build a therapeutic partnership between the patient, carers and professionals.

The service used the 'friends and family' test as a means of gaining feedback about care and treatment. Between 3 March 2018 and 31 March 2018 there had been five responses to the survey, four of these responses answered that they would be extremely likely or likely to recommend the service and one did not provide either answer.

Cygnet Health Care Ltd employed an expert by experience lead for the north region. During the inspection we talked to the expert by experience to obtain their views about the service.

They told us that the leaders and managers at Bierley had a strong focus on an ethos of service user involvement and also on reducing restrictive practice across the hospital.

Requires improvement

Forensic inpatient/secure wards

We saw that the role of expert by experience had been valuable to patients and to the service. They visited regularly and talked to patients about their care and treatment. They reported the feedback from service users to the governance meetings and project boards to ensure the patient's voice could be heard across the organisation. The expert by experience reported that the service users had told them that they felt 'empowered' by being involved in projects and from learning when things had gone wrong.

Locally, Cygnet Hospital Bierley also employed a service user involvement lead which confirmed the hospital's ethos of ensuring patients were involved and directive in the care provided at the service. The role of this staff member was to 'create a voice for service users'. The involvement lead held a monthly meeting with patients from each ward. Patients took the minutes of these meetings and were encouraged to be creative about ideas to improve the service, including projects and activities. This meeting also devolved into working groups of patients to resolve issues around changes to policy and practices and ensure the patient voice was part of any changes to the service, for example, to ensure the new policy for the use of e-cigarettes met the needs of patients. The involvement lead also supported patients to take part in the 'recovery college' and in various other involvement projects via the use of media.

Are forensic inpatient/secure wards responsive to people's needs?

(for example, to feedback?)

Good

Access and discharge

From June to December 2017, the average bed occupancy was 99% on Shelley ward and 78% on Bronte ward. The majority of patients admitted to the wards were from the local area.

Patients always had access to a bed on return from leave; a patient's bed was not used whilst they were on leave for another patient.

Patients were not moved between wards at the hospital. Should a patient require a more intensive care setting, the hospital would meet with relevant parties to arrange appropriate transfers to other services. The service was committed to the appropriate discharge of patients to less secure settings. In the previous 12 months, the number of patients admitted to Bronte ward was 11 and they had discharged six patients. On Shelley ward there were three admissions and three discharges. The average length of stay of patients discharged during this period was 713 days on Shelley ward and 438 on Bronte ward.

The service had not reported any delayed discharges of patients from the low secure forensic wards but staff said they sometimes had difficulties identifying suitable placements for patients, particularly those who wished to move out of area or required accommodation within a supported living setting.

The facilities promote recovery, comfort, dignity and confidentiality

The hospital had a range of facilities to support the delivery of care and treatment including rooms off the ward areas which patients could access at set times. Facilities on both wards included two lounges (one designated a quiet lounge and the other with television and games consoles), a kitchen with facilities to allow patients to practice food preparation, a dining room, an activity room, and a room with an internet computer. Off the ward, patients had access to a tuck shop, a gym with fitness equipment, a sensory room, and an activity room with a pool table and computers. The hospital had a multi-faith room a designated space for patients to meet with visitors. Each ward had a secure garden area and laundry facilities.

Patients were able to use a ward telephone with a privacy hood located on the ward, however, most patients told us they used a basic mobile phone issued by staff. Patients had access to the internet subject to individual risk assessments and could access their rooms at any time of day or night.

Staff provided patients with access to flasks of hot water to make hot drinks, as well as juices and snacks at any time of the day or night. Some patients told us there was a good choice of food but some patients said they did not like the food on offer. Patients were able to order takeaways to the ward and staff told us they organised barbecues in the courtyard area in summer where patients helped with the cooking.

Requires improvement

Forensic inpatient/secure wards

Patients had their own bedrooms, which they were able to personalise. Each bedroom contained secure storage and patients also had the option to place valuables in a locked room on the ward.

We saw staff had put activity timetables in communal areas of the ward. We also saw individual activity timetables in each patient's file. Patients had access to physical activity both within the hospital and through attendance at a local leisure centre. Patients could volunteer at the hospital tuck shop and had access to a recovery college. At weekends, staff were starting to facilitate ward-based activities and also trips out, however, two patients told us they could become bored at weekends if they did not go out on home visits.

Meeting the needs of all people who use the service

The wards were all on the ground level and accessible. Patients had access to an occupational therapist to assess any equipment or adaptations they may need. Occupational therapy staff provided any equipment or adaptations needed by patients with mobility issues.

The hospital told us they could produce leaflets in different languages as required and that many staff on the wards spoke a variety of community languages. Staff told us the hospital provided patients with access to an interpretation service and they had used this service with a patient whose first language was not English to explain their rights under detention.

Each ward had information displayed to enable patients to understand their rights, as well as information on advocacy services, how to complain and how to contact the Care Quality Commission. The ward also had a file in patient lounges containing information about local services and different treatments.

Lunch and evening meals were prepared in the hospital kitchen and delivered in heated trolleys to the wards. There was a selection of hot meals including vegetarian options. The hospital could provide alternative options for patients with special diets, for example, gluten free or low sugar. Staff told us food could be prepared according to patients' religious or cultural preferences but they encouraged patients to cook their own food. We saw occupational therapy staff helping patients bake and prepare food in the ward kitchens.

Listening to and learning from concerns and complaints

From January to December 2017, there were three complaints on Bronte ward and three complaints on Shelley ward. None of the complaints were upheld. We reviewed the complaint files and could see that staff had carried out a thorough investigation and responded to the complainant within the appropriate timescales. During this time period, none of the complaints from Bronte or Shelley wards had been referred to the Ombudsman for further investigation. During the 12 months prior to or inspection Bronte ward received eight compliments and Shelley ward had received six.

The patients we spoke with told us they knew how to complain and give feedback to staff about any aspect of their treatment. The complaint records we reviewed showed evidence that independent advocacy had been involved with several complaints on patients' behalf. Staff told us they dealt informally with most of the concerns raised by patients and felt confident to respond to patient concerns.

Staff told us they received feedback about complaints through team meetings and in supervision. They could give us examples of changes they had made to practice because of patient complaints. For example, managers had reminded staff to respect patients' personal space following a complaint by a patient. The carer's we spoke with also told us they knew how to complain and we saw evidence that one carer had complained to the hospital.

Are forensic inpatient/secure wards well-led?

Requires improvement

Vision and values

Cygnet Health Care Ltd had an overall vision to be the 'provider of choice'. Both the low secure wards aimed to deliver a high quality health care service that promoted social inclusion and independence for people with severe and enduring mental health problems.

The values of the provider were:

- Helpful
- Respectful

- Honest
- Empathetic

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. Staff behaviour across the service, including Bronte and Shelley wards, 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 at appraisal. Templates staff used for supervision and appraisal on both wards included prompts to discuss behaviours that underpinned the values.

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. Every six months the senior leadership team from Cygnet Hospital Bierley met with the board and corporate managers for corporate governance meetings. Ward managers, senior staff, and senior members of the multidisciplinary team attended a local Cygnet Hospital Bierley, monthly governance meeting. This meeting was structured and followed the same format as the corporate governance meetings and discussions included advocacy, medicines 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. At this meeting, staff also reviewed any blanket restrictions in place on the wards. The ward managers were responsible for reviewing and presenting a monthly data pack of this ward level information to the local governance meeting, and then for feeding back to staff and completing the key actions to improve quality and address any shortfalls discussed in the local governance meetings.

The service had a number of key performance indicators in place 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 service had made improvements in establishing their governance systems since the time of our last inspection. Clinical staff were appraised and supervised and had opportunities for specialist training and development. The service planned and managed staffing well and we saw evidence that poor performance was effectively dealt with by managers. The service had a 6% sickness rate and five staff leavers. Staffing levels were closely monitored and we reviewed rotas that showed no shifts had been left unfilled.

The service employed a service user involvement lead, healthy lifestyle lead and an expert by experience to ensure patient's voices were heard and that patient involvement in care was high on the agenda.

At ward level there were opportunities for staff to learn from incidents. Staff felt supported because team meetings, supervision and debriefs were taking place. Staff were able to give us clear examples of how important information was shared across the service and across all hospitals managed by the provider.

The hospital had a local risk register, which fed into the corporate risk register. Ward staff told us they could submit items to the local risk register via their ward managers. Senior managers could escalate concerns to the corporate risk register after discussion with the corporate risk manager. They told us that they felt confident and encouraged to do so, and had developed sound corporate relationships which allowed them to raise concerns at a corporate level and obtain additional support at service level as required, for example in response to the fire enforcement notice.

The hospital had ten current risks on their local risk register, which they monitored through the monthly governance meetings. These risks included staffing vacancies, a patient death, access to primary health care, heating systems, seclusion rooms, anti-barricade locks, structural concerns and fire safety deficiencies.

Senior managers were aware of the risks and priorities for the service. Minutes from the local governance meetings showed that staff conducted regular audits to ensure they were improving quality and safety on the low secure wards.

Managers had recognised issues relating to the recording of rapid tranquilisation and seclusion, and had taken action to improve this, including the introduction of training sessions.

However, governance systems and processes were not entirely effective. Despite the service's approach to audit we found ongoing concerns in relation to; physical health monitoring after rapid tranquilisation, and in one record there was not the appropriate recording of seclusion checks. The audits carried out by the service had not identified that the monitoring of the side effects of patient's medication was not always taking place according to the provider's own policy.

Staff told us that the supervision of allied health professionals was not in line with Cygnet policy. Senior managers were not of aware of this concern until the time of the inspection.

There was a lack of oversight at senior management level regarding the application of the Mental Capacity Act. Although staff were trained, they lacked confidence to understand the inference between the Mental Capacity Act and the Mental Health Act. This had developed into an incorrect culture of staff understanding what decisions they could make on behalf of detained patients.

The senior management team were aware of the risks of moving patients using stairs to the ground floor seclusion room. However, there was not a risk assessment or protocol for staff to follow in order to manage this risk.

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. Patients could nominate staff members to receive an employee of the month award. One patient on Shelley ward had nominated a staff member for the employee of the month award.

The provider conducted a hospital-wide staff survey in November 2017. There were 64 respondents to the survey. The results of the survey were not broken down to ward level to protect staff anonymity. The overall staff survey 'positive score' was 78%. Staff feedback was mixed with 83% (53 respondents) of respondents stating that they enjoyed working for the provider although only 69% stated that they were proud to work for the provider. The staff survey showed low levels of satisfaction with staffing levels, stress at work, staff benefits and pay, and staff experiencing bullying, harassment or abuse from service users. The service continued to monitor this via the hospital's overarching local action plan.

When we spoke with staff on the low secure wards, they told they enjoyed their job roles and relationships between staff and mangers on the wards were good. Staff had respect for their immediate line managers and thought they did a good job. Staff told us the hospital encouraged leadership development opportunities and some of the staff we spoke with had been promoted into managerial roles.

Staff felt able to raise concerns without fear of victimisation and confirmed they knew about whistleblowing processes. They felt they could contribute with ideas for the developing the service through multidisciplinary and other meetings. For example, a staff member told us they had ideas to improve patient engagement with care plans and managers were looking at developing these.

Commitment to quality improvement and innovation

Bronte ward and Shelley Ward participated and successfully completed the quality improvement component of the Royal College of Psychiatrists' Quality Network for Forensic Mental Health Services. This involved a self-assessment against the published standards followed by a peer-review visit by external staff working in similar secure services in November 2017.

During the inspection, we found a number of innovative projects in delivering therapy to patients, and ensuring that outcomes were met. Many of these projects were routed in patient involvement and the hospital strived to ensure patient involvement was an integral part of their work with the employment of their own expert by experience and service user involvement lead.

Some of these projects included;

- In March 2018 the hospital celebrated their Recovery College being awarded accreditation by the Assessment and Qualifications Alliance (AQA).
- The hospital have also won awards for their dialectical behavioural therapy programme with The Association of Psychological Therapies (APT) awarding the staff for

Requires improvement

Forensic inpatient/secure wards

their 'demonstrable commitment to deliver all five functions and corresponding modes of dialectical behavioural therapy, and to do so consistently and to a high standard' in April 2017.

- The therapy teams had undertaken several media projects with patients such as producing an 'understanding borderline personality disorder film, a mental health stigma film. The hospital were also shortlisted for a national service user award for the development of a Dialectical behaviour therapy recovery inspiration group. Patients had entered a Cygnet wide dragon's den competition to raise funds for audio and information technology equipment.
- Both Bronte and Shelley wards had the 'Full Monty' award from the social justice charity Bright. The award celebrates excellence in in-patient care and is awarded to services who implement inspiring ideas for improving patients' quality of time and treatment outcomes.

Personality disorder services

Safe	
Effective	
Caring	
Responsive	
Well-led	

Are personality disorder services safe?

Safe and clean environment

Cygnet Hospital Bierley had one specialist personality ward, which provided care for up to 20 female patients, which included an annexe space for four patients. At the time of the inspection there were 15 patients admitted to the ward, of which two were in the annexe.

Bowling ward had an 'L' shaped layout which did not allow staff a clear line of sight of both corridors in order to observe patients. The service mitigated through staff observations and the use of mirrors on corridors.

Ligature points were identified throughout both communal areas and individual patient's 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 manager had completed a ligature audit of the ward in March 2018. However, we saw that there were ligature points throughout the ward that were not present on the ligature audit. These included swivel taps, and trailing wires from a television and a piano in one of the communal lounges at the entrance to the ward. Within the kitchen area, there were blinds across the window with trailing cords as well as wires from a kettle and a toaster. Within the dining area, there were trailing wires from the water cooler, microwave and fridge. Staff stated that patients would supervised whilst in the kitchen area; therefore mitigating those risks. However, patients had twenty-four hour unsupervised access to the communal lounge and dining areas and therefore the unidentified ligature points in these areas could pose a risk to patients. Risk was increased because this was a high risk patient group, and there had been a serious incident within the last three months prior to the inspection where a patient had self harmed via a ligature.

Staff explained that they mitigated against identified ligature risks through observation levels, which were determined on an individual basis for each patient. The manager had placed a visual map display in the staff office of the ligature points on the ward to increase their awareness of ligature points and vigilance during observations on this part of the ward. However the ligature points outstanding on the audit were similarly not present on the ligature map.

The ward was for female patients only and was therefore compliant with the Mental Health Act Code of Practice and Department of Health guidance on eliminating mixed sex accommodation.

The ward had a clinic room with equipment present to allow staff to monitor patients' physical health needs, including an examination couch, blood pressure monitors and blood glucose monitors. The clinic room was tidy and all equipment was clean. Fridge temperatures were up to date and within the correct range.

Staff had access to an emergency resuscitation bag kept in the staff office. However, the bag was not entirely in order because two syringes used to inflate oxygen masks were not stored in sterile packaging. The oxygen cylinder did not have a date of expiry noted. Staff did have access to a defibrillator, ligature cutters, a first aid kit and medication to treat serious allergic reactions. Ligature cutters were also readily available on a board in the ward office.

The hospital had two seclusion rooms, one located on the ground floor of the hospital near Shelley ward, and one on the first floor. The first floor seclusion room had been closed for an upgrade since 17 March 2018. Bowling ward was located on the ground floor so if seclusion was required for a patient, staff were able to use the remaining seclusion room without the need to use the stairs.

The seclusion room complied with guidance in the Mental Health Act code of practice because it had a viewing panel

allowing staff to observe patients, a working clock, natural light and toilet facilities. Patients could communicate with staff via an intercom. However, we were concerned that patients could use the mattress, which was not fixed at any point, to restrict staff observation.

The ward and the communal areas of the hospital were clean and furnishings on the ward were clean and generally well maintained. Three patients confirmed that the domestic staff kept the ward clean. Domestic staff were observed cleaning communal areas and patient bedrooms during our visit However, patients stated that there was a problem with ants on the ward. The general manager told us that they were aware of the problem and were working to rectify it with an external contractor.

Staff had undertaken an internal infection control audit on 28 February 2018. The audit covered hand hygiene, environment, kitchen area, disposal of waste, bodily fluid spillage, personal protective equipment, sharps handling, specimen handling, vaccine transport and storage, and decontamination. All areas of Bowling ward were above 85% compliance, with an overall compliance rate of 99%.

The hospital had a general manager who was responsible for overseeing all environmental, health and safety and fire risk assessments and compliance. The general manager held a monthly health and safety meeting where any environmental risks were discussed and escalated for action as required. Staff health and safety representatives from all wards attended this meeting.

The estates lead and general manager completed regular environmental audits of the entire hospital site, which included weekly ward tours to monitor and manage environmental concerns. Staff confirmed they were able to request support from the maintenance team where they identified repairs required on the wards. The hospital employed three full time maintenance staff to carry out duties on site as required. These staff were responsible for overseeing the maintenance log; all maintenance actions required throughout the hospital were entered onto this central log with an estimated date for completion for all tasks. The hospital had developed a process to improve the management of fire risks. This included employing an independent fire risk assessor to visit the hospital, and planning enhanced face to face training for staff.

In February 2018 the hospital received a fire enforcement notice from the West Yorkshire fire brigade, because the fire brigade had a number of concerns about risk following a fire assessment. The hospital had responded to this via the completion of a time limited action plan. We reviewed this action plan during the inspection and found the service was completing the actions within the timescales required. The fire brigade will re-visit the hospital to check on compliance in May 2018. The general manager told us that the hospital had been supported by the corporate provider to make the required changes and become compliant.

We reviewed fire policies, procedures and safety during the inspection and found that the estates team had undertaken tests of emergency lighting, fire extinguishers, lift safety, gas safety and electrical equipment within the last twelve months.

All staff carried an alarm that when activated showed up on a central panel to indicate the location where the alarm had been pressed. All ward staff were observed to carry personal alarms, and nurse call alarm buttons were present in patient's bedrooms. Staff checked alarms were working each morning when they collected them from reception. Each day the shift leader allocated a staff member to respond first if an alarm sounded. Staff told us colleagues responded promptly when they needed assistance. Patients had access to alarm call points in their bedrooms and communal areas including bathrooms.

Safe staffing

On Bowling ward there were 11.8 whole time equivalent qualified nursing posts, and 16.6 whole time equivalent health care support worker posts. Data provided from 1 November 2017 to 31 January 2018 showed that there were six whole time equivalent qualified nursing vacancies. At the time of inspection staff stated that a four of these posts had recently been recruited into and that they were awaiting start dates for these new members of staff.

The hospital used an internal staffing matrix to establish the number of staff required per shift based on the number of patients admitted to the ward. At the time of inspection, 15 patients were admitted to the ward, which included two in the annexe.

There were two qualified nurse and five healthcare support workers during the day and two qualified nurses and three healthcare support workers during the night. The ward manager explained that they were able to bring in additional staff if they felt this was required due to the particular dynamics of the ward at any given time.

Additionally, the clinical manager explained that the staffing matrix allowed the ward manager to increase qualified nurse numbers from two to three during a day shift without the need to obtain permission from senior management. If the ward manager felt that any more staff were required that raised numbers above the staffing matrix this would be discussed at the hospital wide morning meeting.

Between 1 January 2017 and 31 December 2017 three members of substantive staff left from Bowling Ward. This included two qualified nurses and one healthcare support worker. The service explained some of the reasons for qualified nurses leaving as career development and work/life balance.

Within the same time period the staff sickness rate was 5.9%.

Within the three month period between 1 November 2017and 31 January 2018 the hospital used bank or agency staff 419 times, bank staff on 37 shifts and agency staff on 382 shifts. Based on baseline staffing requirements this was 33% of available shifts. The hospital utilised agency staff familiar with the ward wherever possible to manage consistency for patients. Additionally where necessary staff members from other wards would be brought across to support Bowling ward.

Qualified nursing staff were observed to be visible on the ward and to interact with patients during our inspection. Of the six patients we spoke with one patient stated that they had experienced planned leave being cancelled because of too few staff. Staff told us that, on occasion patient leave may be cancelled due to staff sickness or other patients being in more urgent need of staff support, for example to attend a hospital appointment. However, they said that they would always rearrange patient leave and would accommodate it at requested times wherever possible. We reviewed patient observation charts on the ward and found that there were enough staff to carry out patient observations on the sheets we had reviewed.

We reviewed staff rotas from 1 January 2018 to 1 April 2018. The rotas provided appeared to show a number of shifts that were unfilled including eight shifts where only one qualified nurse was noted as working and nine shifts where there were no qualified nurses noted as working at all. We followed this up with the clinical managers who showed us that these shifts were all filled by qualified bank or agency staff and that only one shift on 6 February 2018 was left unfilled due to the sickness of two qualified nurses. We were assured by one of the clinical managers that the ward manager provided support to the remaining qualified nurse on duty to ensure the safety of the ward. Three patients we spoke with had concerns about staffing. They said that agency staff did not respond to them as well as permanent staff, which they thought was due to a lack of detailed understanding of their needs. One patient stated that they felt there were not enough staff on the ward to talk to, whilst another commented that their escorted leave had been cancelled due to a lack of staff.

All staff were trained in the management of violent and aggressive behaviour and there were enough staff on the ward to safely carry out physical interventions should they be required. Staff told us that doctors were present and approachable and that there was adequate medical cover during the day and night.

Prior to the inspection we asked the hospital to provide us with data relating to staff training. There were 26 separate mandatory training modules for staff to complete, depending on their designation, in areas including equality and diversity, Deprivation of Liberty Safeguards and the Mental Capacity Act, the Mental Health Act and the Code of Practice, infection control, information governance, risk management and short-term assessment of risk and treatability, Dialectical Behaviour Therapy and basic life support. The provider had a mandatory training target of 95% and 18 of the 27 courses had achieved this rate with an average mandatory training rate for staff of 93%. All areas of the mandatory training were above 75%.

Assessing and managing risk to patients and staff

Between 1 July 2017 and 31 December 2017 there were no incidents of seclusion or long-term segregation recorded for Bowling ward, Staff spoken to on inspection stated that they could not recall the last time seclusion was used on the ward. The provider had policies in place regarding seclusion, which were available to all staff via the intranet.

Between 1 July 2017 and 1 December 2017, staff on Bowling ward had used restraint on 50 occasions with nine patients, and eight of these restraints took place in the prone position.

We reviewed six risk assessments of patients admitted to the ward at the time of the inspection. Staff used a recognised risk assessment tool; the 'short term

assessment of risk and treatability', to complete detailed risk assessments with all six patients within 24 hours of admission. However, it was unclear from patient files how regularly risk assessments were reviewed. One file contained only the patient's most recent risk assessment and within another file, it did not appear that the patient's risk assessment had been reviewed for over a year. One patient had two review dates two months apart and a further two patients had two review dates over four months apart. One of the six risk assessments we reviewed showed that the patient had a regularly reviewed risk assessment. Staff explained that risk was reviewed daily during staff handovers and also within multi-disciplinary meetings. We observed a staff handover and witnessed these discussions taking place for each patient. However, we remained concerned that the risk assessments were not being updated following these discussions and meetings.

The ward had a number of restrictions in place such as locked access to the kitchen, laundry and outdoor space. The laundry room was locked because this operated on a shared basis to allow all patients access to complete their own laundry, and the ward kitchen was locked due to the high risk items stored. Access to the outdoor space was locked due to the ward sharing this space with other wards at the hospital. These restrictions were justified, as they were necessary and proportionate responses to the risks identified for this patient group, and were therefore in line with the Mental Health Act Code of Practice.

The clinical manager told us that the ward manager had undertaken blanket restrictions audits to ensure these were continually monitored and reviewed. However, audits showed that in February 2018 only one blanket restriction in relation to access to hot water for drinks was reviewed. There remained blanket restrictions in place in relation to all patients using polystyrene drinking cups and limited access to cutlery, which staff counted in and out for every patient after each meal. Neither of these blanket restrictions was entered into the blanket restriction audit.

Patients had access to mobile phones, and other items including hairdryers and hair straighteners could be used once risk assessed on an individual basis. However, patients had access to hot and cold drinks and snacks in the dining room 24 hours a day.

There were two informal patients admitted to the ward at the time of inspection. The service had issued them with photographic identification cards, which allowed them to freely leave the hospital when they chose too, in order to prepare from for independence and discharge. Patients were aware of how to utilise this system in order to leave the hospital at any time they wished to do so.

Patient observation levels differed dependent on the risk that they presented at any specific time. These observation levels varied from every five minutes to hourly observations and were discussed during twice daily handover meetings. A board in the ward office clearly displayed which staff member was in charge of observations at any given time and responsibility was rotated every hour. Staff explained that if there were a larger number of patients requiring five minute observations then an extra member of staff would be allocated to observations to provide support to ensure observations were completed as required. The clinical manager undertook regular closed circuit television audits against observation charts to ensure they were carried out thoroughly.

The service had a search policy, which staff adhered to. Searches were only carried out with patients' consent and where a risk was identified, such as on return from unescorted leave. Where patient's refused searches, enhanced observations would be considered as an alternative to searching, considering risk and the least restrictive intervention.

We reviewed a five restraint records for patients who had been restrained between February and March 2018. They showed that incidents of restraint had a long length of duration but four of the five were low level guiding arm holds. Staff interviewed all stated that restraint would be used a last option if de-escalation failed. Staff shared that they had been trained by in-house psychologists to use dialectical behavioural therapy skills with patients in the first instance to try and de-escalate situations. Staff also offered examples of other de-escalation opportunities that they would offer the patients such as talking to a member of staff or walking around the courtyard with them. However, of the six patient care plans reviewed during inspection, there was not always evidence of staff having these discussions with patients and documenting this. One patient said they felt staff occasionally restrained patients when they didn't need to, and three other patients stated that the use of restraint could depend on the staff

members on duty, with two of the three stating that they felt agency staff were less likely to use dialectical behaviour therapy techniques and more likely to use restraint and/or medication with patients in distress.

In response to our previous concerns, the service had continued to work on a reduction in the use of prone restraint. We saw that between January 2018 and March 2018, restraint had been used 45 times, but prone restraint was only used on four occasions, which was a significant reduction in its use. Prone restraint had only been used in one of six episodes of intra-muscular medication, and this was a proportionate use due to the risk presentation of the patient.

We reviewed the provider's staff training package for the management of violence and aggression. The training model included training staff in the use of pain compliance holds 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 these methods but were clear that they were last resort methods. The provider was aware of the need to monitor and measure the use of these types of restraint holds and had conducted an audit of their use. This audit had identified one incident where staff had recorded the use of holds that could be described as pain compliance. The service had recognised that the recording of this incident was poor and had held an individual supervision session with the staff member involved to rectify their understanding.

Between 1 July 2017 and 1 December 2017, staff had used rapid tranquilisation with three patients. The National Institute for Health and Care Excellence describes rapid tranquilisation as 'use of medication by the parenteral route (usually intramuscular or, exceptionally, intravenous) if oral medication is not possible or appropriate and urgent sedation with medication is needed'.

During inspection we reviewed five rapid tranquillisation records of episodes taking place between November 2017 and March 2018. We found that staff had not recorded observations following rapid tranquilisation in accordance with national guidance and the hospital policy on three occasions. For example, 15 minute checks were not always completed during the first hour post injection, and reasons given for discontinuing observations were not clear such as the patient being alert though it was unclear specifically what this meant. On one occasion no reason was given at all. Physical observations recorded were also incomplete with many stating the patient refused. However, it was not clear what action staff had taken to reduce risk in those cases where physical checks were refused.

The provider had both safeguarding children and adult policies in place which staff had access to. Staff were able to explain the process for recording and reporting safeguarding concerns. Staff had regular mandatory training in safeguarding both adults and children. There were on-site social workers who were available for staff to approach for advice. Staff also stated that they had a good relationship with the Local Authority safeguarding team.

There were two separate designated rooms in the communal area of the hospital for children to visit which contained a variety of toys and games.

The provider had an appropriate medicines management policy, which incorporated ordering, storing, administering and destroying medicines. The hospital had an agreement with a pharmacy provider who provided advice and support to staff to manage medicines safely. We reviewed all patient medication charts and found that staff kept accurate records of the treatment patients received. Prescriptions for medicines to be given as or when required contained sufficient information to enable staff to administer them safely.

The pharmacy provider carried out monthly prescription card audits and fed results back to senior managers. We reviewed medication audits for September 2017 to March 2018. We were able to see that staff had made changes to practices to improve compliance with audits and the ward had achieved no errors by March 2018.

We found that two patients on Bowling ward were administering their own medicines supported by hospital staff. However, we found that risk assessments had not been completed or recorded for these patients to ensure these were safe and appropriate methods of medication management. Another patient had been issued a medical device, due a physical health condition, which they kept in their bedroom. It had been recorded in the patient's risk assessment that she had stated on five different occasions between 2 May 2016 and 18 June 2017 she had attempted

to self-harm using this device. However, the patient continued to use the device unsupervised and there was no clear plan to mitigate the risk posed from potential self-harm with the device.

Track record on safety

Between 8 February 2017 and 16 February 2018, the service reported five serious incidents on Bowling ward. These related to three serious incidents of self-harm; one involving ligatures and two involving medications, one patient who had absconded, and one incident of alleged assault of one patient while outside the hospital. All incidents had been investigated by senior leaders within the organisation and root cause analysis completed where appropriate.

For one incident on Bowling ward the regional quality manager held a root cause analysis meeting with the patient and their family to discuss the outcome of the investigation and lessons learned from the incident. As a direct result of this incident, an action plan had been put into place, and staff had been re-trained and provided with additional guidance on ensuring the safety and security of the clinic room doors.

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 service's 'overarching local action plan' which was regularly reviewed during monthly governance meetings to track the progress.

Staff received feedback from incident investigations, both internal and external to the service. The service had a corporate and local lessons learned log, which they disseminated to all staff. However, three members of staff spoken to stated that they did not always receive feedback or a de-brief after incidents and suggested this would only take place following very serious incidents. One member of staff stated that they had had to ask for a debrief following an incident where a patient ligatured, as one was not offered to them. Three staff members stated that they felt negative aspects of incident management were prioritised and that staff were rarely given praise for what they had done well.

Staff were able to tell us about incidents at a local level and in other Cygnet Health Care locations where they had made changes to local processes to reduce risk. For example staff told us about an incident on another ward at the hospital whereby a patient had thrown scolding water at a staff member causing injury. As a result, staff had removed hot water geysers from Bowling ward and had ordered new temperature controlled water vessels in their place. Managers disseminated lessons learned to staff via a monthly quality newsletter.

The service had re-focussed their approach to governance to ensure closer involvement at ward level since August 2017. Ward managers received monthly data packs, including the incident data per ward. They presented this data at monthly clinical governance meetings to discuss action they would take to reduce identified risks. The team managers shared learning via the local learning lessons log, team meetings, and supervision with ward level staff.

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. However, around half of the staff spoken with were unclear as to what the Duty of Candour was or how to implement it. Staff did state that they would always be open and honest with patients and other staff members and apologise to patients if things went wrong with their care. There was an example of the service using the Duty of Candour in relation to serious incident where a patient was able to access medication on the ward. The service had provided written and verbal apologies to the patient and their family.

Are personality disorder services effective?

(for example, treatment is effective)

Assessment of needs and planning of care

We reviewed the care plans of six patients admitted to the ward. Each patient had a care plan in place, which was completed within 24 hours of her admission to the ward.

Staff updated care plans monthly using a 'care plan evaluation template'. Care plans included aspects such as 'understanding my mental health', 'my safety planning', 'moving on', 'staying healthy' and 'my life skills'. However, whilst we observed the presence of patient views within multi-disciplinary meetings and psychology sessions, this information and the patient's own words did not always transfer to the care plans we reviewed. For example, there was not always evidence in care plans of goal orientated discharge planning. Each patient had a 'moving on' care plan, however, detail contained within these plans was typically generic, with no recorded specific time scales for achieving goals or for discharge, yet this information was regularly discussed in patient meetings and therapy sessions. The involvement of family and carers within care plans was not always evident. In two of the care plans reviewed family members were mentioned in relation to visits due to take place and the arrangements around these. In one of the six care plans reviewed the patient had stated that they did not want their family involved but there was no evidence within the other five care plans that questions around family and carers had been asked. However, patient's families were invited to meetings and were regularly asked for feedback by the service. Therefore, care planning did not always evidence the supportive work being carried out by the service.

Information needed to deliver care was split between paper-based and electronic systems. All patients had a paper file stored in the ward office where the majority of information was kept. Staff explained that they had recently begun to write daily nursing notes on an online system but had not begun transferring other information. All the staff we spoke with stated that they had no concerns or problems finding necessary information. Clinical managers told us that the transfer to an electronic system was taking place gradually to ensure staff understood all aspects of the system and how to use them correctly.

The hospital had appropriate information sharing policies in place and we saw how staff protected patient information by having agreements in place with patients about who they wanted staff to share their information with. Staff also protected patient information by having secure procedures for the access and storage of confidential information.

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 ward also adhered to National Institute for Health and Care Excellence guidance when treating patients with personality disorders by following 'borderline personality disorder: recognition and management' guidance by offering a comprehensive programme of dialectical behaviour therapy.

The service conducted regular audits of the storage and prescribing of patients' medication, and the monitoring of the physical health of patients prescribed anti-psychotic medications. However, we found that there were occasions when this monitoring had not taken place according to national guidance. We looked at four physical health charts and found that staff kept records of blood tests, investigations and physical observations in each patient's physical health file. However, for three of the patients on the ward we found that monitoring had not been completed, and blood tests and electrocardiograms were overdue or had not been recorded. This meant that patients were at increased risk as adverse effects from their treatment may go undetected.

We reviewed six patient physical health records. Patients in all six records reviewed had a physical health examination completed on admission and their files contained a separate physical health care plan. Of the six care plans reviewed, three patients were detailed as having particular physical health concerns including diabetes. For these patients care plans detailed how the condition should be managed and particular signs and symptoms for staff to be aware of in order to support the patients to manage their physical health. However, one patient was also identified as having a long term physical health condition and we found that this patient had not had a recent review of this health condition with an appropriate practitioner. We were told

that there were difficulties registering patients with a GP. However, staff had not recorded reviews of patient's long-term health conditions monthly in accordance with the hospital's physical healthcare policy.

A physical healthcare policy was in place and the service had employed a registered general nurse to oversee the physical long term health care needs of patients (they had not yet started employment at the time of the inspection). Patient access to being able to register with a GP practice was an ongoing challenge. However, access to GP services was via a long-standing service level agreement with a local GP practice who provided a weekly dedicated clinic for patients. Managers had entered this concern on the service risk register and senior managers continued to work with local commissioners to resolve the concern.

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

The service had an in-house psychology who conducted psychology assessments with patients to identify a psychology treatment pathway dependent on the individual needs of patients. This included providing either individual or group-based psychological therapies dependent on the assessment, such as dialectical behaviour therapy, cognitive behaviour therapy and acceptance and commitment substance misuse programmes.

On Bowling ward there was a comprehensive dialectical behaviour therapy programme, which formed the main focus of treatment. Patients were seen by two dialectical behaviour therapy therapists within seven working days of their admission in order to explain and discuss the programme. For those that decided to engage with dialectical behaviour therapy, both groups and one to one sessions were available on a weekly basis with members of the psychology team. Patients were asked to sign a contract prior to engaging in dialectical behaviour therapy, which set out ground rules including patients not missing more than four consecutive sessions otherwise they would be considered to have dropped out of the programme. Notes from one to one sessions showed discussions around progress and areas to work on which were developed collaboratively with the patient and were specific to the individual. A group session was observed with, patients rewarded for their participation with a choice of activity they would like to engage in.

Outcomes were measured for all patients engaging in dialectical behaviour therapy at a number of intervals using seven different psychometric measures. Two patients interviewed commented on the benefits of dialectical behaviour therapy for them. We saw good evidence of patient centred care, for example, one patient had decided to withdraw from dialectical behaviour therapy, and the psychologist had clearly detailed how the patient could re-engage with therapy and encouraged her to do so.

Patients could also engage with the 'Find Your Way' substance misuse programme which was based on Acceptance and Commitment Therapy. Sessions addressed patient's individual reasons for using or not using substances and promoted acceptance and the application of skills to manage unwanted experiences that may lead to substance misuse. Again, both group and individual sessions were available on a weekly basis. Whilst information provided by the hospital stated that the aim of sessions was to develop plans for discharge, this did not always transpire into written evidence in care plans. The service's psychology team were aware of this and had begun to create dialectical behaviour therapy care plans for each patient; the ones we reviewed were detailed and high quality.

The psychology team monitor and measure patient outcomes after therapy by mapping reductions in symptoms, and measure patient satisfaction to improve the quality of therapy offered. Wait times for patients on Bowling ward to access in house psychological therapy had improved from 51% in 2016 to 65% of patients seen within six weeks from referral in 2017.

The team were aware of the newly published (January 2018) 'power, threat, meaning' framework developed by the British psychological society, and plans in place for implementing this framework within the service.

Occupational therapists also followed best practice guidance with patients completing assessments and outcomes monitoring with patients using the model of human occupation screening tool, occupational self-assessment, and occupational circumstances assessment. These assessments were used to create care plans with patients to develop life and independence skills. An occupational therapist was allocated to work across each ward on a one to one and group basis with patients.

As well as social workers, occupational and psychological therapy, patients were supported by a healthy lifestyles co-ordinator and service user involvement lead.

The hospital had an onsite accredited recovery college where patients were able to undertake a variety of courses, for example in baking and multimedia.

Senior staff undertook a variety of audits, following a yearly audit programme to monitor the quality and safety of the service. This included the following audits:

- Infection control
- Psychology outcomes
- Prevention Management of Violence and Aggression
- Complaints
- Patient notes
- Blanket rules audit
- Restrictive practice audits; seclusion, restraint, prone restraint, blanket rules, rapid tranquilisation

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.

Skilled staff to deliver care

The service had experienced and qualified staff from a range of different disciplines including psychiatry, psychology, mental health nursing, occupational therapy, healthcare support workers and social workers.

Staff received an appropriate local and corporate induction; all temporary bank staff received the same induction as permanent staff.

The provider had a thorough recruitment policy. During the inspection, we reviewed staff files for managers, nurses, health care support workers, doctors and temporary staff. All staff had the appropriate paperwork in place to ensure safe recruitment including disclosure and barring checks, references, and copies of qualifications and professional registration.

The provider had a clinical supervision target of 90%. Data provided stated that, as of 31 January 2018, 81% of staff on Bowling ward had received clinical supervision every four weeks as per Cygnet Health Care Ltd.'s own policy.

Managerial supervision took place alongside clinical supervision if this was required and was not recorded separately by the service. Additionally the service told us that 78% of staff on Bowling ward had received an appraisal in the last 12 months. This had increased to 96% compliance with appraisal by the time of the inspection.

However, supervision offered to staff was not always in line with policy. Three members of staff spoken with during inspection commented that it could be hard to take time out to have supervision, and that supervision was not regularly a formal process and a chat with the ward manager or senior nurse on duty could be considered supervision. One member of staff stated that they felt that supervision was not particularly helpful as when it did take place as any issues raised would not be taken any further or resolved. None of the staff spoken with could indicate a date for future supervision or detail any particular action points or priorities set moving forwards.

Staff from social work and occupational therapy departments told us that supervision was not always formalised and that it took place on an ad hoc basis. The provider's own policy stated that all health professionals must have monthly supervision.

All the doctors who needed to had completed re-validation within the last twelve months across the hospital.

The hospital recognised the need for specialist training for staff working in the area of personality disorders and as such, the psychology team within the hospital had completed considerable in-house training with staff. All staff have undertaken 'an induction to psychologically informed care' training and staff across the service have received dialectical behaviour therapy skills training. There has also been two days training in 'introduction to dialectical behaviour therapy' on Bowling ward, as well as staff attending trauma informed care training days. Staff spoken with commented on the benefits of receiving dialectical behaviour therapy training and explained how they were able to use techniques learnt to reduce the need for physical interventions with patients. Staff appeared to have a good understanding of dialectical behaviour therapy and recognised its importance when engaging with and supporting patients on the ward. Staff have also previously received training in eating disorders and bespoke training for working with a patient with Autism Spectrum Disorder) when the need for this became apparent in order to support a patient on the ward.

The psychology team also supported the multi-disciplinary team to ensure patients had access to psychologically informed care. They did this by offering monthly case consultations on all wards, monthly reflective practice sessions with staff and supported staff de-brief sessions following incidents.

The service addressed poor staff performance promptly and effectively. Two members of staff from Bowling ward had been suspended between January and December 2017. In one case, the staff member concerned had their suspension lifted following a full investigation where no harm was found. Another member of staff was suspended due a lapse in renewal of their Disclosure and Barring Service check and certification and returned to work when this had been resolved.

Multi-disciplinary and inter-agency team work

The multi-disciplinary team at the hospital was made of up professionals including psychiatrists, psychologists, mental health nurses, occupational therapists and social workers.

There was clear involvement from various members of the multi-disciplinary team within separate patient care plans. Regular face-to-face multi-disciplinary team meetings also took place with professionals, patients and their families. We also saw evidence of collaborative working between the psychology and social care teams to complete capacity assessments for a patient, as well as between ward staff and the occupational therapy team to support a patient with her hygiene needs. Staff also stated that they would maintain contact with relevant community mental health teams in the patient's locale; inviting them to patient review meetings on a regular basis.

The hospital had a dedicated social work service who supported patients with housing, benefits, contact with families and supported capacity and best interests processes with individual patients.

Twice daily handover meetings were held on the ward at the start of each shift. We observed a morning handover shift whereby information was handed over by the lead nurse from the night shift to the whole team starting the day shift. Staff discussed each patient in turn including details of their mental state and mood, medications including any requests from patients or any medications given, food intake, any pertinent discussions with staff, and any risks. Staff appeared to have a good understanding of the patients and their individual needs and what they could do going forwards to support them. Staff discussed a recent admission to the ward and how they could support her to integrate and socialise with other patients on the ward. Staff also discussed a patient with an upcoming upsetting anniversary and considered what support they could offer her through a difficult time to reduce the likelihood of any untoward incidents. There were three members of agency staff in the handover due to the work the day shift. The two qualified nurses on duty stayed behind after handover to discuss the patients again with these staff members to ensure they had a good understanding of the dynamics of the ward.

Staff told us that the service worked to maintain relationships with professionals outside of the service. Ward managers remained in contact with community mental health teams around the country depending on where patients were from and there was evidence of community teams being invited to patient meetings to discuss ongoing care and support. Patient access to being able to register with a GP practice was an ongoing challenge. However, access to GP services was via a long-standing service level agreement with a local GP practice who provided a weekly dedicated clinic for patients. Managers had entered this concern on the service risk register and senior managers continued to work with local commissioners to resolve the concern.

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

At the time of inspection, 87.5 % of staff on Bowling ward had completed mandatory training in the Mental Health Act.

The service had on on-site Mental Health Act administrator who was available to give advice and support to staff. Staff knew who the administrator was and how to access them.

The Mental Health Act administrator told us that they oversaw admission paperwork, ensured accuracy of section papers, monitored dates for patient's tribunal meetings and renewals, and gave reminders to staff when action was required. They also told us that they maintained a spreadsheet allowing them to regularly audit paperwork to ensure it was correct and complete, and that staff were applying the Act appropriately. The Mental Health Act administrator also had the opportunity to feedback to

senior hospital managers on a monthly basis; raising any concerns or problems with any aspect of the Mental Health Act and adherence to it, to ensure compliance hospital wide.

The corporate lead for the Mental Health Act also provided guidance and support where required. Support was also available from local solicitor's firms with whom the service held relationships to make sure staff were providing the correct information and support to patients.

Section 17 leave records were signed by the relevant clinicians and were stored within individual patient files on the ward. If a patient took allocated leave this would be clearly recorded to ensure staff knew what leave patients had remaining.

We reviewed consent to treatment documentation for four patients on Bowling ward and found that medicines were not always prescribed in accordance with the provisions of the Mental Health Act. For two of the four patients reviewed on the ward we saw that capacity and consent for treatment had changed. The relevant certificates and capacity assessments had not been updated correctly or in a timely manner to ensure a legal authorisation was in place to continue treatment. Our specialist pharmacy inspector discussed this with staff at the time of the inspection.

Staff recorded that they explained patient's rights to them regularly as per the requirements of the Act.

Patients had access to an Independent Mental Health Advocate who visited the ward of a weekly basis. Information boards on the ward also explained how patients could access advocacy services at any time. Staff stated that they supported patients to access an Independent Mental Health Advocate where there may be concerns regarding capacity.

Our Mental Health Act reviewer last visited Bowling ward in January 2018. They raised concerns that timescales for achieving patient discharge were vague or a long way into the future. We did not see improvements in this area during a review of patient care plans.

Good practice in applying the MCA

The Mental Capacity Act is a piece of legislation, which maximises an individual's potential to make decisions for themselves wherever possible. The Act and associated code of practice provides guidance and processes to follow where someone is unable to make their own decisions.

The provider had a Mental Capacity Act policy in line with the Act's code of practice. The policy contained appendices with forms for recording capacity assessments and best interest decisions.

Staff participated in mandatory training in the Mental Capacity Act and Deprivation of Liberty Safeguards. The compliance rate for staff on Bowling ward was 91%. Despite the high compliance rate in this training, staff had limited knowledge on capacity assessments and stated that they would refer to social work staff if they had doubts about a patient's capacity to make decisions. Social work staff or, in some cases, the responsible clinician carried out all capacity assessments and best interest decision making processes within the hospital. This meant staff on the ward did not always identify when capacity assessments needed to be reviewed and they did not always identify what constituted a best interest decision and how this should be recorded in the patient's file.

Patient records contained some evidence of capacity assessments but we did not see evidence that staff always recorded best interest decisions where they assessed that a patient lacked capacity to make a specific decision. We saw an example in the care record of a patient on Bowling ward who lacked capacity to make decisions around contact with certain family members and acquaintances. Staff devised a graded exposure plan for the patient to be able to use their mobile phone. However, there was no evidence that staff had carried out a best interest decision regarding the patient's use of a mobile phone, taking into account the importance of the patient's wishes. According to the Mental Capacity Act 2005 Code of Practice, staff should make sure a record is kept detailing the process of working out the best interests of a person who lacks capacity. Previous capacity assessments completed with the same patient were not kept in their file and had to be requested from the social work department so it was not immediately clear to see how often capacity was reviewed or whether there was any changes in capacity.

Two patients on Bowling ward were informal patients at the time of inspection. However, staff spoken with had limited understanding of the Deprivation of Liberty

Safeguards and when they may be required. One staff member stated that they do not use Deprivation of Liberty Safeguards on Bowling ward. Another staff member stated that they were aware of a patient in the past who was informally on the ward and was then placed under Deprivation of Liberty Safeguards. The ward manager stated that they were aware of the Deprivation of Liberty Safeguards but had not had to use them and would approach the social work team for advice if necessary.

Social work staff agreed that implementation of the Mental Capacity Act and knowledge of best interest decision-making processes was not consistent across the hospital. They told us the provider did not carry out any audits or monitoring of staff adherence to the Mental Capacity Act and the associated code of practice other than monitoring staff compliance with specific training.

Are personality disorder services caring?

Kindness, dignity, respect and support

We spoke with six patients and three carers from Bowling ward. We also observed interactions between a number of patients and members of staff during group activities.

Feedback from patients regarding their care and treatment was generally positive, with patients describing staff as "very caring" and sharing that they felt they had good relationships with staff and were treated with dignity and respect. However, one patient did comment that they felt there were not always enough staff to talk to on the ward and another commented that some staff treated patients as equals whilst others did not.

We observed warm interactions between staff and patients and saw members of staff spending time with patients in the communal areas of the ward; mainly the quiet lounge and the television lounge.

Staff talked respectfully about patients during ward handover meetings. Staff appeared to have a good knowledge of each individual patient and their needs and discussed individualised ways to support patients. For example, a new patient had recently been admitted to the ward and appeared to be isolating herself so staff suggested she be offered the support of a staff member to encourage her to spend time outside of her room.

The involvement of people in the care they receive

Staff explained to us that prior to a new patient's admission to the ward current patients were encouraged to write positive messages of support for the new patient on a whiteboard in their bedroom. We saw evidence of this on inspection with a number of messages written. Staff also showed us a 'welcome to Bowling ward' booklet, which they stated, was given to each patient on admission. This booklet gave information about the ward and what to expect, and about facilities, services and contacts within the hospital.

Staff stated that they work with patients to create individualised care plans, and that patients were encouraged to identify their own personal goals and consider how to work towards them. We reviewed six patients' care plans. We found that whilst goals were identified on all care plans these were not always personalised and many did not appear to use the patient's own words, for example goals included 'for patient's physical observations to be monitored regularly' and 'for patient to feel safe on the ward'. Only one of the six patients interviewed indicated that they had written their care plan with staff and had a copy. One patient stated that her care plan had not been updated for over four months.

Staff explained that patients had collaboratively designed the activities timetable alongside occupational therapists in order to meet their individual needs.

All patients had access to advocacy via an advocate who visited the ward on a weekly basis. Outside of this, there was information available via posters on the ward explaining to patients how they could access advocacy at any time.

There was minimal evidence of family and carer involvement within the care plans reviewed. However, it was unclear whether this was because they were not invited to contribute or whether it was patient choice not to have their relatives involved. There was evidence within daily patient notes that patients were supported to visit their families on leave, with patients being escorted by staff out of area on a regular basis in order to maintain contact however, this information was not reflected within care plans. Staff stated that patients and carers are encouraged to attend multi-disciplinary meetings and one carer confirmed that they had attended a meeting recently, which they had found useful.

Personality disorder services

Two out of three carers interviewed agreed that staff were polite and caring. One carer stated that they felt some staff had been hostile and rude to them on occasion when they had attempted to find out information about the care of a patient. The same carer stated that they had not been involved in their family member's care plan and were not invited to attend meetings on a regular basis. Further to this, they stated that they felt information in care plans was often copied over from other patient's plans as her family member had previously received a care plan with other patient's name in it. However, two out of three carers stated that they had had some involvement in their family member's care plan with one stating that staff were happy to involve them but that the patient themselves was reluctant for them to be involved.

Communication was raised as a concern by two of the carers. One carer stated that they had not been given a family pack when their family member was admitted and found it occasionally difficult to book visits as they had previously been able to arrange visits with any member of staff but had been told recently that this must be arranged with a nurse. Another carer stated that they felt staff 'normalised' certain events, for example when their family member was taken to general hospital following an incident of self-harm they were distressed at her physical presentation; something staff had not thought to discuss with them prior to their arrival.

Patients were able to give feedback about services at daily morning meetings, and also via written or verbal communication with staff.

Two out of the three family members stated that they had attended a carer's day organised by the hospital, with one carer stating they found the day helpful and interesting.

The service used the 'friends and family' test as a means of gaining feedback about care and treatment. Between 3 March 2018 and 31 March 2018 there had been two responses to the survey from carers of patients on Bowling ward. Both responses were positive with carers stating they were happy with the care their family member was receiving.

Cygnet Health Care Ltd employed an expert by experience lead for the north region. During the inspection, we talked to the expert by experience to obtain their views about the service.

They told us that the leaders and managers at Bierley had a strong focus on an ethos of service user involvement and also on reducing restrictive practice across the hospital.

We saw that the role of expert by experience had been valuable to patients and to the service. They visited regularly and talked to patients about their care and treatment. They reported the feedback from service users to the governance meetings and project boards to ensure the patient's voice could be heard across the organisation. The expert by experience reported that the service users had told them that they felt 'empowered' by being involved in projects and from learning when things had gone wrong.

Locally, Cygnet Hospital Bierley also employed a service user involvement lead which confirmed the hospital's ethos of ensuring patients were involved and directive in the care provided at the service. The role of this staff member was to 'create a voice for service users'. The involvement lead held a monthly meeting with patients from each ward. Patients took the minutes of these meetings and were encouraged to be creative about ideas to improve the service, including projects and activities. This meeting also devolved into working groups of patients to resolve issues around changes to policy and practices and ensure the patient voice was part of any changes to the service, for example, to ensure the new policy for the use of e-cigarettes met the needs of patients. The involvement lead also supported patients to take part in the 'recovery college' and in various other involvement projects via the use of media.

Are personality disorder services responsive to people's needs?
(for example, to feedback?)

Access and discharge

At the time of inspection there were 15 patients admitted to Bowling ward. Of these patients, 12 were on the main ward, two were in the annexe, and one was in the process of transferring between the ward and the annexe. The annexe was designed by the service to provide a step down opportunity for patients. Patients using the annexe were observed by staff on an hourly basis, they made their own

meals and completed their own laundry and cleaning tasks. The space gave patients opportunities to learn new skills and prepare for independence and discharge to less restrictive settings.

Between 1 July 2017 and 31 December 2017, the average bed occupancy for the ward was 71%. Between 1 January 2017 and 31 March 2018, there were eight admissions and 10 discharges for Bowling ward.

The average length of stay for current patients was 15 months. The average length of stay for patients discharged between 1 January 2017 and 31 December was 975 days, or around 31 months.

Whilst we saw evidence of some section 117 aftercare plans for patients that included consideration of voluntary, work we saw little evidence of clear discharge planning within patients' care plans, including a lack of specific goals or clear timeframes for discharge in all care plans that were reviewed. Goals relating to discharge did not always contain the patient voice, for example some of the goals stated were 'to engage with therapy', and 'for patient to use section17 leave appropriately'. Within one patient's care plan, they had stated that they did not wish to move into supported living accommodation. However, within their care plan it was detailed that the plan was for the patient was to engage in an assessment as a local support living facility. One patient residing in the annexe had a graded plan looking at self-medication and plans to consider supported living accommodation. However, no specific timescales or dates were provided. Staff were able to give details of two patients on the ward who were nearing discharge. However, their care plans contained little detail about what their discharge plan was.

Due to the specialised nature of the ward the service admitted patients from outside of the local area. However, beds remained available for patients in the local catchment area.

When patients had overnight leave at another location, the ward did not use these beds for other patients.

Where patients required more intensive treatment staff considered transfers to other wards within the hospital to the psychiatric intensive care unit, or outside the hospital with the support of the patient's commissioners. Staff did not move patients between wards without justified clinical grounds.

The service had not reported any delayed discharges of patients from Bowling ward to other settings. However, staff said there could be difficulties in moving patients on to more appropriate settings, particularly those who wished to move out of area or required accommodation within a supported living setting due to the ongoing specialist treatments patients often required

The facilities promote recovery, comfort, dignity and confidentiality

Patients had free access to a variety of unlocked rooms on the ward, which included three separate lounge areas; one of which was a quiet room with no TV and another of which contained a piano and pool table as well as a number of games, and a dining room. Patients also had access to rooms off the ward including therapy and meeting rooms, and a private clinic room. Patients also had access to laundry facilitates which they could use independently based on individual risk assessment. There was a clearly detailed timetable outside the laundry room indicating when each patient would get time to use it.

Patients could use visitors' rooms on a communal corridor of the hospital. Two of the visitors' rooms contained games and books for children who may be visiting. Access to visitors' rooms was based on individual risk assessment with some patients being escorted where required.

Patients had access to a communal outdoor area, which contained gym equipment. The door to the outdoor area was kept locked. However, patients spoken with stated that staff would open this whenever a patient requested. Staff confirmed that the outdoor area was available for patients to use at any time of the day or night.

Patients were able to use a ward telephone located at the far end of the ward corridor in order to make phone calls. Patients also had access to their own personal mobile phones.

Patients had access to hot and cold drinks and snacks throughout the day and night. Staff stated that due to a recent serious incident on another ward the hot water geysers had been removed from all wards. Staff stated that until new temperature controlled hot water tanks were delivered they had to fill small flasks of hot water from the kitchen, which they would then place in the dining area for patients to use. Whilst on inspection we observed a patient requesting for the hot water to be refilled. This was done immediately by a member of staff.

Patients told us that there was a good choice of food. Patients were also able to order takeaways to the ward.

Patients had their own bedrooms which they were able to personalise should they wish to do so. Each bedroom contained secure storage and patients had the option to place valuables in a locked room on the ward. One member of staff each shift would be responsible for the keys for this room and would log when a patient requested a belonging from this room or if they added something for storage.

Copies of activity timetables were present in communal areas of the ward and individual activity timetables were kept in each patient's file and in patient's bedrooms. Group activities available included exercise, walking, and arts and crafts groups. However, three of the six patients interviewed stated that they would like more choice of activities, and would like alternatives to be available rather than just one activity at a time. Occupational therapy provision was only available during the week. However, ward staff stated that at weekends, they engage in activities with the patients including movie nights, and trips outside the hospital to do activities such as ice-skating. Staff stated that they are able to use a therapy budget to support the provision of activities on weekends.

Meeting the needs of all people who use the service

Bowling ward was located on the ground floor of the hospital and was therefore accessible to those with mobility difficulties. We spoke with one patient who had mobility difficulties. Occupational therapy staff had engaged with this patient to find out their particular needs and had then installed grab rails and a shower chair within the patient's room. The patient also had access to a wheelchair but preferred to mobilise with the crutches provided.

The ward had a patient information board which contained posters detailing how patients could complain and information around advocacy support. An advocate visited the ward on a weekly basis and patients were encouraged to use the support provided should they wish to complain or raise concerns about care and treatment.

Staff stated that they were able to access interpreters if required for patients whose first language was not English. However, we did not see information provided in any other formats such as more accessible formats for those patients who may have limited understanding. Staff told us that they did not have immediate access to this information on the ward but that they were able to access if required.

Catering staff offered patients a choice at each mealtime. Posters were clearly displayed in the dining area requesting patients to inform staff immediately of any allergies or intolerances they may have so that the catering team could provide suitable alternatives at meal times. We did not speak with any patients who stated particular dietary needs due to culture or religion however, staff stated that needs of this kind would be accommodated.

The hospital had a spiritual room for patients to use as required. Patients we spoke to stated that staff would facilitate visits externally to churches or other places of worship.

Listening to and learning from concerns and complaints

Cygnet Hospital Bierley reported that there were 34 complaints received between 1 January 2017 and 31 December 2017. Of these 34 complaints, three were in relation to Bowling ward.

Complaints related to hospital transport breaking down, suspension of leave, and staff attitude. The complaint in relation to hospital transport was upheld. All complaints were investigated appropriately and feedback was given to the complainants.

Patients and carers told us that they knew how to complain should they wish to do so. An advocate was also available to support patients to complain or raise concerns.

However, three patients indicated that they did not feel complaints were always responded to and that they would not feel like staff would do anything even if they did complain. A carer spoken to following inspection also stated that they did not always receive a response when sending emails of complaint to the ward manager.

Staff stated that they would always support patients to make complaints. One member of staff stated that a complaint had been against them by a patient and as a result, the ward manager had instigated mediation in order to successfully resolve the situation.

Half the staff spoken with stated that learning from complaints would be fed back through staff meetings or

handovers. However, the other half of staff members spoken to stated that learning from complaints was not consistent, and feedback would not always be shared. We saw evidence of three compliments given to staff; two from patients thanking staff for their help and one from an independent mental health advocate thanking a particular staff member for their positivism with patients.

Are personality disorder services well-led?

Vision and values

Cygnet Health Care Ltd had an overall vision to be the 'provider of choice'. The values of the provider were:

- Helpful
- Respectful
- Honest
- Empathetic

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. Staff across the service displayed these values in their direct work with patients.

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. Every six months the senior leadership team from Cygnet Hospital Bierley met with the board and corporate managers for corporate governance meetings. Ward managers, senior staff, and senior members of the multidisciplinary team attended a local Cygnet Hospital Bierley, monthly governance meeting. This meeting was structured and followed the same format as the corporate governance meetings and discussions included advocacy, medicines 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. The ward managers were responsible for reviewing and presenting a monthly data pack of this ward level information to the local governance meeting, and then for feeding back to staff and completing the key actions to improve quality and address any shortfalls discussed in the local governance meetings.

The service had a number of key performance indicators in place 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 service had made improvements in establishing their governance systems since the time of our last inspection. The service planned and managed staffing well and we saw evidence that they dealt with poor performance effectively. The service had a 6% sickness rate and three staff leavers in the last twelve months. The service monitored staffing and we reviewed rotas, which evidenced that no shifts had been left unfilled.

The service employed a service user involvement lead, healthy lifestyle lead and an expert by experience to ensure patient's voices were heard and that patient involvement in care was high on the agenda.

At ward level there were opportunities for staff to learn from incidents. Staff felt supported because team meetings, and debriefs were taking place. Staff were able to give us clear examples of how important information was shared across the service and across all hospitals managed by the provider.

Senior managers were aware of the risks and priorities for the service. Minutes from the local governance meetings showed that staff conducted regular audits to ensure they were improving quality and safety within the service. Managers had recognised issues relating to the recording of rapid tranquilisation and seclusion, and had taken action to improve this, including the introduction of training sessions.

The hospital had a local risk register, which fed into the corporate risk register. Ward staff told us they could submit items to the local risk register via their ward managers. Senior managers could escalate concerns to the corporate risk register after discussion with the corporate risk manager. They told us that they felt confident and encouraged to do so, and had developed sound corporate

relationships which allowed them to raise concerns at a corporate level and obtain additional support at service level as required, for example in response to the fire enforcement notice.

The hospital had ten current risks on their local risk register, which they monitored through the monthly governance meetings. These risks included staffing vacancies, a patient death, access to primary health care, heating systems, seclusion rooms, anti-barricade locks, structural concerns and fire safety deficiencies.

However, governance systems and processes were not entirely effective. Despite the service's approach to audit, we found concerns on Bowling ward ward in relation to the recording of risk assessments, physical health checks, the monitoring of anti-psychotic medication side effects and monitoring of patients following the use of rapid tranquilisation. In addition, the supervision of staff was not always in line with Cygnet policy. Senior managers were not of aware of all of these concerns at the time of the inspection.

There was a lack of oversight at senior management level regarding the application of the Mental Capacity Act. Although staff were trained, they lacked confidence to understand the inference between the Mental Capacity Act and the Mental Health Act. This had developed into an incorrect culture of staff understanding what decisions they could make on behalf of detained patients. Despite Mental Health Act audits taking place and noting compliance we found a number of errors in patient's consent to treatment paperwork.

The senior management team were aware of the risks of moving patients using stairs to the ground floor seclusion room. However, there was not a risk assessment or protocol for staff to follow in order to manage this risk.

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. However, two of the staff members we spoke with on inspection stated that they did not always feel positive aspects of their work and contribution were fed back to them, with senior managers tending to focus on negative aspects of their work. Staff also stated that whilst there was the opportunity to engage in non-mandatory training there was not always consideration for in-house role development.

The provider had conducted a hospital-wide staff survey in November 2017. There were 64 respondents to the survey. The results of the survey were not broken down to ward level to protect staff anonymity. The overall staff survey 'positive score' was 78%. Staff feedback was mixed with 83% (53 respondents) of respondents stating that they enjoyed working for the provider although only 69% stating that they were proud to work for the provider. The staff survey showed low levels of satisfaction with staffing levels, stress at work, staff benefits and pay, and staff experiencing bullying, harassment or abuse from patients. The service were addressing these concerns via the hospital's local overarching action plan and by obtaining regular feedback from staff.

Whilst staff stated that they knew how to complain or raise concerns, three out of six members of staff spoken with stated that they did not feel that they could do so without fear of reprisal or concern about the information being passed on to other parties. One member of staff also stated that they did not feel able to use the whistleblowing process for fear of reprisal.

Staff opinions on whether feedback was provided following complaints was also mixed with three out of six staff members spoken with stating that feedback was not always given to staff. Two staff members commented that when feedback was given senior management would focus on what staff had done wrong and would not give any praise about positive aspects. Staff also commented that they did not always feel listened to if they raised areas for service improvement, They said that if they did raise concerns they did not believe these would be kept confidential or protect their anonymity.

Whilst the majority of staff spoken with stated that they were happy to work on Bowling ward they did also indicate that there were current morale issues present. Clinical managers stated that they were aware of some of the morale concerns with staff on Bowling ward and had organised for external psychology provision to be made available to offer supervision and mediation to staff.

Personality disorder services

Between 1 January 2017 and 31 December 2017 sickness rate for ward staff was 5.9% and there had been only three staff leavers; signifying that morale issues were being dealt with in a timely manner so as not to impact on staffing.

Commitment to quality improvement and innovation

During the inspection we found a number of innovative projects in delivering therapy to patients, and ensuring that outcomes were met. Many of these projects were routed in patient involvement and the hospital strived to ensure patient involvement was an integral part of their work with the employment of their own expert by experience and service user involvement lead.

Some of these projects included;

- In March 2018 the hospital celebrated their Recovery College being awarded accreditation by the Assessment and Qualifications Alliance (AQA).
- In January 2018, two projects involving patients from Bowling ward were shortlisted for the National Service User Awards. This included a project whereby a patient made and sold bracelets to raise money for Make Them Smile; a charity supporting children with life hindering illnesses, and a project whereby patients made a short film, “An End to Stigma”; enabling patients to tell their stories of mental health.
- The hospital have also won awards for their DBT programme with The Association of Psychological Therapies (APT) awarding the staff for their ‘demonstrable commitment to deliver all five functions and corresponding modes of DBT, and to do so consistently and to a high standard’ in April 2017.
- The hospital have also won awards for their dialectical behaviour therapy programme with The Association of Psychological Therapies awarding the staff for their ‘demonstrable commitment to deliver all five functions and corresponding modes of DBT, and to do so consistently and to a high standard’ in April 2017.

Outstanding practice and areas for improvement

Outstanding practice

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- The hospital have also won awards for their DBT programme with The Association of Psychological Therapies (APT) awarding the staff for their 'demonstrable commitment to deliver all five functions and corresponding modes of DBT, and to do so consistently and to a high standard' in April 2017.
- The hospital's psychology team have introduced bit size recovery skills sessions on Denholme (psychiatric intensive care service) to ensure that despite sometimes short stays on the ward, patients have access to therapy where they can learn skills and coping mechanisms.
- Both Bronte and Shelley wards had the 'Full Monty' award from the social justice charity Bright. The award celebrates excellence in in-patient care and is awarded to services who implement inspiring ideas for improving patients' quality of time and treatment outcomes.

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that there is a protocol and risk assessment in place for staff to follow regarding the movement of patients in restraint to seclusion rooms using stairs.
- The provider must ensure that staff can observe patients at all times whilst they use seclusion.
- Where a person lacks capacity to make an informed decision, or give consent, staff must act in accordance with the Mental Capacity Act and associated Code of Practice.
- The provider must ensure that patient's prescribed anti-psychotic medications have appropriate and timely monitoring of the side effects of these medications on their physical health.
- The provider must ensure that the governance systems and processes in place are effective and ensure proper assessment, monitoring and mitigation of risks.
- The provider must ensure that patient's with long term physical healthcare needs on the low secure forensic wards receive appropriate and timely support and reviews with professionals.
- The provider must ensure that patients are given adequate and timely physical health checks on admission to Denholme ward, and that staff assess the risk of refusal.
- The provider must ensure that patients receiving rapid tranquilisation on the psychiatric intensive care unit and specialist personality disorder service have appropriate monitoring of their physical health as per the provider's own policy.
- The provider must ensure that patients are admitted to the psychiatric intensive care unit via an entrance to the hospital, which ensures their dignity and privacy.
- The provider must ensure that the use of prone restraint on the psychiatric intensive care unit is line with national guidance.

Outstanding practice and areas for improvement

- The provider must ensure that all ligature risks on the specialist personality disorder service have been risk assessed and mitigated.
- The provider must ensure that patient risk assessments on Bowling ward are updated regularly and after each incident.
- The provider must ensure that blanket restrictions in place on Bowling ward are reviewed, monitored and risks mitigated.

Action the provider SHOULD take to improve

- The provider should ensure that all staff, including allied health professionals are supervised in line with their own policy.
- The provider should ensure that staff record the monitoring of patients following the use of rapid tranquilisation and during episodes of seclusion on the low secure forensic wards.
- The provider should ensure that they continue to monitor, review and audit blanket restrictions on the low secure forensic wards.
- The provider should ensure that there are adequate staff on duty to ensure that patients are able to access leave and activities on the low secure forensic wards and specialist personality disorder service.
- The provider should ensure that the involvement of patients and their care planning is clear and recorded in the patient's own words, as transferred from discussions in patient meetings on the psychiatric intensive care unit and the specialist personality disorder service.
- The provider should ensure that care plans include the advanced decisions made by patients in relation to the management of violence and aggression on the specialist personality disorder ward.
- The provider should ensure that all staff have completed mandatory training on the psychiatric intensive care unit.
- The provider should ensure that patients have adequate monitoring of their long term physical health needs on the psychiatric intensive care unit and the specialist personality disorder service.
- The provider should ensure that staff have a policy to follow to provide guidance on working with post-partum patients as per national guidance on the psychiatric intensive care unit.
- The provider should ensure that oxygen cylinders within emergency grab bags are dated and replaced appropriately on the psychiatric intensive care unit and the specialist personality disorder service.
- The provider should ensure that all patient information is locked away securely on the psychiatric intensive care unit
- The provider should ensure that communication with carers is improved in the specialist personality disorder service.
- The provider should ensure that staff have access to debriefs following incidents in the specialist personality disorder service.
- The provider should ensure that staff working on the specialist personality disorder ward have a knowledge and understanding of working with patients with a diagnosis of personality disorder.

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 10 HSCA (RA) Regulations 2014 Dignity and respect **How the regulation was not being met:** The admittance of patients to the psychiatric intensive care unit did not ensure the dignity and privacy of the patient was respected because patients were admitted via a main hospital entrance. **This is a breach of regulation 10 (1) (2) (a)**

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:** Across all three core services, care and treatment of patients 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. In the psychiatric intensive care unit and the specialist personality disorder wards. The registered person did not act in accordance with the Mental Health Act because appropriate consent to treatment was not in place. **This was a breach of regulation 11 (1) (2) (3) (4)**

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 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. Staff did not always assess the risks to health and safety of service users receiving care or treatment and do all that was practicable to mitigate such risks.

On Bowling (specialist personality disorder) ward risk assessments were not always reviewed by staff in a timely manner and following incidents.

On Bowling (specialist personality disorder) ward and Denholme (psychiatric intensive care unit) ward staff did not always carry out appropriate monitoring of patient's physical health following the use of rapid tranquilisation.

On Shelley and Bronte (low secure forensic inpatient) wards staff did not always monitor the long term physical health conditions of patients.

On Denholme ward staff did not follow the provider's physical health policy by ensuring that all newly admitted patients had a timely physical health assessment on admission. Staff did not record that they had undertaken risk assessments when patients refused physical health checks.

The premises used by the provider were not entirely safe for use for their intended purpose and used in a safe way. There was no protocol or risk assessment in place for the movement of patients down stairs to the seclusion facility.

Staff could not always observe patients using the seclusion facility used by all wards on the ground floor.

Not all ligature risks on Bowling ward had been risk assessed and mitigated by staff because they did not form part of the ligature risk assessment. This included a lack of specific care for one patient using medical equipment.

This was a breach of regulation 12 (1) (2) (a) (b) (d)

Regulated activity	Regulation

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 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. Staff used planned prone restraint for the administration of intra-muscular medication and for exit from seclusion in the psychiatric intensive care unit, without recording that other methods were attempted. There were blanket restrictions in place on Bowling ward which had not been individually risk assessed, reviewed and monitored. **This was a breach of regulation 13 (1) (4) (b)**
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:** The governance systems in place were not entirely effective. The systems in place did not entirely assess, monitor and improve the quality and safety of the service and mitigate all risks to the health, safety and welfare of patients. **This was a breach of regulation 17 (1) (2) (a) (b)**