Cygnet NW Limited

Cygnet Bury Hudson

Inspection report

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

Ratings

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

Summary of findings

Overall summary

This service has now been removed from special measures.

Our rating of this service improved. We rated it as requires improvement because:

- The ward environments needed redecoration and refurbishment. Seclusion suites did not have easy access to bathroom facilities and fresh air. Risk assessments were not always updated following incidents.
- The patient care record system was a mixture of electronic records and paper records. This meant some documents were difficult to locate and paperwork was duplicated.
- An epilepsy care plan was not detailed enough to ensure staff responded appropriately.
- There continued to be medicine management concerns. There were medicines on Upper East ward with no expiry dates. This meant that staff could not be assured that these medicines were safe to administer.
- Patients felt the quality of food was poor.
- There were gaps in governance processes that failed to identify areas of concern.

However:

- The wards had enough nurses and doctors. The service had significantly improved its recruitment and retention rates. They minimised the use of restrictive practices and followed good practice with respect to safeguarding and complaints. The safeguarding and complaints processes had been improved and were now working effectively.
- Staff developed holistic, recovery-oriented care plans informed by a comprehensive assessment. They provided a range of treatments suitable to the needs of the patients and in line with national guidance about best practice. Staff engaged in clinical audit to evaluate the quality of care they provided.
- The ward teams included or had access to the full range of specialists required to meet the needs of patients on the wards. Managers ensured that these staff received supervision and appraisal. The ward staff worked well together as a multidisciplinary team and with those outside the ward who would have a role in providing aftercare.
- Staff understood and discharged their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, and understood the individual needs of patients. They actively involved patients and families and carers in care decisions.
- Staff planned and managed discharge well and liaised with services that would provide aftercare. As a result, discharge was rarely delayed for other than a clinical reason.
- There were now more audits in place and there were processes for considering and feeding back lessons learnt. The service had been successful in implementing a co-production approach to quality improvement.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Forensic inpatient or secure wards	Requires Improvement 	See overall summary

Summary of findings

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Summary of this inspection

Background to Cygnet Bury Hudson

Cygnet Bury Hudson hospital provides low and medium secure inpatient services for men: There are six wards and 78 beds:

- West Hampton ward –13 bed medium secure ward for males (due to reopen, date unknown)
- Lower East ward – 13 bed medium secure ward for males
- Madison ward – 13 bed medium secure ward for males with a personality disorder
- Columbus ward – 13 bed medium secure ward for males with a personality disorder
- Upper East ward – 13 bed low secure ward for males
- East Hampton ward – 13 bed low secure ward for males

The service has a registered manager. It has been registered with the Care Quality Commission since 30 April 2021 to carry out the following regulated activities:

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

The hospital was last inspected in June 2022 where it was rated inadequate overall.

- Safe – Inadequate
- Effective – good
- Caring – Inadequate
- Responsive – Requires improvement
- Well-led – Inadequate

The hospital was placed in special measures. When an independent healthcare service is in special measures it is the provider's responsibility to improve it. We expect the provider to seek out appropriate support to improve the service from its own resources, and from other relevant organisations or oversight bodies or both.

What people who use the service say

Carers we spoke to said that staff went above and beyond their job roles and were worth their weight in gold. Carers commented that they had a lot of admiration for all the staff and they were extremely polite and caring.

Carers felt that their loved ones had improved in their appearance and wellbeing.

Carers said they were well informed and involved in loved ones care and that any concerns were addressed promptly.

Carers were able to describe activities their loved ones were engaged in which included, the recovery college, gym, playing pool, watching football, gardening, attending to the chickens, cleaning jobs, attending university three times a week and painting and woodworking courses.

Summary of this inspection

Some carers commented that patients had too many takeaways and there were not enough occupational therapy activities for patients without leave.

Two carers confirmed their loved ones leave had been cancelled.

Patients told us that they felt involved in their care and that staff treated them with kindness and respect. Patients commented that the service had improved in recent months. Improvements had included the patient forums, pool tables, less agency staff and protected staff and patient time.

Patients commented that the food was either reasonable or poor.

How we carried out this inspection

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

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

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

This was an unannounced comprehensive inspection which meant staff did not know we were coming.

Our inspection team comprised three CQC inspectors, a nurse working as specialist advisor to the CQC and an expert by experience with experience of forensic and secure services.

During the inspection visit, the inspection team:

- spoke with the registered manager and hospital director
- spoke with the quality governance and safeguarding leads
- spoke with six ward managers
- Spoke with five other senior leaders
- spoke with 17 other staff members including nurses, healthcare assistants, occupational therapists, a Mental Health Act administrator and three doctors
- spoke with 22 patients who were using the service and 12 carers
- spoke with an independent advocate involved with the service
- contacted commissioners for feedback about the service
- looked at 20 patients' care records
- looked at the ward environments, including the review of health and safety related documentation
- looked at the medicines management arrangements within the service
- observed two multidisciplinary team meetings, three ward community meetings, one co-production meeting and three activities held at the recovery college.
- observed how staff were interacting with patients, this included completing five short observations for inspection 2 (SOFI2) which are structured observations which capture people's experience of care.

Summary of this inspection

- looked at documents relating to the running of the service

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

Outstanding practice

We found the following outstanding practice:

- The service had endeavoured to use co-production techniques to drive improvements from patient and staff objectives. Staff and patient forums were held to formulate ideas and suggestions. Improvement ideas were then fed into governance structures and promptly introduced into operational practice wherever possible. This method had been successful and the hospital had seen significant reductions in incidents, seclusion episodes, use of rapid tranquilisation, and improvement in staffing levels and patient and staff engagement.

Areas for improvement

- The service must ensure that care records are contemporaneous and complete. Patient risk assessments must be updated following incidents and without delay. (Regulation 17 (2) (c))
- The service must ensure that there are systems and processes that effectively identify and address service quality issues. This includes, contemporaneous care records, medicine management, ward and seclusion environments, staff training oversight, risk assessments and MHA and MCA documentation.(Regulation 17 (2) (a))
- The service must ensure that medicines are managed safely. All medicines must have an expiry date clearly displayed. (Regulation 12 (2) (g))
- The service must ensure that ward environments are properly maintained and that redecoration is planned and completed promptly. (Regulation 15 (1) (e))
- The service must ensure that privacy and dignity of patients is maintained at all times. Seclusion suites must have easy access to bathroom facilities and outside space. (Regulation 10 (2) (a))

Action the service SHOULD take to improve:

- The service should ensure that it continues to improve the electronic care record system to include Mental Health Act and Mental Capacity Act paperwork to avoid confusion and duplication.
- The service should consider including Mental Health Act and Mental Capacity Act training figures within its mandatory training compliance set to ensure better oversight of this data.
- The service should ensure that epilepsy care plans are detailed for staff to follow.
- The service should consider ways to improve the quality of the food given considering the poor feedback from patients directly and within surveys.

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Forensic inpatient or secure wards	Requires Improvement	Good	Good	Good	Requires Improvement	Requires Improvement
Overall	Requires Improvement	Good	Good	Good	Requires Improvement	Requires Improvement

Requires Improvement

Forensic inpatient or secure wards

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

Is the service safe?

Requires Improvement

Our rating of safe improved. We rated it as requires improvement.

At the last inspection in June 2022, we rated safe as inadequate as safeguarding concerns were not clearly logged, acknowledged or investigated fully. Patients were not informed of the outcome in line with provider policy and lessons learned from investigating safeguarding concerns were not implemented and shared with staff within the service.

At this inspection we found that a new safeguarding process had been introduced that worked well and met the needs of patients and staff**.**

Safe and clean care environments

All wards were mostly safe, clean, well equipped and well furnished. However, not all wards were well maintained and seclusion suites were not fit for purpose.

Safety of the ward layout

Staff completed and regularly updated thorough risk assessments of all wards areas and removed or reduced any risks they identified. A fire risk assessment had been completed in December 2022.. A legionella risk assessment had been completed in September 2022. A health and safety audit had been completed in February 2023 and also noted the fire doors required repairing. There was an action plan in place to repair or replace all fire doors by 15 March 2023.

Staff could observe patients in most parts of the wards. Most ward areas had good lines of sight or had parabolic mirrors to support staff observation of patients. However, on Madison ward the bedroom corridor had fire doors in the middle of the corridor. This meant that it was difficult to observe patients beyond the fire doors. It also meant that managing a physical intervention would be difficult in the restrictive area behind the fire door. Despite this, two staff were assaulted by a patient in the bedroom corridor approximately four weeks prior to our inspection and remained on sick leave. CCTV had previously covered this area and could be monitored live by staff in the office. The practice of observing live CCTV feeds was no longer permitted. Senior managers confirmed that observation via live CCTV is not a positive and engaging form of observation. The ward manager and staff confirmed that this area of the ward was always entered by two staff in order to mitigate the risk.

Requires Improvement

Forensic inpatient or secure wards

The wards complied with guidance and there was no mixed sex accommodation. The Hudson unit was solely for male patients.

Staff knew about any potential ligature anchor points and mitigated the risks to keep patients safe. All wards had ligature audits completed in March 2023. Each ward also had a heat map to support staffs understanding of the ligature location. Ligature cutters were stored in the nursing office and staff confirmed they were aware of the location of the ligature cutters.

Staff had easy access to alarms and patients had easy access to nurse call systems. All staff and visitors were issued with alarms. There were pagers for the nurse in charge and the response team. There were appropriate nurse call alarms throughout the building.

Maintenance, cleanliness and infection control

All wards were mostly safe, clean, well equipped and, well furnished. However, not all wards were well maintained and seclusion suites were not fit for purpose. East Hampton ward had been redecorated and appeared significantly cleaner and brighter than other wards. All other wards appeared tired and in need of refurbishment. On Madison ward there was damage to a bedroom door panel, uneven paving slabs in the courtyard, bathroom grouting was stained and there was loose plaster on the recovery college walls. On Lower East ward there was privacy screening missing from a bedroom window and plaster was missing from around a bedroom door frame. Patients complained of shower trays being slippery due to being too worn. Senior managers confirmed there was a programme of works due to refurbish all the wards and this was due to be completed by December 2023. This included a full redecoration of all wards.

Staff made sure cleaning records were up-to-date and the premises were clean. All wards were mostly clean and there was visible cleaning in progress. Some wards appeared unclean due to paintwork being worn.

Staff followed infection control policy, including handwashing. We observed staff washing their hands when appropriate and using hand sanitiser.

Seclusion room

Seclusion rooms allowed clear observation and two-way communication. They had a toilet and a clock. However, four out of six wards did not have showering facilities and only one seclusion suite had access to outside space and fresh air. The seclusion suite on Madison ward was next to the activities room which meant privacy and dignity could be compromised. The seclusion suite on West Hampton ward was currently being refurbished. There was a plan to upgrade all seclusion suites by December 2023. The last episode of seclusion was over three months ago. We checked the records for this and found that all paperwork including reviews by doctors had taken place and had been recorded appropriately.

Clinic room and equipment

Clinic rooms were fully equipped, with accessible resuscitation equipment and emergency drugs that staff checked regularly. Clinic rooms were clean and contained the necessary equipment such as defibrillators and resuscitation bags. There was detailed documentation of the resuscitation bag contents and this was checked by staff. However, there were no examination couches on Madison and East Hampton wards. If required staff could access the examination couch in the GP office or use the sofa in the quiet room. We found medicine with no expiry date on Upper East ward. This included aspirin and codeine. Staff immediately replaced this medicines during our site visit.

Staff checked, maintained, and cleaned equipment. All equipment contained visible stickers to ensure it had been maintained and that this check was in date.

Requires Improvement

Forensic inpatient or secure wards

Safe staffing

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

Nursing staff

The service had enough nursing and support staff to keep patients safe. All ward managers reported having a full complement of registered nurses and that the service had deliberately over-recruited to support previous staffing difficulties. Madison, Columbus and East Hampton wards did not have any vacancies for support workers. However, there were four support worker vacancies on Upper East ward and one on Lower East ward. One vacancy had been appointed to and were waiting on employment checks to be completed. The service were able to provide data that confirmed nursing staff vacancies were minimal.

The service had low and reducing vacancy rates. Vacancy rates were high during the last inspection and the service had been heavily reliant on agency staff. However, there were now only a small number of vacancies and agency usage had reduced significantly.

The service had low and reducing rates of bank and agency nurses and support workers. Agency staff were used to cover 1345 shifts in March 2022. In February 2023 this had reduced to 317 shifts. Bank staff were used to cover 583 shifts in March 2022. In February 2023 this had reduced to 504. Agency usage had reduced to just 15% across the Hudson unit.

Managers limited their use of bank and agency staff and requested staff familiar with the service. Managers sought to utilise bank staff who were familiar with the service as a priority when filling vacant shifts. Managers also had access to some agency staff who were familiar with the service and requested them as necessary.

Managers made sure all bank and agency staff had a full induction and understood the service before starting their shift. Bank staff received the same full induction as permanent staff members. Agency staff had a separate induction. All staff had a local staff induction into the ward environment. Ward managers completed a daily ward safety checklist which required them to check whether any bank or agency staff on shift had received the correct induction. This information was fed into the daily staffing call.

The service had reducing turnover rates. The turnover rate was steadily reducing. The monthly turner rate was:

- October 2022 36%
- November 2022 35%
- December 2022 29%
- January 2023 29%

Managers supported staff who needed time off for ill health. Managers spoke of adopting a supportive role for staff who were absent from work due to illness. Managers were supported by human resources policies and procedures.

Levels of sickness were low and reducing. Sickness rates had also been steadily reducing. The monthly sickness rates were:

- October 2022 8%
- November 2022 7%
- December 2022 8%
- January 2023 5%
- February 2023 3%

Requires Improvement

Forensic inpatient or secure wards

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants for each shift. Staffing levels were adjusted daily to match the acuity of the patient group. We saw examples of staffing being increased to meet the needs of patients who required enhanced observations.

The ward manager could adjust staffing levels according to the needs of the patients.

Patients had regular one to one sessions with their named nurse. We saw evidence of one to one sessions with named nurses being recorded within the care records system. Staff spoke of having plenty of time for one to one sessions and patients confirmed these went ahead.

Patients rarely had their escorted leave or activities cancelled, even when the service was short staffed.Over the last 12 months leave had been cancelled on eight occasions and activities had been cancelled on 24 occasions. Leave had not been cancelled due to staffing since September 2022.

The service had enough staff on each shift to carry out any physical interventions safely. Wards were expected to have two registered nurses on shift during the day with five support workers. During the night the staffing levels were two registered nurses with three support workers. There was a response team responsibly for responding to incidents. There were enough staff for this to work safely and effectively. Staff reported response to alarms to have improved. Previously alarms were activated frequently and staff were tired and despondent. Now alarms were rarely activated and the response was prompt when required.

Staff shared key information to keep patients safe when handing over their care to others. We reviewed a selection of handover documents. Handovers contained pertinent information to ensure the shift ran safely. New risks or incidents were discussed and safeguarding issues were a standing item agenda. Other patient information included risk levels and observation levels.

Medical staff

The service had enough daytime and night time medical cover and a doctor available to go to the ward quickly in an emergency. There was sufficient medical cover during the day and at night. The medical team were well established in their roles. There were three consultant psychiatrists for the Hudson unit. The medical staff team were all permanent staff members. Each ward had access to a junior doctor. There was an on call rota covering the whole site which consisted of approximately 12 staff. Doctors reported being able to be onsite within 30 minutes to address any emergency needs.

Managers could call locums when they needed additional medical cover.

Managers made sure all locum staff had a full induction and understood the service before starting their shift. Locum and agency had a local ward induction prior to starting work. A checklist was completed by the ward manager and fed into daily staffing meetings.

Mandatory training

Staff had completed and kept up-to-date with their mandatory training. Staff on each ward were up to date with their mandatory training which consisted of 11 modules. The providers target was 90%. This was being met in most instances. However, immediate life support training was slightly below target on the following wards:

- East Hampton 88%
- Upper East 80%

The provider confirmed that outstanding staff were booked onto this training in the next two weeks.

The mandatory training programme was comprehensive and met the needs of patients and staff. The training modules included:

- Basic life support
- Dealing with concerns
- Equality and diversity
- Food safety
- Immediate life support
- Infection prevention control
- Information governance
- Health and safety
- Response to emergencies
- Safeguarding
- Safety intervention compliance

Managers monitored mandatory training and alerted staff when they needed to update their training. There was an electronic system in place that alerted both managers and staff to upcoming training that was due. Staff were alerted to training that was due within three months and managers were able to book staff onto the training and adjust staffing and rotas to accommodate this. Staff confirmed there were no issues booking onto modules and that availability was good.

Assessing and managing risk to patients and staff

Staff mostly assessed and managed risks to patients and themselves well. They achieved the right balance between maintaining safety and providing the least restrictive environment possible to support patients' recovery. Staff had the skills to develop and implement good positive behaviour support plans and followed best practice in anticipating, de-escalating and managing challenging behaviour. As a result, they used restraint and seclusion only after attempts at de-escalation had failed. The ward staff participated in the provider's restrictive interventions reduction programme.

Assessment of patient risk

Staff used a recognised risk assessment tool. Staff used a recognised risk assessment tool called the Short-Term Assessment of Risk and Treatability (START). Patients also had forensic risk assessments called Historical, Clinical and Risk Management – 20 (HCR-20)

Staff completed risk assessments for each patient on admission / arrival, using a recognised tool, and reviewed this regularly. However risk assessments were not routinely updated following any incident. Staff did not automatically update either the HCR-20 or START assessments in response to an incident or change in presentation or circumstance. Instead the service completed a Daily Risk Assessment which was captured in the daily clinical notes. The Daily Risk Assessment on each ward covered:

- Daily risk rating (red, amber or green)

- Overview of last 24 hours

- Management plan

• Observation level

We reviewed 20 records and the clinical notes in each of them had a daily risk assessment for each day. Daily risk assessments were brief but covered each of the relevant areas. Staff were aware of the daily risk assessments and were aware of each patients current risk.

The daily risk assessment was also shared in shift handovers.

Although the daily risk assessment was updated each day, the main risk assessment document (START) was only updated at three monthly intervals. We saw six examples of patient incidents not recorded on the START document.

Management of patient risk

Staff knew about any risks to each patient and acted to prevent or reduce risks. Staff were aware of patients risks for the last 24 hours as this was clearly documented within the daily risk assessment. Staff had START and HCR-20 risk assessment documents to refer to for all historical risks. However, information was only updated on the START or HCR-20 documents at three and six monthly intervals. This meant that risk information for the last three months was not easily available for staff to view.

We saw evidence of staff responding to risks such as increasing observations or reducing leave to minimise patient risks.

Staff identified and responded to any changes in risks to, or posed by, patients.

Staff followed procedures to minimise risks where they could not easily observe patients. In areas of the ward where observation was not easy to carry out, staff monitored the area. A staff member was allocated to carry out observations of the wards which posed a risk due to poor lines of sight.

Staff followed providers policies and procedures when they needed to search patients or their bedrooms to keep them safe from harm. The provider had a search policy dated October 2020. The policy described reactive searches based on relational security information such as banned items potentially on the ward, missing items, threats, and damage to the ward environment. Other types of searches were routine random searches. The policy described this being applicable in certain settings due to the level of risk posed by patients.

Use of restrictive interventions

Levels of restrictive interventions were low and reducing. Over the last six months the number of restraints were:

- September 2022 73
- October 2022 51
- November 2022 76
- December 2022 44
- January 2023 34
- February 2023 4

Of these the number that were in the prone position were:

- September 2022 1
- October 2022 3
- November 2022 7

- December 2022 0
- January 2023 2
- February 2023 0

The use of rapid tranquilisation was also low with this only being used once in the last six months.

Ward managers and nursing staff described the wards as much calmer. Staff attributed this to having less agency staff and the co-production culture that had made staff and patient relationships better.

Staff participated in the provider's restrictive interventions reduction programme, which met best practice standards. The provider had a restraint and violence reduction policy dated February 2023.

Staff made every attempt to avoid using restraint by using de-escalation techniques and restrained patients only when these failed and when necessary to keep the patient or others safe. Staff described using verbal de-escalation and distraction skills to avoid incidents escalating. All staff were trained to use de-escalation skills and staff acknowledged that restraint was only used as a last resort. All patients had positive behaviour support plans that were detailed and comprehensive. Staff were able to describe individual techniques to de-escalate patients.

Staff understood the Mental Capacity Act definition of restraint and worked within it.

Staff followed NICE guidance when using rapid tranquilisation. Rapid tranquilisation had only been used once in the last six months. We checked this record and found that all the correct documents had been completed and this met best practice.

When a patient was placed in seclusion, staff kept clear records and followed best practice guidelines. The use of seclusion was reducing. On the day of our visit there were no patients using any of the seclusion suites. There had been 30 episodes of seclusion in the last 12 months. During the last six months the number of seclusions were:

- September 2022 6
- October 2022 2
- November 2022 1
- December 2022 5
- January 2023 3
- February 2023 0

All seclusion records were held in paper format. We reviewed these records for two patients and found these to be accurate and following best practice. All doctors reviews had taken place and were clearly documented in the care record.

Staff followed best practice, including guidance in the Mental Health Act Code of Practice, if a patient was put in long-term segregation. There had been five patients placed in long term segregation over the last 12 months. The longest being for one year. There were no patients in long-term segregation at the time of our visit. Staff were aware of guidance within the Mental Health Act code of practice to safeguarding patients.

Safeguarding

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

Requires Improvement

Forensic inpatient or secure wards

At the last inspection in June 2022, safeguarding concerns were not clearly logged, acknowledged or investigated fully. Patients were not informed of the outcome in line with provider policy and lessons learned from investigating safeguarding concerns were not implemented and shared with staff within the service.

At this inspection we found that a new safeguarding process had been introduced that worked well and met the needs of patients and staff.

Staff received training on how to recognise and report abuse, appropriate for their role. All staff had completed safeguarding individuals at risk training, which included safeguarding children, that was mandatory training. 99% of staff were compliant with this module. Ward managers had completed enhanced training equivalent to safeguarding level 4. Staff in the social work department had also delivered in-house safeguarding training face to face with staff to improve staff knowledge and understanding.

The service had reviewed and amended the safeguarding training offered to staff to ensure it met with the safeguarding intercollegiate guidance.

Staff were kept up-to-date with their safeguarding training. Safeguarding training was completed during induction and then every 12 months to ensure staff were up to date.

Staff could give clear examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. Staff were able to give examples of recent safeguarding concerns and also able to explain current safeguarding themes on each ward such as financial abuse due to patients trading items. Staff were able to talk about the process they would follow should a safeguarding concern be identified. This process was robust and there was a clear audit trail to ensure all actions had been taken.

Safeguarding was becoming embedded into daily practice. Safeguarding was considered and discussed for each patient during handover meetings and documented on the handover form.

Each ward had a daily designated safeguarding staff member to observe communal areas and be aware of any safeguarding matters arising. The safeguarding person wore a different coloured lanyard to the rest of the staff so that it was clear to patients and other staff that this person had a particular role.

Staff knew how to recognise adults and children at risk of or suffering harm and worked with other agencies to protect them. Staff had built strong links with the local authority and an agreed threshold for referrals had been agreed and understood. Staff could give clear examples of how to recognise abuse.

Staff followed clear procedures to keep children visiting the ward safe. Children were not permitted to visit the wards. However, there was a family visiting room in a non patient area that was suitable for child visitors. Staff were aware to complete a risk assessment prior to any child visits to the site. There was a visitor policy dated March 2021 for staff to refer to.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. There were now clear processes for staff to follow for safeguarding concerns. This included; logging the incident, discuss in daily multidisciplinary meeting, complete safeguarding alert, inform patients involved if appropriate, complete safeguarding action whilst investigation continues, report back to the patient if appropriate to conclude the safeguarding outcome.

There were weekly safeguarding meetings held each Monday to discuss all open safeguarding concerns.

Requires Improvement

Forensic inpatient or secure wards

The providers safeguarding lead met weekly with the local authority to discuss safeguarding referrals.

We reviewed 16 safeguarding concerns across all the wards and found that appropriate action and measures had been put in place on each occasion.

Managers took part in serious case reviews and made changes based on the outcomes.

Staff access to essential information

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

Patient notes were comprehensive and all staff could access them easily. Care records were split across three systems which included an electronic care records system. The electronic care record system contained care plans, daily clinical notes and daily risk assessments.

There was also a shared drive for each ward with a folder for each patient. The folder included a range of risk assessments and care plans including the HCR-20 and START risk assessments, PBS plans, OT and psychology assessments and some physical health records and results.

Each patient has a paper file on the ward. It included printed out versions of documents that were on either the electronic care record system or the shared drive such as positive behaviour support plans, HCR-20 and START assessments as well as Mental Health Act and Mental Capacity Act paperwork.

Staff were comfortable navigating the systems and discussed plans to move onto the newer version of the electronic care record system which would allow the service to be paper free. The newer version of the electronic care record system was due to be installed in November 2023.

Although the service used a combination of electronic and paper records, staff made sure they were up-to-date and complete. The patient care records were much improved and items were generally stored in the same place for each patient on each ward. We did however find examples of a duplicate patient folder on the shared drive and printed out versions of Mental Health Act paperwork that had not been fully completed. There was another copy held at the Mental Health Act office that was correct.

When patients transferred to a new team, there were no delays in staff accessing their records.

Records were stored securely. Electronic patient records were stored on a system with password protection and other security settings. Paper records were held in locked cabinets in rooms with no patient access such as the nursing office.

Medicines management

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

Staff followed systems and processes to prescribe and administer medicines safely. Medicine was prescribed and reviewed by the consultant psychiatrist on a weekly basis. Medicine was administered by nurses. There was a medicine management policy dated June 2021 for staff to follow. Records were held in paper format. There was a plan for electronic prescribing in the near future.

Requires Improvement

Forensic inpatient or secure wards

Staff reviewed each patient's medicines regularly and provided advice to patients and carers about their medicines. Medicines were regularly reviewed in multidisciplinary meetings. Patients told us they understood why they were taking their medicines and felt involved in decisions about their treatment.

Staff completed medicines records accurately and kept them up-to-date. We checked 25 patients medicines charts and found that medicine records had been completed correctly.

Staff did not always store and manage all medicines and prescribing documents safely. This had not improved since the last inspection in June 2022. At this inspection we found some medicines on East Hampton with no expiry dates. This meant that staff could not be assured that these medicines were safe to administer. We raised this with ward staff who removed the medicines immediately. All documents were otherwise present and correct.

Staff followed national practice to check patients had the correct medicines when they were admitted or they moved between services. There was an admission checklist for staff to follow. This included checking whether medicines information had been received from the referring hospital and to ensure a two-week supply of medicines was in place.

Staff learned from safety alerts and incidents to improve practice.

The service ensured people's behaviour was not controlled by excessive and inappropriate use of medicines. Excessive use of medicines was considered a part of patient's medicine reviews. Staff and patients were able to report whether patients appeared over sedated and doctors could reduce medicine as needed.

Staff reviewed the effects of each patient's medicines on their physical health according to NICE guidance. Staff used the relevant side effect monitoring tool to assess the impact of any side effects of medicine on each patient. Staff regularly monitored patient's physical health and recorded this on the electronic system.

Track record on safety

The service had a good track record on safety.

Reporting incidents and learning from when things go wrong

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

Staff knew what incidents to report and how to report them. Staff were able to describe situations that would be recorded as incidents, such as patient to patient altercations, threats and violent or aggressive behaviour. There was an electronic reporting system that staff could log all incidents onto. Staff knew how to use the electronic reporting system.

The number of incidents was reducing. In September 2022 there were 301 incidents reported. In February 2023 this has reduced to 42.

Staff raised concerns and reported incidents and near misses in line with provider policy. There was an incident reporting and management policy dated May 2022 for staff to refer to. We saw examples of incidents being logged onto the electronic reporting system and acted upon.

Requires Improvement

Forensic inpatient or secure wards

Staff reported serious incidents clearly and in line with provider policy. There had been 11 serious incidents reported in the last 12 months.

The service had no never events on any wards.

Staff understood the duty of candour. They were open and transparent, and gave patients and families a full explanation if and when things went wrong. Ward managers and members of the nursing team were aware of the principles of duty of candour and when this may apply. Staff were able to give examples of situations when the duty of candour was considered and enacted.

Managers debriefed and supported staff after any serious incident. Both staff and patients confirmed they received de-briefs following incidents.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations. Ward managers had oversight of all incidents on the wards. Information from incidents fed into patient review meetings and care programme approach meetings. There was a system in place to ensure patients and families received feedback about incidents

Staff received feedback from investigation of incidents, both internal and external to the service.

Staff met to discuss the feedback and look at improvements to patient care. Themes and outcomes from incidents were reported into patient community meetings. This allowed patients to be able to consider any effective changes that might improve safety and patient care. Information from incidents also fed into governance structures to allow staff to look for themes and trends.

There was evidence that changes had been made as a result of feedback. Ward managers described drug error incidences that had resulted in changes to practice. This included ensuring all staff used the 24 hour clock in documentation and that when investigating medicine errors, all ward managers should use the same investigation tool.

Managers shared learning with their staff about never events that happened elsewhere.

Is the service effective?

Good

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

Assessment of needs and planning of care

Staff assessed the physical and mental health of all patients on admission. They developed individual care plans which were reviewed regularly through multidisciplinary discussion and updated as needed. Care plans reflected patients' assessed needs, and were personalised, holistic and recovery-oriented. They included specific safety and security arrangements and a positive behavioural support plan.

Requires Improvement

Forensic inpatient or secure wards

Staff completed a comprehensive mental health assessment of each patient either on admission or soon after. We examined 20 patient care records and found that each had a comprehensive admission assessment which include a physical health assessment.

This included paper documents which were stored on the shared drive and available in the patients paper files on each ward. Some of the assessments used older paperwork and in two cases assessment paperwork from previous providers.

The comprehensive assessment included:

- Circumstances leading to admissions
- Past psychiatric history
- Family history
- Medical history
- Forensic history
- Personal and social history
- Premorbid personality
- Mental state on admission
- Cognitive function
- Patient Insight
- Impression / diagnosis
- UTE risk assessment
- Management plan

All 20 records we reviewed had a completed and comprehensive assessment completed on or soon after admission.

There was also an admission checklist available in patient files. The admission checklist covered:

- MHA paperwork in order
- Nearest relative informed of admission
- Responsible Clinician identified
- Ministry of Justice informed of admission if applicable

- Initial risk assessment and agreed observation levels completed
- Initial care plans completed
- S17 leave status assessed and agreed
- Medicines information received from referring hospital
- Two-week supply of medicines in place
- Patient read rights
- Named nurse identified
- Patient informed of named nurse and have met
- Tour of ward and building
- Welcome leaflet given

All patients had their physical health assessed soon after admission and regularly reviewed during their time on the ward. The physical health assessment was completed by the admitting doctor and nurse within four hours of admission. We reviewed 20 care records and found that physical health had been assessed on admission for all patients. There was good physical health monitoring in place for all 20 care records we reviewed. The ongoing physical health assessments captured:

- Baseline observations
- Smoking / drinking / substance use
- Weight / height
- Blood pressure
- Urinalysis
- Blood glucose test
- Pregnancy
- Dental care
- Health passport if applicable

We also noted that medical tests such as ECG, full blood counts, glucose, serum lipids and serum prolactin were all done within 48 hours and added to the system within seven days.

Requires Improvement

Forensic inpatient or secure wards

We examined four patient care records specifically for annual health checks. We found evidence that annual physical health checks had taken place for all four patients. These were stored in the patients paper file on each ward.

There were several examples of ongoing physical healthcare documented in the physical health care plan which included diabetes, epilepsy, pain medicine, falls, angina and national monitoring schemes.

Patients over the age of 65 had care plans detailing engagement with national screening programmes such as bowel screening, diabetic retinal screening and abdominal aortic aneurism.

Staff developed a comprehensive care plan for each patient that met their mental and physical health needs. Care plans were recorded on the electronic care record system. There were nine care plans for each patient. They had all been reviewed on a monthly basis. The care plans contained information relating to:

• Understanding my mental health

• My safety planning

• Learning more about myself

• Recovery from drug and alcohol use

• Moving on

• Staying healthy (captured physical health care plans)

• My life skills

• My life relationships

• Safeguarding

We found that physical health care was well documented within each staying healthy care plan. In particular, there were eight patient care records relating to the management of diabetes. Diabetes care plans included instructions for frequency of blood monitoring and advice on how to respond to different readings. In some cases patients were being supported to undertake their own blood monitoring.

However, there was one staying healthy care plan relating to epilepsy that was not detailed and staff were unclear on how to respond. This meant that during epilepsy emergency situations, the care plan did not clearly explain to staff what action to take and therefore put patients at risk.

Staff regularly reviewed and updated care plans when patients' needs changed. All care plans were up to date and contained relevant and pertinent information. All care plans had been reviewed every month.

Care plans were personalised, holistic and recovery-orientated. We examined 20 care plans and all were comprehensive, contained the patients views and evidenced multi-disciplinary input. They also captured care plan goals and identified actions, those responsible for them and a review date.

Requires Improvement

Forensic inpatient or secure wards

Best practice in treatment and care

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

Staff provided a range of care and treatment suitable for the patients in the service. The service was focussed on recovery and rehabilitation. Care and treatment available to patients consisted of medicine reviews, utilising a therapeutic community approach, occupational therapy assessment and ongoing input, psychological assessment and therapy, nursing interventions and a range of activities and approaches to support mental health recovery.

Staff delivered care in line with best practice and national guidance (from relevant bodies eg NICE).

Staff identified patients' physical health needs and recorded them in their care plans. All patients had physical health care plans that were comprehensive and met their needs.

Staff made sure patients had access to physical health care, including specialists as required. There was a GP available on site to address any physical health concerns. Patients also had access to community physical healthcare. We noted examples in patient care records of input from specialists such as angina nurses and the pain management clinic for individual patients.

Staff met patients' dietary needs, and assessed those needing specialist care for nutrition and hydration. Patients had access to food, drinks and snacks.

Staff helped patients live healthier lives by supporting them to take part in programmes or giving advice. There were a number of activities for patients to become involved with to support healthier living. For patients with Section 17 leave agreed, this included, swimming groups, walking groups and football sessions. There was also a gym with an instructor for patients able to leave the ward. Staff were able to give patients advice during one to one sessions relating to improving health such as smoking cessation.

Staff used recognised rating scales to assess and record the severity of patients' conditions and care and treatment outcomes. Health of the Nation Outcome Scores were used on admission, review and discharge to track patients progress in relation to recovery and progress. Other outcome measures included internal tools called global assessment of progress and the care pathway. More broadly the care programme approach process also measured and monitored progress of patients in detail.

Staff used technology to support patients. Patients who had been risk assessed as appropriate were issued with key fobs to allow them access to otherwise restricted areas such as gardens, kitchens and laundry rooms. Key fobs could be programmed individually to work on each door. This meant lower risk patients were not unnecessarily restricted.

Staff took part in clinical audits, benchmarking and quality improvement initiatives. Ward managers were responsible for a number of audits such as:

- self-medication audit,
- rapid tranquilisation audit,
- CCTV audit,
- covid audit

- Staff meeting minutes audits
- Handwashing audits
- Basic life support and immediate life support simulation audit.

Ward managers completed these audits or delegated them to team leaders depending on the experience of the staff team. Ward managers did not audit their own ward and there was a process to ensure wards audited each other. Outcomes were fed back to ward managers and also fed into governance systems.

Managers used results from audits to make improvements. Medicine audits had highlighted mistakes due to staff not all using the 24 hour clock in documentation. Staff were informed of this and now all documentation was written using the 24 hour clock.

Skilled staff to deliver care

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

The service had (access to) a full range of specialists to meet the needs of the patients on the ward. Each ward had the following staff allocated to work specifically with the patient group:

- One occupational therapist
- One occupational therapy assistant
- One activity coordinator
- One psychologist
- One consultant psychiatrist

Most wards had this full complement of staff with the exception of Madison and Columbus wards who shared an occupational therapist. There were also social workers assigned to the wards and based in a central team.

Managers ensured staff had the right skills, qualifications and experience to meet the needs of the patients in their care, including bank and agency staff. Staff were trained in a range of modules suitable for their roles. Staff had also received specialist training which included, personality disorder levels one and two, Oliver McGowan Mandatory Training on Learning Disability and Autism Level 1, Autism awareness level two, Compassion Focussed Therapy and Learning Disability. All modules had a good compliance rate with the exception of:

- Compassion Focussed Therapy on Columbus 49%, Lower East 65%, Madison 50% and Upper East 39%
- Learning disability on Columbus 56%, Lower East 65%, Madison 68% and Upper East 48%

All staff had received training in epilepsy with an average compliance rate of 71%. However, this was low on Madison 51% and Upper East 45%.

Managers gave each new member of staff a full induction to the service before they started work. There was a thorough induction process for each new member of staff. The induction was approximately three weeks and included all mandatory training. There were appropriate checks and audits in place to ensure this was appropriate for the needs of the service and staff member. There was an agency assurance strategy in place that made sure agency staff had the correct knowledge prior to commencing work. This included a ward tour, emergency actions, observational competencies, observations completed in pairs initially and understanding patients one page profiles.

Managers supported staff through regular, constructive appraisals of their work. There was a system in place to ensure all staff had yearly appraisals. The average compliance rate was 95% for this service. Staff described feeling supported in their roles and that career aspirations and opportunities were in place. There was an appraisal policy for staff and managers to follow and refer to.

Managers supported permanent medical staff to develop through yearly, constructive appraisals of their work. Medical staff described having good support for development. There were support and appraisal systems in place to ensure medical staff had annual formal appraisals.

Managers supported non-medical staff through regular, constructive clinical supervision of their work. Staff confirmed they had regular, good quality supervision. Staff had quarterly managerial supervision and monthly clinical supervision. Managerial supervision was 97% compliant and clinical supervision was 99% compliant. Staff spoke very highly of the usefulness of supervision and the various formats of supervision they had access to. This included weekly reflective practice sessions (facilitated by a psychologist), safeguarding supervision and external supervision by a professional of choice.

Managers supported medical staff through regular, constructive clinical supervision of their work. Medical staff had managerial supervision every three months and weekly group clinical supervision. Medical staff confirmed that they felt supported and that the supervision process was embedded in the culture of their work.

Managers made sure staff attended regular team meetings or gave information from those who could not attend. We reviewed the minutes of ten ward team meetings . The format was consistent and comprehensive. Each meeting discussed topics such as lessons learnt, incidents, risk register concerns and safeguarding. The minutes listed staff who attended and was emailed out to all staff.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. The service had introduced improved career opportunities for staff to support recruitment and retention. This included healthcare assistants accessing registered nurse training, nurse prescriber training and individual development opportunities.

Managers made sure staff received any specialist training for their role. Staff had access to extra training which included, personality disorder levels one and two, Oliver McGowan Mandatory Training on Learning Disability and Autism Level 1, Autism awareness level two, Compassion Focussed Therapy, Learning Disability and epilepsy.

Managers recognised poor performance, could identify the reasons and dealt with these. Managers were aware of the performance management strategy and there was a policy to follow. Managers also had access to a human resources team to support decision making and processes. Managers described using this appropriately and to good effect.

Multi-disciplinary and interagency team work

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

Staff held regular multidisciplinary meetings to discuss patients and improve their care. Each patient had access to weekly multidisciplinary meetings which they could attend. We observed some multidisciplinary meetings and noted these to be professional and patient centred. Staff respected other roles and their was a clear emphasis on improving outcomes for patients.

Staff made sure they shared clear information about patients and any changes in their care, including during handover meetings. There were clear handover meetings with clear minutes taken and a list of attendees. Each handover meeting had a format which included any changes in risks, any incidents, observation levels and safeguarding concerns for each patient.

Ward teams had effective working relationships with other teams in the organisation. Ward staff had good connections with staff from other departments such as occupational therapy, social work and psychology. Other professionals were able to input into multidisciplinary meetings and care plans.

Ward teams had effective working relationships with external teams and organisations. We received feedback from three commissioning groups for the service. This was all positive in terms of improvements and progress. Commissioners felt that liaison with patients multidisciplinary teams had improved and that they were able to give clear and indepth updates on patients progress. Commissioners felt there were good local links with the integrated care board designated safeguarding nurse.

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

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

Staff received, and kept up-to-date, with training on the Mental Health Act and the Mental Health Act Code of Practice and could describe the Code of Practice guiding principles. Staff we spoke to were knowledgeable regarding the Mental Health Act and understood this is accordance to their role. Staff confirmed they received and were up to date with Mental Health Act training. However, this was not reflected in the mandatory training figures we requested which did not include Mental Health Act training.

However, during the report factual accuracy process, the provider acknowledged that Mental Health Act awareness training data was collated separately and was 98% compliant.

Staff had access to support and advice on implementing the Mental Health Act and its Code of Practice. There was a Mental Health Act team and administrator who were available to staff for guidance. The Mental Health Act administrator liaised with ward teams regarding Mental Health Act paperwork to ensure all was completed correctly and on time. There were copies of the Mental Health Act code of practice available for staff to refer to.

Staff knew who their Mental Health Act administrators were and when to ask them for support. Staff confirmed they knew the Mental Health Act administrator and regularly liaised with them.

The service had clear, accessible, relevant and up-to-date policies and procedures that reflected all relevant legislation and the Mental Health Act Code of Practice. There was a Mental Health Act policy in place dated November 2020.

Patients had easy access to information about independent mental health advocacy and patients who lacked capacity were automatically referred to the service. Independent mental health advocacy was well embedded within the wards. The independent mental health advocate was well known to patients and staff. There were posters in communal patient areas explaining the role of advocates and how to contact them. We saw evidence of patients being automatically referred to advocates within the patient care records.

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

Staff made sure patients could take section 17 leave (permission to leave the hospital) when this was agreed with the Responsible Clinician and/or with the Ministry of Justice. Section 17 leave went ahead as planned unless there was an increased risk.

Staff requested an opinion from a Second Opinion Appointed Doctor (SOAD) when they needed to. There was evidence of SOAD reviews within patient care records.

Staff stored copies of patients' detention papers and associated records correctly and staff could access them when needed. All Mental Health Act paperwork was in order. However, not all of the paperwork was available on the ward as paper files had not been updated. The Mental Health Act administrator had introduced a tracker to support ensuring paperwork was correct. We found this to be working well. There was a plan to move Mental health Act paperwork onto the electronic care record system to address the issue of patient paper files not always being up to date.

This forensic service did not routinely admit patients who were not detained under the Mental Health Act. However, there was a policy and process to follow for informal patients if required. There were no informal patients on any of the wards we visited.

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

Managers and staff made sure the service applied the Mental Health Act correctly by completing audits and discussing the findings. The Mental Health Act administrator had systems and audits to ensure the Mental Health Act was implemented correctly. The Mental Health Act administrator was able to highlight to managers and staff if any paperwork was due to expire.

Good practice in applying the Mental Capacity Act

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

Staff received, and were consistently up-to-date, with training in the Mental Capacity Act and had a good understanding of at least the five principles. Staff had a good understanding of the Mental Capacity Act relevant to their role. Staff and managers confirmed staff received training in the Mental Capacity Act. However, Mental Capacity Act training figures were not provided within the mandatory training data we requested.

However, during the report factual accuracy process, the provider acknowledged that Mental Capacity Act awareness training data was collated separately and was 100% compliant.

There were no deprivations of liberty safeguards applications made in the last 12 months. All patients were detained under the Mental Health Act.

Requires Improvement

Forensic inpatient or secure wards

There was a clear policy on Mental Capacity Act and deprivation of liberty safeguards, which staff could describe and knew how to access. There was a clear Mental Capacity Act policy in place, dated July 2022 for staff to follow and refer to. The provider's policy was to assess capacity on admission, after three months and then at a minimum of six monthly intervals.

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

Staff gave patients all possible support to make specific decisions for themselves before deciding a patient did not have the capacity to do so. We saw examples in the patient's care records that patients were supported to make decisions as much as possible.

Staff assessed and recorded capacity to consent clearly each time a patient needed to make an important decision. All patient records had a capacity assessment completed on admission. However, other capacity assessments were difficult to locate as the paper files on the ward weren't all up to date. The Mental Health Act team had introduced a tracker to monitor capacity assessments. The tracker showed compliance with the required schedule. There was a plan to move Mental Capacity Act paperwork onto the electronic patient record system. The MHA team had copies of all capacity assessments if they needed.

When staff assessed patients as not having capacity, they made decisions in the best interest of patients and considered the patient's wishes, feelings, culture and history. We saw three examples in the patient notes that clearly demonstrated best interests processes were being followed for patients lacking capacity.

Staff made applications for a Deprivation of Liberty Safeguards order only when necessary and monitored the progress of these applications.

The service monitored how well it followed the Mental Capacity Act and made changes to practice when necessary.

Staff audited how they applied the Mental Capacity Act and identified and acted when they needed to make changes to improve. There were appropriate Mental Capacity Act audits in place with associated action plans if required.

Is the service caring?

Good

Our rating of caring improved. We rated it as good.

At the last inspection in June 2022 we rated caring as inadequate. It was rated inadequate due to patients reporting staff were rude to them and they felt unsafe. There was a lack of carer involvement and responding to concerns raised by patients and carers was inconsistent. At this inspection we found that these areas had improved and that patients now had a voice and there were clear processes to follow for any concern raised.

Kindness, privacy, dignity, respect, compassion and support

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

Requires Improvement

Forensic inpatient or secure wards

Staff were discreet, respectful, and responsive when caring for patients. We observed staff interacting with patients in a professional and caring manner. Patients agreed that staff respected their privacy as much as possible and knocked on doors prior to entering whenever possible.

Staff gave patients help, emotional support and advice when they needed it. Patients confirmed that staff always had time to deliver one to one sessions to patients with their named nurse. This was also evidenced within the patient care records.

Staff supported patients to understand and manage their own care treatment or condition. Patients were well informed in relation to their diagnosis, treatment and care plans. We observed multidisciplinary meetings where patients were given information and choices about care options.

Staff directed patients to other services and supported them to access those services if they needed help. Staff made referrals to external agencies on behalf of patients when required. Staff supported patients to attend any appointments by arranging transports and escorting staff.

Patients said staff treated them well and behaved kindly. Patients and carers confirmed that staff were always polite and approachable towards them. Patients and carers also stated that any rare issues with staff behaviour were addressed quickly.

Staff understood and respected the individual needs of each patient. Staff were able to describe at length each patients needs and treatment. Staff spoke in a respectful manner regarding any difficulties.

Staff felt that they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards patients. There was a speak up guardian in place for staff to approach if necessary. The service had revisited boundary training for all staff due to historical issues with relationships developing between staff and patients. Staff were able to describe appropriate and non appropriate conversations to have with patients and how to not disclose too much personal information. Staff felt that they would speak to the ward manager in the first instance of any concern and report via the incident reporting system and safeguarding processes.

Staff followed policy to keep patient information confidential. All patient information was stored on a secure electronic care record system or within paper records that were kept in locked cupboards in non patient areas.

Involvement in care

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

Involvement of patients

Staff introduced patients to the ward and the services as part of their admission. Each patient was given a tour of the ward as part of the admission process. Booklets were also available explaining the ward rules and functions to support orientation.

Staff involved patients and gave them access to their care planning and risk assessments. All patients were involved in their care planning and could speak about their progress and next steps. The patients voice was evident in most care plans and all care plans included the patients views. Care plans were partially reviewed with patients on a weekly basis. (Feedback from patients demonstrated that patients were overwhelmed looking at the full care plan document at once.) Care plans were adjusted so the wording could easily be understood by patients.

Requires Improvement

Forensic inpatient or secure wards

Staff made sure patients understood their care and treatment (and found ways to communicate with patients who had communication difficulties). Care and treatment was discussed with patients indepth during multidisciplinary meetings and during one to one sessions with named nurses. Patients confirmed they could approach staff to discuss any aspect of their care. Each patient had a communication care plan and communication passports had been developed for patients who required them.

Staff involved patients in decisions about the service, when appropriate. The service had dramatically improved its patient involvement programme. There were now monthly patient forums where patients could raise concerns and ideas in order to improve the service. Members of the senior leadership team also attended the meetings and facilitated and supported any changes suggested. Examples of changes driven by patient involvement include improved communication and engagement between staff and patients. Each ward had an hour each day of protected time where all staff and patients engage in therapeutic activities or discussions. This had helped improve relationships between patients and staff. Patients were also involved in the recruitment process and invited to attend handover meetings. Pool tables had been installed in each ward to improve socialisation and occupation.

Patients could give feedback on the service and their treatment and staff supported them to do this. Patients could give feedback about the service via the monthly patient forum, informal and formal complaints processes, compliments processes, patient surveys, and speaking to staff. Feedback from patients was fed into the governance structures to support improvement initiatives. An expert by experience completed a review of the service in February 2023. The review involved speaking with patients for their feedback and checking the ward environments. The review concluded that patients felt safer, the atmosphere was more relaxed, least restrictive and therapeutic. This had been achieved by improving the environments, introducing better activities and staff no longer talking in their own first language. Patients also feedback any issues during weekly ward community meetings.

Staff supported patients to make advanced decisions on their care.

Staff made sure patients could access advocacy services. Independent mental health advocates and independent mental capacity advocates were well embedded within the wards. The advocates were well known to patients and staff. There were posters in communal patient areas explaining the role of advocates and how to contact them. We saw evidence of patients being automatically referred to advocates within the patient care records.

Involvement of families and carers

Staff informed and involved families and carers appropriately.

Staff supported, informed and involved families or carers. Families and carers were contacted on a fortnightly basis by the ward managers or the social work team. The purpose of the telephone calls were to check on the welfare of the carers and provide any relevant update on their loved ones care. Families and carers were invited to multidisciplinary team meetings and Care Programme Approach reviews with the patients consent. This was often facilitated by video link due to the travelling distance involved. Families and carers described feeling involved in their loved ones care as much as possible. Carers felt they understood the service due to the information brochure they received explaining the care and treatment available. Carers had attended carer open day events run by the service and found these to be helpful.

Requires Improvement

Forensic inpatient or secure wards

Staff helped families to give feedback on the service. Carers had completed a survey during 2022 asking for their opinions on the service. The results were very positive for areas such as good quality care plans, knowing who to contact, feeling confident to complain, and polite staff. However, only 62% of carers felt the wards were clean and well maintained. Families and carers could also give feedback via the informal and formal complaints processes or by speaking to staff. Carers explained that any concern raised by them was addressed promptly by the service and rectified.

Staff gave carers information on how to find the carer's assessment. Feedback from families and carers was mixed with most saying they were unsure about how to access a carers assessment. However, two carers said they did know about accessing carers assessments and one carer having a carers passport.

Is the service responsive?

Good

Our rating of responsive improved. We rated it as good.

At the last inspection in June 2022 we rated responsive as requires improvement. We rated it as requires improvement because there were insufficient processes in relation to complaints. At this inspection we found that the complaints process was now clear and robust. Patients now receive feedback about complaints. There was an audit process in place to ensure all complaints were addressed in a timely way.

Access and discharge

Staff planned and managed patient discharge well. They worked well with services providing aftercare and managed patients' moves to another inpatient service or to prison. As a result, patients did not have to stay in hospital when they were well enough to leave.

Bed management

Managers made sure bed occupancy did not go above 85%. Average bed occupancy over the last 12 months was above 85% for four wards:

- East Hampton 98%
- Lower East 98%
- Madison 96%
- Upper East 93%
- Upper West 65%
- Columbus 81%

Managers regularly reviewed length of stay for patients to ensure they did not stay longer than they needed to. Ward managers had good oversight of length of stays and patient progress. Managers ensured patients were stepped up or down within the service pathway in a timely manner.

The service had some out-of-area placements. The majority of patients were from Lancashire, Merseyside and Manchester. Some patients were from Wales and the south of England.

Requires Improvement

Forensic inpatient or secure wards

Managers and staff worked to make sure they did not discharge patients before they were ready. There were regular ward meetings to discuss the progress of patients and their suitability for discharge. Patients, care coordinators and commissioners were invited to attend meetings to discuss discharge and make suitable plans.

When patients went on leave there was always a bed available when they returned. Patients beds were not utilised in their absence.

Patients were moved between wards only when there were clear clinical reasons or it was in the best interest of the patient. There was a clear rationale for moving patients between wards. There were appropriate escalation procedures in place to move patients promptly when there care needs changed.

Staff did not move or discharge patients at night or very early in the morning. Patients were always discharged at an appropriate time of day with a suitable care package in place.

Discharge and transfers of care

Managers monitored the number of patients whose discharge was delayed, knew which wards had the most delays, and took action to reduce them. Over the last twelve months there had been six delayed discharges across Columbus, Lower East, Madison, Upper East and Upper West wards. Ward managers stated delayed discharges were due to awaiting low secure beds to become available or waiting for external resources to be available.

Patients did not have to stay in hospital when they were well enough to leave.

Staff carefully planned patients' discharge and worked with care managers and coordinators to make sure this went well. All patients had discharge care plans within their care records. Commissioners acknowledged that planning for discharge had improved therefore reducing the likelihood of delayed discharges occurring.

Staff supported patients when they were referred or transferred between services. Patients were given information when they were referred into the service such as a booklet about the service. Staff supported patients to understand the content and orientate them to the ward environment. When patients were due to be transferred to other services information was given to support patients to understand their plan.

The service followed national standards for transfer.

Facilities that promote comfort, dignity and privacy

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

Each patient had their own bedroom, which they could personalise. All patient bedrooms were individual with en-suite bathrooms. Patients were encouraged to take pride in their rooms and make them homely.

Patients had a secure place to store personal possessions. All wards had access to security cupboards to store valuable items.

The service had a full range of rooms and equipment to support treatment and care. Staff and patients could access the rooms. Wards had access to occupational therapy kitchens, activity rooms and quiet rooms. Patients could access these rooms dependant on their level of risk. Patients with less risk, mostly on the low secure wards, had been issued with keys fobs which allowed them independent access to rooms and outside space.

There was less accessibility for patients on the medium secure wards. For example, the activity room and the kitchen were always locked on the medium secure wards. On the low secure wards these rooms were open for patients to use freely. Also, on the medium secure wards, patients only had access to melamine crockery. On the low secure wards patients had access to regular crockery.

The service had quiet areas and a room where patients could meet with visitors in private. There were visitor rooms located away from the wards near the reception area.

Patients could make phone calls in private. Some patients, dependant on their risk, had basic mobile phones. All wards had telephone booths.

The service had an outside space that patients could access easily. All wards had access to outside space. However, Upper East and Columbus wards were located on the first floor so access was less easy. Patients with key fob access could access the garden areas independently, dependant on their risk level. This was mostly patients on the low secure wards.

Patients could make their own hot drinks and snacks and were not dependent on staff. There was hot water and a fridge available in the communal areas for all patients to access.

The service offered a variety of food but the quality was poor. Feedback regarding food was mixed. Some patients described the food as poor quality and bland. The patient survey completed in October to December 2022 also scored low on food quality at only 20% for very good quality and 80% for fair to poor quality. Feedback about food was shared with the catering department who met with patients about how to improve this. Some patients felt the food was adequate.

Patients' engagement with the wider community

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

Staff made sure patients had access to opportunities for education and work, and supported patients. Some patients assessed as low risk, mostly on the low secure wards, had access to educational opportunities such as attending college and university in the community. Other patients had access to resources at the onsite recovery college. This included short educational courses, woodwork, IT, decorating, well-being and art. Patients with leave could engage with various outdoor groups such as walking groups, swimming groups, and other sports. There was an internal gym that patients could use. Access to the gym had improved as most staff were now trained in escorting patients to the gym and the keys were located more conveniently. There was a monthly leisure group that organised day trips to Blackpool and other places of choice. Leave was now more meaningful and driven by ideas from the patient and staff forums. Some patients had paid roles such as gardening, shop assistant, painting and interviewing future employees.

Patients without leave, (mostly patient on the medium secure wards), and unable to access the recovery college, had access to activities delivered within the ward by the occupational therapy staff and activity coordinators. The occupational therapy team were based within the central park OT centre. The OT team had been focussed on delivering

activities which were relevant to the patients. All patients were asked to complete a checklist of interests. There was an emphasis of making activities more age appropriate. Pool tables had been introduced in the last few months. New board games had been purchased that were less child orientated. This had been led by patient ideas and feedback from the interests checklists. Other initiatives included having a healthy "fakeaway" night to encourage better diets.

Staff helped patients to stay in contact with families and carers. The service endeavoured to include families and carers wherever possible. Families and carers were invited to meetings where appropriate such as weekly multidisciplinary meetings and care programme review meetings. Staff kept families up to date in relation to patients progress with patients' consent. The service had paid for the travel and hotel costs for some families who lived some distance away. The service facilitated home leave when appropriate.

Staff encouraged patients to develop and maintain relationships both in the service and the wider community. Improving relationships had been a major driving force in the services improvement journey. The service had introduced protected time to encourage appropriate socialisation between staff and patients. Since then, there had been a reduction of aggressive incidents, violence and seclusion episodes. Patients and staff confirmed that the service felt safer. Patients with leave (mostly on the low secure wards) had opportunities to develop relationships via college and university courses. All patients where appropriate were encouraged to maintain links with family and friends.

Meeting the needs of all people who use the service

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

The service could support and make adjustments for disabled people and those with communication needs or other specific needs. All patients had communication care plans. Where necessary patients also had communication passports. Some patients had whiteboards in their bedrooms to support communication needs. Madison ward had a disabled access bedroom with a disabled access wet room. Other wards did not have disabled access bedrooms or bathrooms. However, there was a lift available for people with limited mobility to access the wards on the first floor, (Upper East and Columbus wards).

Staff made sure patients could access information on treatment, local service, their rights and how to complain. Patients were well informed about treatments that were available to them. This had been delivered verbally and via leaflets. Patient rights were displayed on posters. The complaints process was well embedded and patients knew how to initiate a complaint. There were posters about complaints in the communal patient areas.

The service had information leaflets available in languages spoken by the patients and local community. There were a range of information leaflets available to patients about many aspects of their care and treatment. Information leaflets could be printed in a range of different languages on request.

Managers made sure staff and patients could get help from interpreters or signers when needed. The service had access to an interpreter agency who supported patients who could not communicate in English or required sign language. The current patient cohort did not require a high use of the interpreter service.

The service provided a variety of food to meet the dietary and cultural needs of individual patients. Alternative food was available to meet specific needs of patients.

Patients had access to spiritual, religious and cultural support.

Requires Improvement

Forensic inpatient or secure wards

Listening to and learning from concerns and complaints

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

At the last inspection in June 2022, there were unclear processes for staff to follow in relation to complaints. At this inspection we found that the complaints process was now clear and robust. Patients now receive feedback about complaints. There was an audit process in place to ensure all complaints were addressed in a timely way.

Patients, relatives and carers knew how to complain or raise concerns. The complaints process had been improved since the last inspection. Patients and carers we spoke to confirmed they knew how to raise a complaint and were confident to do so.

The service clearly displayed information about how to raise a concern in patient areas. The complaints process was displayed on posters in communal areas for patients to clearly see. Outcome of complaints were feedback during community meetings if appropriate to do so.

Staff understood the policy on complaints and knew how to handle them. Staff were well informed about how to address any complaint received. Complaints were discussed in team meetings. There was a complaints and compliments policy dated February 2023 for staff to follow and refer to.

Managers investigated complaints and identified themes. The complaints process had been improved and there was now a clear audit trail and timeline for each complaint. There were systems in place to ensure patients received outcomes. There were four paths to raising a concern which were:

- Posting a letter (these were collected weekly by the complaints team)
- Formal
- Informal
- Speaking directly to the complaints team

We examined complaints on each ward and found they had all been investigated and addressed appropriately and that feedback had been given to the complainant in each case.

Staff protected patients who raised concerns or complaints from discrimination and harassment. Staff were aware to remain impartial and professional and to support patients to access the complaints process.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint. Patients explained that staff were available to support them to make complaints. Staff agreed they signpost patients to make complaints if there is an area of their care, they are unhappy about. Managers were aware of the process to feedback to patients following the outcome of the complaint.

Managers shared feedback from complaints with staff and learning was used to improve the service. There had been 157 complaints during 2022. Feedback from complaints was shared during patient community meetings and in staff meetings. Themes from complaints were around quality of care, poor staff attitudes and missing personal belongings. There was an action plan in place to address these concerns as part of the wider service improvements. Staff confirmed they were considering having larger lockable storage and discouraging patients from collecting too many items. Trends from complaints data also demonstrated that there were now less complaints relating to staff attitude.

Requires Improvement

Forensic inpatient or secure wards

The service used compliments to learn, celebrate success and improve the quality of care. The service collated compliments from patients. In 2022 there had been 38 compliments. During January and February 2023 there had already been 36 compliments. The highest compliments were in relation to the attitudes of staff and quality of care.

Is the service well-led?

Requires Improvement

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

At the last inspection in June 2022 we rated well-led as inadequate due to issues regarding poor governance such as a failure to respond to patient feedback, lack of access to patient care records and a lack of audits and implementing actions from audits. At this inspection we found these areas had improved but we continued to find gaps within governance structures such as some care records, medicines management, MHA and MCA training figures not included in mandatory training data and risk assessments not being fully updated following incidents.

Leadership

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

There was strong leadership from ward managers to senior leaders. Ward managers were effective and understood the service and patients well. Ward managers were knowledgeable about targets and governance structures. They were aware of improvements that were required and pertinent issues that were on the risk register. Ward managers were able to talk at length about recent improvements and how these had been implemented. Senior leaders had been effective in acknowledging and fulfilling changes promptly and utilising co-production approaches. Senior leaders had been successful in improving recruitment and retention rates, patient and staff experience, reducing restraints and incidents, implementing better safeguarding and complaints processes, centralising audits and other governance systems, refurbishing some ward areas and improving staff morale and culture. A new managerial role had been introduced. There was now a clinical manager to oversee the quality of nursing care provided.

It was also clear that patients knew ward managers and senior leaders well and found them approachable.

Vision and strategy

Staff knew and understood the provider's vision and values and how they (were) applied to the work of their team.

The vision of the Cygnet organisation was:

"Our vision is to provide high quality, sustainable specialist services that: Ensure service users and residents feel safe and supported, staff are proud of, commissioners and service users select, and stakeholders trust."

The values of the service were:

"Our values are to care for our service users, staff and visitors, to respect them, to ensure a bond of trust is built among us, to at all times empower those we look after as well as our staff, to deliver quality services with integrity."

Requires Improvement

Forensic inpatient or secure wards

The vision and values of the service were revisited by staff during supervision and appraisal sessions and team meetings.

Culture

Staff felt respected, supported and valued. They said the service promoted equality and diversity in daily work and provided opportunities for development and career progression. They could raise any concerns without fear.

The culture of the service had improved and was continuing to improve.

The service had completed a staff survey between February and April 2022. The results from the survey were included in an action plan to improve staff experience and staff retention. This included:

- Staff away days
- The introduction of staff forums
- Group de-briefs and reflective practice sessions
- Reduction of agency staff usage
- Better induction processes for new staff
- Review of staffing levels based on acuity
- Quality improvement training for staff and patients
- All staff to revisit Cygnet values during supervision and other meetings
- Improve the wellbeing support offered
- Provide compassion focussed therapy to all staff
- Ensure the Freedom to Speak Up ambassador is utilised
- Improve incident reporting
- Review the pay offered to staff
- Highlight to staff any apprenticeship routes available
- Focus on career goals for staff

The service had implemented the above changes and were seeing the benefits. Bank and agency staff usage had dramatically reduced and staff felt they were now able to build a positive culture between staff and patients. Staff now felt that they were valued and listened to. There were less incidents of violence and aggression.

Staff told us equality and diversity was promoted within their work and that training regarding this was ongoing.

Staff felt there were opportunities for career progression and additional training if desired. This included nursing apprenticeships and nurse prescriber training.

All staff said they felt they could raise any compliant or concern without fear of retribution.

Morale had improved. Staff felt engaged in the changes being developed which were patient and staff led.

Governance

Our findings from the other key questions demonstrated that governance processes had improved and were operated more effectively at team level and that performance and risk were managed well. However, there continued to be gaps within some areas.

Requires Improvement

Forensic inpatient or secure wards

Systems and processes were not fully effective in ensuring the service was safe and well-run. We found gaps in the following areas:

- There was a duplicate patient folder on the shared drive.
- Mental Health Act paperwork that had not been fully completed.
- We found some medicines on Upper East ward with no expiry dates.
- Mandatory training figures did not include Mental Health Act training or Mental Capacity Act training. These were collated separately.
- Risk assessments were not always updated following incidents
- Mental capacity assessments were difficult to locate as the paper files on the ward weren't all up to date.

However, other governance areas had improved. This included staff training, environmental safety, patient care records and staffing levels. There were appropriate audits in place to check and challenge the quality of the service. Audits were now completed and overseen centrally rather than at individual ward level. This gave an extra layer of external scrutiny. Governance systems had been successful in identifying and improving some aspects of the quality of the service. This led to a reduction in restraints, incidents, seclusion and rapid tranquilisation.

Ward managers felt they could be creative in their roles and that ideas would be supported by senior managers to drive improvement and change.

Management of risk, issues and performance

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

Ward managers had access to data that was useful for quality checking the service. Ward managers monitored the data within their day to day work. This included, staffing levels for each shift, staff mandatory training compliance rates and staff supervision and appraisal figures.

Managers and staff were aware of key performance indicators and the relevance of meeting and monitoring these targets.

There was a risk register in place that captured relevant and current service level risks. There were actions in place to mitigate these risks and timeframes for completion. Risk issues could be escalated to senior managers within a framework of quality and governance meetings. There was a risk register file in each ward office for staff to read and understand. The risk register was discussed with staff during team meetings and in supervision.

There was a clear process for issues raised by staff and patients to be fed into the relevant governance meetings and board meetings. There was a strong emphasis for improvements to be driven by staff and patient ideas.

Information management

Staff collected analysed data about outcomes and performance and engaged actively in local and national quality improvement activities.

Outcomes and performance were measured by tools such as the health of the nation outcome scales at regular intervals throughout the patient journey. Other measures included progress through the care programme approach, internal forensic care pathway and via the monthly global assessment of progress tool.

Requires Improvement

Forensic inpatient or secure wards

The service had systems and processes in place to collate and analyse data from various sources. This included an electronic incident reporting system and data produced from audits. Ward managers and senior managers were able to use the data to look for themes and trends.

Key performance indicators were produced to measure quality and shared with commissioning bodies on a monthly basis.

Engagement

Managers engaged actively other local health and social care providers to ensure that an integrated health and care system was commissioned and provided to meet the needs of the local population. Managers from the service participated actively in the work of the local transforming care partnership.

The service actively sought and responded to advice and support offered from local commissioners in relation to the quality of the service and improvements required. The service had developed links with local authorities in relation to the handling of safeguarding concerns and complaints. Feedback from commissioners was positive in relation to discharge planning arrangements.

Learning, continuous improvement and innovation

Co-production was at the heart of the service improvement plan. The majority of changes had been driven by patient and staff voices. The service had improved its staffing and retention problems by ensuring the service was a safe and satisfying place to work.

Staff and patients had received training in quality improvement initiatives. This was modelled in staff and patient forums. There was a plan to work towards all staff being training in quality improvement.

The service had learned and improved its staffing figures by:

- Pursuing the international recruitment of nursing team members
- Conducting fortnightly interviews of prospective new staff (by staff and patients) to enable a faster recruitment process and ensuring the correct candidates are recruited
- Regular recruitment events such as open days
- Review of the induction processes and content to ensure new staff are better equipped to work in ward environments
- Introduced a staff wellbeing strategy
- Increasing the pay award
- Improved career opportunities (apprenticeships, nurse prescriber training, practice development opportunities)

The service was working towards being accredited by the enabling environments standards set by the Royal College of Psychiatry.

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 15 HSCA (RA) Regulations 2014 Premises and equipment The service did not ensure that ward environments were properly maintained and that redecoration was completed promptly. (Regulation 15 (1) (e))

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 The service did not ensure that privacy and dignity of patients was maintained at all times. Seclusion suites did not have easy access to bathroom facilities and outside space. (Regulation 10 (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 17 HSCA (RA) Regulations 2014 Good governance The service did not ensure that care records were contemporaneous and complete. Patient risk assessments were not updated following incidents and without delay. (Regulation 17 (2) (c))

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance

This section is primarily information for the provider

Requirement notices

The service did not ensure that there were systems and processes that effectively identified and addressed service quality issues. This included, contemporaneous care records, medicine management, ward and seclusion environments, risk assessments and MHA and MCA documentation.(Regulation 17 (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 12 HSCA (RA) Regulations 2014 Safe care and treatment The service did not ensure that medicines were managed safely. There were medicines that did not have an expiry date clearly displayed. (Regulation 12 (2) (g))