Cygnet Health Care Limited

Cygnet Hospital Wyke

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	Inadequate
Are services safe?	Inadequate
Are services effective?	Requires Improvement
Are services caring?	Requires Improvement
Are services responsive to people's needs?	Requires Improvement
Are services well-led?	Inadequate

Summary of findings

Overall summary

Our rating of this location went down. We rated it as inadequate because:

- We have taken enforcement action against the provider to make sure they improved their governance systems. This normally limits the rating for that key question to inadequate.
- The service was not always well led and the governance processes did not always ensure that ward procedures were effective. There were gaps in governance processes that failed to identify areas of concerns.
- The service did not provide safe care. It did not manage medicines, medicine fridges and medical supplies safely and risk assessments were not always complete. Medicine records were found to have been filled in retrospectively by staff when gaps were identified at our inspection. Prescribed medicines were not always in stock and available and that accurate records of medicines were not always made. Medicines were not always lawfully prescribed prior to administration.
- The service was using both a paper and electronic records system, we found that paper records did not contain the most up to date risk assessments for people in 4 out of 4 records we reviewed on Adarna ward.
- Staff on Adarna ward were not all bare below the elbow in accordance with the provider's own policy.
- The environment was not always clean, we found food on the floor, staining on furniture, cigarette ends in the lounge and some of the furniture was ripped.
- Staff on Adarna ward did not always understand the individual needs of people. They did not always actively involve families and carers in care decisions. Care plans on Adarna ward did were not always of sufficient quality and detail to meet the needs of people
- Physical health was not always managed safely on Adarna ward in respect of bowel monitoring, particularly for people taking medication that caused a risk of bowel obstruction.
- The ward environment on Adarna ward was still too noisy and steps taken to reduce the level of noise for people since our last inspection had not been fully effective.
- On Adarna ward Staff restricted people's access to items on the ward and this was not always based on individual needs.

However:

- There was enough staff working on the wards to keep people safe with low levels of vacancies. The wards had enough nurses and doctors. Staff followed good practice with respect to safeguarding and complaints. Use of restrictive practices was minimised.
- Mandatory training compliance rates were high and managers had oversight of when training was due to be renewed.

Summary of findings

- Staff provided a range of treatments suitable to the needs of the patients and in line with national guidance about best practice. Staff engaged in clinical audit to evaluate the quality of care they provided.

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

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

- Staff treated patients with compassion and kindness, respected their privacy and dignity.

- Therapeutic activities took place and people described things they enjoyed doing both on and off the ward.

- Staff worked well with external stakeholders and professionals to support people's discharge plans.

Letter from the Chief Inspector of Healthcare, Dr Sean O'Kelly:

"I am placing the service into special measures. This is because the service has had two inadequate ratings against any key question on two consecutive inspections. Services placed in special measures will be inspected again within six months. If insufficient improvements have been made such that there remains a rating of inadequate overall or for any key question or core service, we will in line with our enforcement procedures to begin the process of preventing the provider from operating the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. The service will be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary another inspection will be conducted within a further six months, and if there is not enough improvement, we will move to close the service by adopting our proposal to vary the provider's registration to remove this location or cancel the provider's registration."

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Acute wards for adults of working age and psychiatric intensive care units	Requires Improvement 	Our rating of this service stayed the same. We rated it as requires improvement because: • The service was not always well led and the governance processes did not always ensure that ward procedures were effective. • Prescribed medicines were not always in stock and available and that accurate records of medicines were not always made. • Medicines were not always lawfully prescribed prior to administration. • The ward areas were not always clean and tidy. However: • The service provided safe care. The ward environments were safe. The wards had enough nurses and doctors. Staff assessed and managed risk well and followed good practice with respect to safeguarding. • Staff developed holistic, recovery-oriented care plans informed by a comprehensive assessment. They provided a range of treatments suitable to the needs of the patients and in line with national guidance about best practice. Staff engaged in clinical audit to evaluate the quality of care they provided. • The ward teams included or had access to the full range of specialists required to meet the needs of patients on the wards. Managers ensured that these staff received training, supervision and appraisal. The ward staff worked well together as a multidisciplinary team and with those outside the ward who would have a role in providing aftercare. • Staff understood and discharged their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005.

Summary of findings

- 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.

Long stay or rehabilitation mental health wards for working age adults

Inadequate

Although this ward falls within the long stay/ rehabilitation core service for CQC inspection purposes, we also used our guidance on inspecting services for people with a learning disability and autistic people to inform the inspection because the ward provides specialist rehabilitation services for autistic people. We expect health and social care providers to guarantee people with a learning disability and autistic people respect, equality, dignity, choices and independence and good access to local communities that most people take for granted. 'Right support, right care, right culture' is the guidance CQC follows to make assessments and judgements about services supporting people with a learning disability and autistic people and providers must have regard to it.
Our rating of this location went down. We rated it as inadequate because:

- We have taken enforcement action against the provider to make sure they improved their governance systems. This normally limits the rating for that key question to inadequate.
- The service did not provide safe care. It did not manage medicines, medicine fridges and medical supplies safely and risk assessments were not always complete.
- The ward was using both a paper and electronic records system, we found that paper records did not contain the most up to date risk assessments for people in 4 out of 4 records we reviewed.
- Medicine records were found to have been filled in retrospectively by staff when gaps were identified at our inspection.
- Staff were not all bare below the elbow in accordance with the provider's own policy.

Summary of findings

- The environment was not always clean, we found food on the floor, staining on furniture, cigarette ends in the lounge and some of the furniture was ripped.
- People did not always feel safe on the ward and some people told us they did not feel they could approach staff when they needed to talk, despite being on the ward for some time.
- Staff restricted people's access to items (hot drinks, cups and spoons) on the ward and this was not always based on individually risk assessed needs.
- Staff did not always understand the individual needs of people. They did not always actively involve families and carers in care decisions.
- Physical health was not always managed safely in respect of bowel monitoring, particularly for people taking medication that caused a risk of bowel obstruction.
- The ward environment was still too noisy and steps taken to reduce the level of noise for people since our last inspection had not been fully effective.
- There were gaps in governance processes that failed to identify areas of concerns.

However:

- There was enough staff working on the ward to keep people safe with low levels of vacancies.
- Mandatory training compliance rates were high and managers had oversight of when training was due to be renewed.
- Use of restrictive practices was minimised and ward staff followed good practice with respect to safeguarding and complaints.
- They provided a range of treatments suitable to the needs of the people and in line with national guidance about best practice.
- Allied health professionals worked with people on a regular basis and had completed specialist training associated with autism.

Summary of findings

- We saw some good examples of care plans, positive behavioural support plans and “grab and go” sheets for staff to understand the needs of people using the service..
- Therapeutic activities took place and people described things they enjoyed doing both on and off the ward.
- Staff worked well with external stakeholders and professionals to support people’s discharge plans.

Summary of findings

Contents

Summary of this inspection

Background to Cygnet Hospital Wyke

Cygnet Hospital Wyke is an independent mental health hospital provided by Cygnet Health Care Limited, situated in West Yorkshire. It has been registered with CQC since November 2010. The hospital is registered to provide care and treatment to up to 46 patients and the following regulated activities:

• Treatment of disease, disorder or injury

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

The hospital had three inpatient mental health wards. These were:

• Bennu - a 12-bed psychiatric intensive care unit for male adults of working age.

• Phoenix - a 19-bed acute mental health ward for male adults of working age.

• Adarna - a 15-bed high dependency rehabilitation ward for male adults with autism and/or a learning disability.

The hospital had a registered manager and an accountable controlled drugs officer.

We have inspected this location 13 times previously. We last carried out a comprehensive inspection of the hospital in September 2022. We rated the hospital as requires improvement overall with requires improvement ratings for all key questions except safe, which was rated inadequate.

At this inspection, we inspected all five key questions across all three wards.

What people who use the Acute wards for adults of working age and psychiatric intensive care units say

Patients told us that they were happy about the environments on the wards and that staff were available when they needed them. They said they felt safe, and that staff treated them with compassion and kindness.

Patients said that they were able to make use of section 17 leave when they wanted to, and that staff were supporting them to make changes in their lives. Those that wanted to be involved in the development of their care plans were and some had copies of them in their rooms.

Carers and families told us that they were involved in the planning of care and treatment of patients where it was appropriate. They said that when they visited that staff were polite and supported them to understand the patient's treatment. They said they knew how to contact the hospital and give feedback. Not all carers and families said it was easy to contact someone at the hospital if they wanted to enquire about a patient.

What people who use the Long stay or rehabilitation mental health wards for working age adults say

Summary of this inspection

Patients told us that staff were not always sensitive to their needs, and that they often made noise on the ward such as shouting people for meals or talking loudly to each other on the corridors. Patients told us the ward was noisy and chaotic, they told us they spent a lot of time in their bedrooms because of this and some patients wore ear defenders. However, patients told us that staff treated them with compassion and kindness most of the time and respected their privacy and dignity.

Patients told us they were able to make use of section 17 leave, and described going out to the gym and the shop. All patients except 1 told us they had a copy of their care plans and had been involved in the development of those to some extent.

We spoke to 7 carers of people on Adarna ward. All but 1 carer told us they felt their loved one felt safe on the ward. However, 6 out of 7 told us they felt communication from the ward could be improved whilst 4 out of 7 told us the ward and toilets and bathrooms used by people were not clean when they visited.

Out of the 7 carers we spoke to, 5 of them told us the service did not keep them as informed as they would like about their loved one . For example, carers told us that they were informed about a change after it had already been made, such as changes in care, medications, care plans and discharge plans. However, 2 carers felt that they had been involved and were kept up to date with relevant information.

How we carried out this inspection

The team that inspected the service included:

4 CQC inspectors (one shadowing for experience)

2 Medicines inspectors

During the inspection, the inspection team:

• visited all three wards

• spoke with 12 patients who were using the service

• spoke with 13 carers/relatives

• spoke with the registered manager

• spoke with 1 acting ward managers and 2 permanent ward manager

• spoke with 22 staff members of staff including nurses, doctors, allied health professionals, support workers, housekeepers and administrative staff

• spoke with 1 independent advocate

• looked at 15 care and treatment records for patients

Summary of this inspection

• attended meetings relating to patient care and the running of the service

• spent time on the wards observing care, including carrying out a Short Observational Framework for Inspection (SOFI)

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

Visits were unannounced and took place during the evening of 15 January 2024 and in the day on the 16 and 17 January 2024.

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

Areas for improvement

Action the service MUST take is necessary to comply with its legal obligations. Action a service SHOULD take is because it was not doing something required by a regulation but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Long stay or rehabilitation mental health wards for working age adults

Action the service MUST take to improve:

- 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 environments, risk assessments and MHA documentation. (Regulation 17)
- The service must ensure that fridge temperatures are monitored effectively, that audits identify when there is a problem and action is taken to mitigate the risk. (Regulation 12)
- The service must ensure that it is clearly marked on medical equipment when checks were last carried out and when the next check is due, in accordance with their own policy. (Regulation 12)
- The service must ensure that they have oversight of medical equipment to ensure that out of date equipment is discarded in a timely manner. (Regulation 12)
- The service must ensure that people who need their bowels monitoring for purposes of medication are monitored in accordance with the bowel monitoring chart, and that any gaps are identified and action is taken to mitigate the risks of constipation. (Regulation 12)
- The service must ensure that systems for monitoring compliance with the Mental Health Act ensure that people only receive medicines which they have consented to, or which have been correctly authorised by a Second Opinion Appointed Doctor (Regulation 12)
- The service must ensure that up to date, complete and contemporaneous records are kept in relation to medicines. (Regulation 12)

Summary of this inspection

- The service must ensure that staff are bare below the elbow for purposes of infection control in accordance with their own policy. (Regulation 12)

- The provider must ensure that they mitigate the risk of running a paper and electronic based system simultaneously, to ensure that all paper based records are the most up to date version. (Regulation 17)

- The provider must ensure that risk assessments of people are complete. (Regulation 12)

- The service must ensure that the environment meets the needs of people residing in the service, including their sensory needs. (Regulation 15)

- The service must ensure that care plans are up to date and have sufficient quality and detail to meet the needs of people (Regulation 9)

- The provider must ensure that all blanket restrictions are reviewed, individually risk assessed and fully justified and action taken to remove unnecessary restrictions. (Regulation 9)

- The service must ensure that staff are working in an autism informed way in relation to the level of noise on the ward and the language they use. (Regulation 9)

A final version of this report, which we will publish in due course, will include full information about our regulatory response to the concerns we have described.

Action the service SHOULD take to improve:

- The service should ensure that alarms are available for the safety of visitors who are coming onto the ward in the evening and at weekends when the reception area is closed.

- The service should ensure that they continue to work towards the hospital becoming a smoke free environment again.

- The service should ensure that they have opportunities available for people to engage in the local community.

- The service should ensure that carers are kept informed of changes to their loved ones care in a timely manner.

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

Action the service MUST take to improve:

- The service must ensure that medicines are lawfully prescribed prior to administration. (Regulation 12)
- The service must ensure that prescribed medicines are in stock and available and that accurate records of medicines are made. (Regulation 12)
- The service must ensure that they have effective systems in place to assess, monitor and mitigate risks relating to the effective oversight of medicines management. (Regulation 17)

Action the service SHOULD take to improve:

Summary of this inspection

- The service should ensure that physical health monitoring such as blood glucose is completed as required.
- The service should ensure that toilets are kept in a condition which enables them to be properly cleaned.
- The service should ensure that outdoor communal areas are kept litter free.
- The service should ensure that stock in clinic rooms is kept tidy.
- The service should ensure that sharps bins are dated so that they can be disposed of effectively and safely.

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Acute wards for adults of working age and psychiatric intensive care units	Requires Improvement	Good	Good	Good	Requires Improvement	Requires Improvement
Long stay or rehabilitation mental health wards for working age adults	Inadequate	Requires Improvement	Requires Improvement	Requires Improvement	Inadequate	Inadequate
Overall	Inadequate	Requires Improvement	Requires Improvement	Requires Improvement	Inadequate	Inadequate

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

Requires Improvement

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.

Safe and clean care environments

The wards were safe, well equipped, well furnished, well maintained and fit for purpose but some areas of the ward were not always clean and tidy.

Safety of the ward layout

Staff completed and regularly updated thorough risk assessments of all wards areas, and removed or reduced any risks they identified. Staff knew about any potential ligature anchor points and mitigated the risks to keep patients safe. Regular assessments were carried out and these contained information for staff which correlated with posters which were displayed in staff areas.

Staff could observe patients in all parts of the wards. Some areas of the wards were locked when they were not in use to minimise the risk to patients. These included areas that contained higher risk items for use in arts and crafts or cooking utensils. These were included on the blanket restrictions log and reviewed regularly.

The wards complied with guidance and there was no mixed sex accommodation. Both wards were single sex wards.

Staff had easy access to alarms and patients had easy access to nurse call systems. We saw staff respond when they were needed, and staff and patients said when they needed support from staff it was available.

Maintenance, cleanliness and infection control

The majority of ward areas were clean, well maintained, well-furnished and fit for purpose. However, we found that one of the yards was littered with cigarette ends. We observed staining on some of the patient toilets in their bedrooms which made it difficult to know if the toilets had been cleaned or not. Patients told us and cleaning records showed that the toilets were cleaned on a regular basis. We raised this issue with the management team during the inspection and they said they were aware of the staining on the toilets and were seeking a long term solution to rectify the problem as soon as possible.

Staff made sure cleaning records were up-to-date.

Staff followed infection control policy, including handwashing.

Seclusion room

One seclusion room was shared by both the acute ward and the PICU. The seclusion room allowed clear observation and two-way communication. It had a toilet and a clock. Patients were very rarely secluded to their bedrooms but when this happened it was effectively risk assessed and for as short a period as possible.

Clinic room and equipment

Clinic rooms were fully equipped, with accessible resuscitation equipment and emergency drugs that staff checked regularly.

Staff checked, maintained, and cleaned equipment. However, some of the storage cupboards and shelves in the clinic rooms were cluttered and untidy with stock. One of the sharps bins in the clinic room had not been dated and therefore it was not possible to say when it should be disposed of.

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. Wards usually had at least 2 qualified nurses on duty and a range of support staff. Both staff and patients said they felt there was usually always enough staff on the wards. Staff working on the wards told us that there were some shifts where there were less staff, but they said that they still felt safe to carry out their duties.

The service had low vacancy rates. There were a small number of vacancies across both wards. Recruitment was ongoing and there was a steady supply of new staff being introduced onto the wards when it was necessary.

The service had low rates of bank and agency staff, this was an improvement since the last time we inspected. Most of the staff working across the wards were permanent staff. There was a small amount of agency usage, but this was mainly to cover increased observation levels as a result of fluctuating risks. These agency staff were usually familiar to the wards and knew the patient group well.

Managers made sure all bank and agency staff had a full induction and understood the service before starting their shift. Although we could not locate one agency staff induction record, we were assured that the agency staff working on the wards knew patients and the wards well. There were processes in place to ensure that staff had access to the right information such as detailed handovers, care plans and risk assessments.

The service had reducing turnover rates. Over the 12 months prior to the inspection the turnover rate across the hospital had dropped from 37% to 20% for all staff.

Levels of sickness were reducing. Over the 12 months prior to the inspection sickness rates across the hospital had fallen from 8.8% to 5.4% for all staff.

The ward manager could adjust staffing levels according to the needs of the patients. The management team met daily to discuss resources across the hospital. This allowed them to ensure that staff were allocated effectively and bring in additional staff where it was required.

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

Requires Improvement

Patients had regular one to one sessions with their named nurse. This was evident in the case notes of each patient and patients told us that generally they were able to spend time with nursing staff when they wanted to.

Patients rarely had their escorted leave or activities cancelled, even when the service was short staffed. When there were not enough ward staff available to facilitate leave, staff were brought in to support activities and escorted leave.

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

Staff shared key information to keep patients safe when handing over their care to others. During the inspection we were able to observe a handover which was well attended and including a useful summary of what each patient had been doing and any new and ongoing risks that staff needed to be aware of.

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.

Mandatory training

Staff had completed and kept up-to-date with their mandatory training. We saw evidence that managers tracked compliance with mandatory training and rates of compliance ranged from between 95% to 100% across the range of modules.

The mandatory training programme was comprehensive and met the needs of patients and staff. Modules included a range of topics relevant to the work that these wards carried out with patients, for example reducing restrictive practice and awareness of self-harm and suicide.

Assessing and managing risk to patients and staff

We looked at 12 care records. Staff assessed and managed risks to patients and themselves well and followed best practice in anticipating, de-escalating and managing challenging behaviour. Staff used restraint 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 completed risk assessments for each patient on admission, using a recognised tool, and reviewed this regularly, including after any incident. Up to date risk assessments were available on the electronic patient record and a summary of each patients' risks was discussed at each handover.

Management of patient risk

Staff knew about any risks to each patient and acted to prevent or reduce risks. Staff discussed new and emerging risks for each patient at relevant meetings and discussed how to mitigate and reduce these risks. Each patient also had a positive behaviour support plan which acted as a quick reference for staff to understand how to support each patient at different times.

Staff used an electronic system to monitor incidents and we saw examples of where discussions had taken place following incidents which led to changes in the way risks were managed, for example changes in observation levels and movement to and from a seclusion suite.

The hospital kept a detailed blanket restrictions log which they reviewed on a regular basis. Patients could feed into this process through regular community meetings that were held on the wards.

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

Use of restrictive interventions

Levels of restrictive interventions remained high as we had identified on our previous inspection. On Bennu ward there had been 194 restraints in the 12 months prior to our inspection and 39 restraints for the same period on Phoenix ward. In total, 57 of the restraints were planned as part of someone's treatment and there were 52 patients involved altogether. Ward managers explained that a large portion of all restraints had been related to a very small number of particularly unwell patients that were no longer at the hospital.

Levels of prone restraint over the last 12 months had reduced from 41 to 13 across both wards.

Staff participated in the provider's restrictive interventions reduction programme, which met best practice standards. Representatives from the hospital attended the provider's reducing restrictive practice meetings and fed back the learning from this to ward based staff. Staff were carrying out reflective practice and debriefs following incidents to try to learn how best to support patients in a least restrictive way.

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. Patients and staff that we spoke to said restraint was only used when it was necessary. Staff displayed a good understanding of the different ways they could support different patients in situations that could lead to a restraint.

Staff had not followed NICE guidance when using rapid tranquilisation. We found that for one patient that had received rapid tranquilisation, monitoring of their physical health after the dose had been given was not fully completed. Rapid tranquilisation had only been used 27 times over the last 12 months across both wards.

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

When a patient was placed in seclusion, staff kept clear records and followed best practice guidelines. We looked at recent examples of seclusion records and these were clear and well documented. Seclusion was only used when needed and it was ended at the earliest opportunity and when safe to do so. The hospital had implemented new systems and processes to better manage periods of seclusion which meant more effective reviewing. This enabled staff to safely move patients back to the ward in a timelier manner.

Safeguarding

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

Staff received training on how to recognise and report abuse, appropriate for their role. Across both wards, 93% of staff had taken part in some form of level 2 safeguarding training.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. We spoke to a range of staff across both wards and they were all able to explain what was expected from them to protect patients.

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

Requires Improvement

Staff knew how to recognise adults and children at risk of or suffering harm and worked with other agencies to protect them.

Staff followed clear procedures to keep children visiting the ward safe. There was a separate visiting area located off the ward that people could access to carry out visits with children and families where this was necessary and appropriate.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. There were several different points of contact that staff could reach out to if they needed support and advice. The hospital had a useful exchange of information with local safeguarding teams, when incidents needed escalation for further advice or investigation.

Staff access to essential information

Staff had easy access to clinical information and it was easy for them to maintain high quality clinical records, which were a combination of paper-based and electronic records.

Patient notes were comprehensive and all staff could access them easily. Although the service used a combination of electronic and paper records, staff made sure they were up-to-date and complete.

Records were stored securely.

Medicines management

Staff did not always follow systems and processes to prescribe and administer medicines safely. Staff did not always complete medicines records accurately and kept them up to date.

We found that for one person three of their medicines were not available to be administered when needed because they were out of stock. We found for some people that when they were unable to take their medicines at the prescribed time for example due to being asleep there was no evidence that staff tried to administer the medicine at another time. We found that prescribers did not always sign for medicines. For a person prescribed creams there had been no risk assessments completed.

This means we could not be assured that people always receive their medicines safely as prescribed.

For one person we found gaps in a chart where two medicines had not been signed for. We found for one person that a medicine used to relieve breathlessness was not prescribed on their chart so staff would be unable to administer if this was required. Staff did not always record medicines stock records contemporaneously when medicines had been transferred between other sites. Staff told us that support workers were used occasionally to be a witness for the administration of drugs that were liable for misuse, however there was no evidence that these staff had received training for this task.

This means we could not be assured that medicines records were accurate.

Staff reviewed each patient's medicines regularly and provided advice to patients and carers about their medicines.

Doctors were available daily on the wards to review and prescribe medicines. A pharmacist attended the wards weekly to review charts but it was not clear that these reviews had been effective.

Staff stored and managed all medicines and prescribing documents safely.

Medicines and prescribing documents were stored securely. Staff monitored and recorded temperatures of areas where medicines were stored, and these were within the recommended range.

The service ensured people's behaviour was not controlled by excessive and inappropriate use of medicines.

Staff did not always review the effects of each patient's medicines on their physical health according to NICE guidance.

We found that for one patient that had received rapid tranquilisation, monitoring of their physical health after the dose had been given was not fully completed. For one patient who was diabetic we found that blood monitoring instructions were not clear, and that they were not always recorded.

Track record on safety

The service had an improving track record on safety. There were a similar number of episodes of reported violence and aggression across the wards. Patient survey results looked at during this inspection showed that people said they felt safer than they did at the last inspection, 50% said they felt safe all of the time and 10% of the responses said they felt safe most of the time. Staff and patients that we spoke to during the inspection said they felt safe on the wards.

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. The hospital used an electronic system to report and track incidents. We looked at a sample of these records. They were clearly reported and investigated. Where managers had identified necessary actions and feedback from the incidents, these were passed on to the staff involved and wider teams.

Staff raised concerns and reported incidents and near misses in line with the provider policy.

Staff reported serious incidents clearly and in line with trust policy. There were 3 serious incidents reported over the last 12 months over the 2 wards. All 3 of these incidents were where a patient had not returned from section 17 leave on time.

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.

Managers debriefed and supported staff after any serious incident. Staff said they were well supported by other staff working on the wards and managers. There were several ways in which staff discussed incidents, including reflective practice sessions, team meetings and routine debrief sessions which could take place immediately following incidents, if needed.

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

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

Requires Improvement

Staff received feedback from investigation of incidents, both internal and external to the service. Staff told us that they received information about lessons learned from serious incidents across the Cygnet group in a monthly email. We saw examples of these lessons learned on posters placed in staff areas.

There was evidence that changes had been made as a result of feedback. For example, as a result of feedback about the decision making around section 17 leave, the hospital had implemented a new process to ensure that authorisation of leave was more robust.

Is the service effective?

Good

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

Assessment of needs and planning of care

We looked at 12 care records. Staff assessed the physical and mental health of all patients on admission. They developed individual care plans which were reviewed regularly through multidisciplinary discussion and updated as needed. Care plans reflected patients' assessed needs, and were personalised, holistic and recovery-oriented.

Staff completed a comprehensive mental health assessment of each patient either on admission or soon after. These were clearly documented on each record that we looked at and included written information as well as a colour coded rating so that staff could see high risk areas easily.

Patients had their physical health assessed soon after admission and regularly reviewed during their time on the ward.

Staff developed a comprehensive care plan for each patient that met their mental and physical health needs. We reviewed assessments and found that each patient's assessed needs were care planned and that specific care plans had been created where needs were identified, for example for specific behaviours that required further detail so that it could be addressed. Patient records also contained positive behaviour support plans for each patient which gave staff a summary of displayed behaviours and how each of these could be addressed.

Staff regularly reviewed and updated care plans when patients' needs changed. We saw examples of incidents that had occurred which, in some cases, meant changes to the way people were cared for. These changes were documented clearly and at the earliest opportunity.

Care plans were personalised, holistic and recovery-orientated. We saw varying examples of patient involvement in the development of care plans with some patients being more involved than others. Some patients had offered small comments that were captured on the care plan whilst others had been much more involved in writing them.

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.

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

Requires Improvement

Staff provided a range of care and treatment suitable for the patients in the service. There were therapeutic sessions available either one to one or in groups and there were also a range of social and educational activities such as a breakfast club, maths and English, arts and crafts, an onsite gym, relaxation, pool, board games and music making. Patients that could leave the hospital were also making use of local amenities such as a swimming pool.

Staff identified patients' physical health needs and recorded them in their care plans. Staff made sure patients had access to physical health care, including specialists as required.

Staff met patients' dietary needs, and assessed those needing specialist care for nutrition and hydration. There were a number of patients that required extra support to ensure that they were eating and drinking well, and this was well documented and monitored. We also saw evidence of this being discussed at handovers to remind staff of additional duties.

Staff helped patients live healthier lives by supporting them to take part in programmes or giving advice about things like quitting smoking, healthy eating and exercise.

Staff used recognised rating scales to assess and record the severity of patients' conditions and care and treatment outcomes. For example, staff used the National Early Warning Score to determine levels of clinical risk.

Managers used results from audits to make improvements in some circumstances. We saw evidence of work that had been done to improve the quality of care planning, which included auditing and feedback to staff about areas that could be improved.

Skilled staff to deliver care

The ward teams included or had access to the full range of specialists required to meet the needs of patients on the wards. 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. These included a psychiatrist, psychologist, activity coordinators, mental health nurses, social worker and support workers.

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. Training records showed that there were a range of courses completed by staff that would ensure they were able to support the patient group they worked with. Agency staff were familiar with the wards and staff checked that they had the right skills and experience before working on the wards.

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

Managers supported all staff through regular, constructive clinical supervision of their work. Data showed that 94% of all staff were up to date with supervision across both wards. This included both the clinical and managerial elements of supervision. This was an improvement since the last time we inspected.

Managers made sure staff attended regular team meetings or gave information from those they could not attend. Staff told us that team meetings and other opportunities to get together happened on a regular basis. We saw evidence of documented team meetings across both wards.

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

Requires Improvement

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Staff told us that the provider was responsive if they requested additional training for their role or for their development.

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 teams 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. We observed a number of meetings where the team came together to discuss patients, this included all relevant professions and the patients themselves. The teams appeared very knowledgeable and spent time listening to patients to get their opinion about their treatment.

Staff made sure they shared clear information about patients and any changes in their care, including during handover meetings. During the inspection we were able to observe a handover which was well attended and included a summary of what each patient had been doing and any new risks that people needed to be aware of.

Ward teams had effective working relationships with external teams and organisations. There was evidence that staff were liaising with other services to try to arrange discharges for those patients that were ready. We also saw examples of joint pieces of work with local service providers which were enhancing the experience of patients at the service, for example supporting the development of a men's talking group.

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. 96% of staff had carried out training on the Mental Health Act. We spoke to a wide range of staff working on both wards and they were able to give a good explanation of the guiding principles and how they impacted their work.

Staff had access to support and advice on implementing the Mental Health Act and its Code of Practice. Staff knew who their Mental Health Act administrators were and when to ask them for support.

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

Patients had easy access to information about independent mental health advocacy and patients who lacked capacity were automatically referred to the service. There were posters up on both wards which contained details about who to contact and how to do so. We also saw an advocate visit the wards while we were on site.

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.

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

Requires Improvement

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. Patients we spoke to said they were able to make use of section 17 leave when they were expecting to. If the staff were not available to facilitate leave then it was always rearranged at the earliest opportunity.

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

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

Good practice in applying the Mental Capacity Act

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

Staff received and kept up-to-date with training in the Mental Capacity Act and had a good understanding of at least the five principles. Every member of staff had undertaken training on the Mental Capacity Act and when we spoke to staff they were able to give a good explanation of the guiding principles and how they impacted their work.

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.

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.

The service monitored how well it followed the Mental Capacity Act and acted when they needed to make changes to improve.

Is the service caring?

Good

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

Kindness, privacy, dignity, respect, compassion and support

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

Staff were discreet, respectful, and responsive when caring for patients. We carried out observations of care whilst we were on the wards and saw that staff were respectful and responsive towards the people that they cared for. There was a good rapport between staff and patients, and it was clear that patients could approach staff for support where it was needed.

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

Requires Improvement

Staff supported patients to understand and manage their own care treatment or condition.

Staff directed patients to other services and supported them to access those services if they needed help. These services included community health services such as doctors and dentists and also access to local health and fitness centre where it was appropriate.

Patients said staff treated them well and behaved kindly. We spoke to 6 patients across both wards and they said that staff helped to keep them safe and treated them kindly. Patient feedback about staff was overall very positive.

Staff understood and respected the individual needs of each patient. This was clear from talking to staff about how to care for each patient and from the level of details documented in each patients care record. We observed meetings including handovers and ward rounds where staff displayed a high level of respect and understanding of patients' needs.

Staff felt that they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards patients.

Staff followed policy to keep patient information confidential.

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. Patients appeared to know the ward and the staff well. The layouts of the wards were straight forward and rooms were clearly signed.

Staff involved patients and gave them access to their care planning and risk assessments. Each care plan had some level of documented involvement from the patient themselves, although different patients were either capable or willing to engage in different ways, some only a little and some much more.

Staff involved patients in decisions about the service, when appropriate. Wards held regular community meetings which were well attended by patients, and patients were able to offer feedback about their experience of being on the ward. As a result of these meetings actions were taken, for example if patients stated there was an issue with food this was fed back to the kitchen or if an area needed additional cleaning this was fed back to the housekeeping staff.

Patients could give feedback on the service and their treatment and staff supported them to do this. As well as the community meetings, the hospital gathered more formal feedback from patients about the quality of their overall experiences. Data gathered as a result of this feedback was discussed at governance meetings.

Staff made sure patients could access advocacy services. There were posters up on both wards which contained details about who to contact and how to do so. We also saw an advocate visit the wards while we were on site.

Involvement of families and carers

Staff had taken steps to ensure that they informed and involved families and carers appropriately.

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

Requires Improvement

Staff supported, informed and involved families or carers. Families and carers that we spoke to said they were kept informed where needed. They said they had opportunities to attend meetings and visit the hospital where it was appropriate. Staff had implemented a system to financially supporting visitors that needed to travel a long way.

Staff helped families to give feedback on the service. Information was displayed in areas that visitors could see it. There were multiple examples of feedback which was positive and constructive which came from carers and families. This feedback was collated by managers and shared with staff working on the wards via bulletins and team meetings.

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

Is the service responsive?

Good

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

Access and discharge

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

Bed management

Managers made sure bed occupancy allowed for admissions when they were necessary.

Managers regularly reviewed length of stay for patients to ensure they did not stay longer than they needed to. We saw evidence of discussions about patients' length of stay and how treatment could be managed to ensure people were progressing appropriately in care records and whilst observing ward rounds.

The service is a private provider and had a contract which block booked the majority of the beds across both wards with an out of area commissioner(s). This meant that most patients came from out-of-area. However, there were specific arrangements in place to ensure that patients could visit their home area when needed and also arrangements to support families and carers to visit the service on a regular basis.

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

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

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

Discharge and transfers of care

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. Staff took actions to ensure that patients that were ready to move on were given the appropriate support to do so. Staff liaised with other services to make arrangements for discharge where necessary.

Staff supported patients when they were referred or transferred between services. We saw an example of the development of a transition plan for one patient which involved staff from different organisations working together to ensure a smooth transition from one service to the next.

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. Many of the patients, especially those that had been at the service longer, had personalised their rooms with photos, posters and their own belongings.

Patients had a secure place to store personal possessions. There was room for each patient to store a small amount of belongings which was located on the wards for easy access when needed, this was securely managed.

Staff used a full range of rooms and equipment to support treatment and care. This included space to carry out one to one work, group work, assisted living kitchens, recreational space, outdoor space and a gym which patients could access on request.

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

Patients could make phone calls in private. Where it was appropriate patients had access to mobile phones and Wi-Fi.

The service had an outside space that patients could access easily. On the psychiatric intensive care unit, the outside space was locked and patients had to request to go outside. This was because of the level of risk in place on the ward when we visited. This was on the blanket restrictions log and reviewed regularly.

Patients could make their own hot drinks and snacks and were not dependent on staff.

The service offered a variety of good quality food. Patients were able to feedback on the quality of food and the service took this feedback into consideration.

Patients' engagement with the wider community

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

Staff helped patients to stay in contact with families and carers. Staff had implemented a system to financially support families and carers to visit the service where it was a long way from their home. There were also additional staff resources made available to ensure that contact with families and carers could be maintained, for example if a long drive was involved which would take staff away from the ward.

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

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

Requires Improvement

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. There were some easy-to-read posters displayed on the wards and although the wards were located on the first floor there was a lift if people needed to use it. The walkways and rooms were wide enough to accommodate somebody with mobility problems if this was necessary. All patients had a personal evacuation plan which would be used in the event of an emergency evacuation being necessary.

Staff made sure patients could access information on treatment, local service, their rights and how to complain. Both wards had a range of displays in the communal spaces and corridors. The displays included information about making a complaint, the Mental Health Act, advocacy, controlled items, reducing restrictive practice, therapy groups and information about different activities that patients could take part in.

The service had information leaflets available in languages spoken by the patients and local community.

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

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

Patients had better access to spiritual, religious and cultural support than when we last inspected. There were displays on both wards which shared information about different religions, traditions and beliefs. There was also a room available on site which patients and staff could use, for example to pray or for some quiet time. Staff had also arranged for different religious representatives to visit the hospital on a regular basis so that patients could maintain or explore their faith where they wished to.

Listening to and learning from concerns and complaints

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

Patients, relatives and carers knew how to complain or raise concerns. The service displayed relevant information around wards and public spaces so patients knew what to do if they wanted to pass on a concern or complaint. The service also kept a detailed log of feedback that they received and how each was concluded. Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint.

The service clearly displayed information about how to raise a concern in patient areas. Staff also held regular patient meetings which gave patients the opportunity to come together and discuss their experiences on the wards and what improvements could be made.

Staff understood the policy on complaints and knew how to handle them.

Managers investigated complaints and identified themes. Governance meeting minutes showed a flow of information which included complaints and concerns. Managers considered any themes identified as a result of the information gathered.

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

Requires Improvement

The hospital kept a detailed lessons learnt log which helped them track events and monitor recommendations that had been put in place. The log included information on different ways patients might self-harm, items that patients could use as weapons, unexpected deaths and inappropriate use of social media. The log included lessons learnt from other provider sites and information received from external sources. This information was fed back to staff via team meetings, briefings and posters displayed in staff areas.

Staff protected patients who raised concerns or complaints from discrimination and harassment. The patients that we spoke to said they felt comfortable raising concerns and sharing feedback about their time on the wards.

The service used compliments to learn, celebrate success and improve the quality of care. We saw a log of recent compliments that the service had received which included feedback from people using the service, families and carers, external professionals and other staff.

Is the service well-led?

Requires Improvement

Our rating of well-led stayed the same. We rated it as requires improvement.

Leadership

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

The hospital had a registered manager in post at the time of our inspection. The senior management team had an understanding of the services being provided across the hospital and were a visible presence on the wards. Each ward had an experienced ward manager who knew the wards well.

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 staff we spoke with were aware of the provider's values and how they impacted their day-to-day work. Each ward had a clear vision of what they wanted to achieve with patients and staff understood this well.

Culture

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

We spoke to a wide range of staff at different levels and they all said they felt supported, valued and that they would feel comfortable raising concerns if they needed to. Staff spoke highly of their managers, including nurses, ward managers and other senior leaders that worked at the hospital. We observed an open and supportive culture between staff for example during ward round meetings where all staff had an equal voice.

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

Requires Improvement

Governance

We identified concerns in relation to the management of medicines on the wards that indicated that governance processes were not always operating effectively. We issued a requirement notice about the management of medicines when we last inspected the hospital and improvements have not been made in this area.

Our findings from the other key questions demonstrated that governance processes apart from those in relation to medicines management generally operated effectively at team level and that performance and risk were managed well.

Governance processes that related to the management of medicines were not effective and had meant that many errors were not picked up and improvements not put in place. The meant that staff and patients were put at unnecessary risk of harm from potential mistakes being made in the management of medicines.

However, there were also a range of well-functioning governance processes in place including a range of audits, environmental checks and reporting processes for incidents, complaints, compliments, and whistleblowing concerns.

A morning managers' meeting took place Monday to Friday at which key information was reviewed including staffing information and incidents occurring on each ward. Regular governance meetings were taking place at which information from the governance processes was reviewed.

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.

Staff monitored and recorded risks to patients well and they used this information to provide effective care. Although there was still a high level of violence and aggression on the wards over the last year, staff were analysing data and trends and there had been some long periods where these types of incidents were lower. This work also saw hospital staff engaging in a national steering group to support the improvement of practice.

The hospital had a risk register in place which documented a range of risks relating to the service, which correlated to risks that we saw and discussed with staff. This was kept under regular review and updated as required, with action being taken to mitigate the identified risks.

At our last inspection we noted that the service had not always made notifications to CQC when required. We found this issue to be resolved at this inspection as appropriate notifications had been submitted when required.

Information management

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

Data about outcomes was monitored and this was regularly reviewed in the hospital's governance meetings.

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.

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

Requires Improvement

We received positive feedback from the representatives of commissioners we spoke with in relation to how the management and clinical teams engaged with them. We saw positive engagement with commissioners and external partners at the ward round we observed and within the clinical notes that we looked at.

Learning, continuous improvement and innovation

The hospital was able to display a culture of learning from incidents through the systems and meetings that staff were involved in. This meant that changes were made and information shared as a result of incidents that occurred. For example, through assessing information about patients that didn't return from leave when they should have, the hospital had been able to implement a new system which aimed to better assess a patient's readiness for unescorted leave. Staff had also made changes to the way that episodes of seclusion were monitored which meant they were able to return patients back to the ward more effectively and in a safer way.

Staff on one of the wards were engaging in a national steering group to support the improvement of practice in relation to violence and aggression, bringing back good practice to the staff working on the wards and sharing theirs with other providers.

Long stay or rehabilitation mental health wards for working age adults

Inadequate

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

Is the service safe?

Inadequate

Our rating of went down. We rated it as inadequate.

Safe and clean care environments

People were not always cared for in wards which were safe, clean, well equipped, well furnished, well maintained or fit for purpose.

Safety of the ward layout

Staff completed and regularly updated risk assessments of all wards areas and removed or reduced any risks they identified. We were able to review the ligature risk assessment for Adarna ward and found it was up to date and captured risks on the ward.

Although staff could not observe people in all parts of the wards, parabolic mirrors and observations of people were used to mitigate this.

The ward complied with guidance and there was no mixed sex accommodation.

Staff knew about any potential ligature anchor points and mitigated the risks to keep people safe.

Staff had access to alarms during the daytime, however, when we conducted our out of hours evening visit there were no alarms available for us to use as visitors, staff on duty did however have alarms This was because the reception area that usually hands out alarms to visitors was closed. When we returned the following day, we entered via reception and alarms were provided for the inspection team. People had easy access to nurse call systems.

Maintenance, cleanliness and infection control

The ward was mostly clean and well maintained. However, we did see some tears in seating and stains on furniture and walls in the main lounge area. Ripped furniture creates an infection control risk as it is not able to be cleaned as

effectively as it should be. The outside area was littered with cigarette ends which were being walked into the lounge area. We raised this at the time of our isnpection and the staff did clean the outside area. These issues had not been identified on the most recent environmental audits that we received following the inspection, and therefore no actions had been identified to resolve the issues.

Staff made sure cleaning records were up-to-date and the premises were mostly clean, although we did see some food on the floor in the dining room and there was some staining on furniture in the lounge.

Staff did not always follow infection control policy. We observed several staff who were not bare below the elbow on the ward including wearing long sleeve cardigans, false nails and wrist watches. Bare below the elbows (BBE) is an infection prevention approach meant to limit patient contact with potentially infectious agents on contaminated clothing. It also allows for effective hand hygiene with the absence of any other object around the wrists or on the hands.

Seclusion room

The Seclusion room was not on Adarna ward but upstairs between the acute ward and psychiatric intensive care unit. It allowed clear observation and two-way communication. It had a toilet and a clock.

Clinic room and equipment

Staff did not always check and maintain equipment effectively. We found that there were lots of out-of-date medical supplies in the clinic room. This included needles, syringes, test fluid for the glucose monitor and dressings and gauze. Some of the equipment was out of date by 3 years. We also found that medical devices such as the blood pressure monitor and the glucometer did not have stickers on to tell staff when the equipment was last checked and when it was next due to be checked. Although the provider supplied us with the proof of testing following the inspection, the provider's policy stated that a sticker should be placed on equipment once a check was completed to let staff know when the next check was due. Both the blood pressure machine and the glucometer stickers stated they were last checked in July 2022. Regular audits of the clinic room and the equipment had not picked up on these discrepancies.

We reviewed the emergency bag and found equipment to be present and daily checks were taking place.

Safe staffing

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

Nursing staff

The service had enough nursing and support staff to keep people safe. The staffing tool used on the ward guided managers on how many staff should be on each shift, dependent on numbers of people in the service and levels of observations. At the time of our inspection, there were 6 staff on a day shift (2 qualified nurses and 2 support workers) and 5 staff on a night shift (2 qualified nurses and 3 support workers).

The service had low vacancy rates. Both staff and people we spoke to told us they felt there was enough staff on shift.

The service had reducing bank and agency use. We reviewed bank and agency use for the 3 months prior to our inspection and found this had been reducing as vacancies were filled.

Long stay or rehabilitation mental health wards for working age adults

Inadequate

Managers limited their use of bank and agency staff and requested staff familiar with the service. Managers made sure all bank and agency staff had a full induction and understood the service before starting their shift. We reviewed the bank and agency induction file for staff working on the ward on the day of our inspection, along with 3 other dates chosen at random, and found that all inductions for staff were present.

The service had reducing turnover rates. We reviewed the turnover for the hospital for the 12 months prior to our inspection and found that this had reduced month on month from 38% in January 2023 to 20% in December 2023.

Managers supported staff who needed time off for ill health.

Levels of sickness were low at around 5% and under for the 12 months prior to our inspection. There had been a slight spike in December 2023 with sickness levels increasing to just under 9%. However, this was due to winter viruses and would be expected to be higher at this time of year.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants for each shift. We saw a staffing matrix that had been created by the service which indicated the baseline numbers for each shift and when these would increase based on individual people's needs.

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

People had regular one- to-one sessions with their named nurse.

People rarely had their escorted leave or activities cancelled, even when the service was short staffed. People told us that they were able to get out on leave when planned and described where they would visit during leave with staff.

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

Staff shared key information to keep people safe when handing over their care to others.

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. Doctors were based either at the hospital or at a nearby hospital during the evenings, nights, and weekends. Staff told us there was usually no problem in getting a doctor on site when required.

Managers could call locums when they needed additional medical cover.

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

Mandatory training

Staff had completed and kept up to date with their mandatory training. We reviewed the mandatory training records for all staff on Adarna Ward. We found that all courses apart from Safeguarding Individuals at Risk (Intermediate) were above 75%, which was at 64%. However, this was a new course (level 3 safeguarding) that was previously only for qualified staff, the provider had taken the decision to roll this out to all staff hence the low compliance rate. The training

was in 2 parts, e learning and then a classroom based session which was not delivered in house. All staff had completed the e-learning session and some staff had completed the classroom training. Further classroom training was booked to ensure compliance rates were improved of the next few months. However, staff had a good understanding of their responsibilities around safeguarding.

The mandatory training programme was comprehensive and met the needs of people and staff. The Oliver McGowan Mandatory Training on Learning Disability and Autism is the government's preferred and recommended training for health and social care staff, it is mandatory in all care settings. Oliver McGowan training was at 100% compliance at the time of our inspection.

Staff had now completed mandatory training in how to interact appropriately with autistic people and people who have a learning disability at a level appropriate to their role.

Managers monitored mandatory training and alerted staff when they needed to update their training.

Assessing and managing risk to people and staff

Staff did not always assess and manage risks to people and themselves well. They did not always achieve the right balance between maintaining safety and providing the least restrictive environment possible in order to facilitate people' recovery. Staff 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 completed risk assessments for each person within 28 days of their arrival, using a recognised tool but these weren't always kept up-to-date. They used the previous risk assessment from the admitting provider up until the point of completion. We found that there were gaps in completion of the risk assessments in 4 out of 4 that we reviewed. This included gaps in signatures, dates, and the content of the risk assessment. Although risks were reviewed regularly, we found that this was not always completed after every incident. The hospital was using both paper and electronic records and in the 4 risk assessments we reviewed, we found that all 4 had a more up to date version on the electronic system to the one stored in the paper record. This meant that staff did not always have access to the most up to date risks about people. This was particularly concerning for bank and agency staff who did not always have access to the electronic record keeping system. We raised this at the end of our onsite visit to the hospital.

Staff used a recognised risk assessment tool the strategic tool for assessing risk, Short Term Assessment of Risk and Treatability(START). Some patients had other more detailed risk assessments based on their history and level of risk in addition to the START.

Management of patient risk

Staff we spoke to generally knew about any risks to each person and acted to prevent or reduce risks.

Staff identified and responded to any changes in risks to, or posed by, people. As well as the START risk assessment, the provider used a daily risk assessment that rag rated (red, amber, green) patients according to risks. Patients would be placed into red for 7 days following a selection of a number of risk catorgories, that would then be discussed daily in the handover and as part of the daily risk assessment, which took place each morning. When we spoke to staff, they were able to tell us about the specific risks of the people they were caring for and how these were managed.

People were now supported better so that people were protected from physical assault from other people on the ward.

Staff followed procedures to minimise risks where they could not easily observe people. For example, there were parabolic mirrors on the ward to mitigate blind spots and staff carried out regular observations of all people. Staff would undertake observations more frequently for those people with known increased risks.

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

Staff restricted people's access to items on the ward and this was not always based on individual needs. The ward had a blanket restrictions audit which was last completed in December 2023. At the time of our inspection, cups were paper only and were kept in the ward office with wooden spoons. People were not allowed to use ceramic cups and plates. This was not individually risk assessed and staff continued to use pot cups out on the ward throughout our inspection. People had to go to the office to ask for cups and spoons to make a hot drink. This meant there was a delay in people accessing hot drinks when they wanted one. The restriction on hot drinks was not included on the blanket rules audit for the ward.

Use of restrictive interventions

Levels of restrictive interventions were low. There were 2 incidents per month of restraint on Adarna ward in the 3 months prior to our inspection. There were no episodes of prone restraint in the 3 months prior to our inspection and 2 in the 12 months before inspection.

Staff participated in the provider's restrictive interventions reduction programme, which met best practice standards. The compliance rate for restraint training on Adarna ward at the time of our inspection was 100%.

Staff made every attempt to avoid using restraint by using de-escalation techniques and restrained people only when these failed and when necessary to keep people or others safe.

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

Staff now followed national guidance when using rapid tranquilisation. Rapid tranquilisation had been used on Adarna ward 5 times in the 12 months leading up to our inspection. It had not been used for 4 months prior to our inspection. Records were reviewed by our medicines inspector and we did not find any issues relating to the use of rapid tranquilisation and post dose monitoring.

There had been no episodes of seclusion for people on Adarna ward for the 6 months leading up to our inspection.

Staff were now not secluding people in their bedrooms. At our last inspection we found that people had been secluded in their bedrooms on occasion. This had not happened on Adarna ward since August 2023.

Long stay or rehabilitation mental health wards for working age adults

Inadequate

Where staff were trained in the use of restrictive interventions, the training was certified as complying with the Restraint Reduction Network Training standards

If staff restricted a person's freedom, they took part in post incident reviews and considered what could be done to avoid the need for its use in similar circumstances

Safeguarding

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

Staff received training on how to recognise and report abuse, appropriate for their role.

Staff kept up to date with their safeguarding training. Safeguarding training level 1 and 2 were at 95%. Level 3 was at 64%. However, this was a new course (level 3 safeguarding) that was previously only for qualified staff, the provider had taken the decision to roll this out to all staff hence the low compliance rate. The training was in 2 parts, e learning and then a classroom based session which was not delivered in house. All staff had completed the e-learning session and some staff had completed the classroom training. Further classroom training was booked to ensure compliance rates were improved of the next few months. However, staff had a good understanding of their responsibilities around safeguarding.

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

Staff knew how to recognise adults and children at risk of or suffering harm and worked with other agencies to protect them. The provider had a safeguarding policy which staff were aware of. We saw examples in care records of safeguarding referrals being made when appropriate to do so. Examples of this included concerns around financial abuse.

Staff followed clear procedures to keep children visiting the ward safe. There was a room off the ward, so children did not need to enter the ward to visit people. Staff would risk assess this prior to a child visiting.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. They reported good relationships with the local authority safeguarding team and found that they were responsive to any concerns they reported.

Staff access to essential information

Staff did not always have easy access to clinical information – whether paper-based or electronic.

Care notes were a mixture of electronic and paper records. We found that the paper records were not always the most up to date version and this could mean that staff did not have easy access to the most up to date information about people. There was a risk that, with information stored in paper records not being kept up to date, that this could potentially lead to incorrect care and treatment being delivered if a staff member only reviewed the paper record.

Records were stored securely.

Medicines management

The service did not safely monitor, administer, record and store medicines, the oversight and audits in place for monitoring medicines was not effective in identifying and reducing risk. The service did not always review the effects of medication on people physical health. However, systems were in place to safely prescribe medicines for the most part.

Staff did not always complete medicines records accurately and keep them up to date.

We found gaps in medicine charts where several doses of medicine had not been signed for. For one person, we found that one medicine had been transcribed inaccurately and they had not received the correct dose. For another person we found their record had not been signed contemporaneously (at the time of administering). This means we could not be assured that people always received their medicines as prescribed. We found several gaps in the recording of whether a person had been given their prescribed medication or if not, a code given to explain the reason why, for example if the person was on leave.

We raised this at the end of our onsite inspection, and asked for assurance from the provider as to why these specific medicines had not been signed for, along with any explanation they could provide. When the provider returned their evidence to assure us, we found that in 3 instances the records had been signed for retrospectively by staff. We queried this with the provider and asked them to undertake a full investigation into this matter which they agreed to do. We also asked that the staff involved were referred to the relevant professional regulator. Falsification of records requires an immediate referral to the professional regulator and the provider gave us evidence that these referrals had been completed.

Staff did not always ensure all medicines were stored safely.

Staff monitored and recorded temperatures of areas where medicines were stored. However, when the temperature went out of recommended ranges (too high) staff did always document if any action had been taken. Although the service had audits completed by an external pharmacy company every month, this issue had not been picked up. We saw 12 occasions in November and December 2023 when the fridge temperature was recorded as being out of the optimum range. If medicines are not stored properly they may not work in the way they were intended, and so pose a potential risk to the health and wellbeing of the person receiving the medicine.

Staff did not always review the effects of each person's medicines on their physical health according to NICE guidance. For one person we found that monitoring of bowel movements was not always recorded. This person was prescribed Clozapine and this medication is known to cause constipation and subsequent complications if not monitored closely.

There were systems in place for staff to obtain medicines prescribed including out of hours. For a person prescribed a medicine to be administered in an emergency the service ensured that staff who supported this person when outside the service were trained and competent to give this medicine if needed.

Long stay or rehabilitation mental health wards for working age adults

Inadequate

Staff reviewed each person's medicines regularly and provided advice to people and carers about their medicines. People we spoke to knew what medication they were prescribed and felt comfortable discussing any concerns with their doctor or nursing team. Staff on Adarna ward had supported 1 person to manage and self-administer their own medicines.

Doctors were available daily on the ward to review and prescribe medicines.

The service ensured people's behaviour was not controlled by excessive and inappropriate use of medicines. Staff understood and implemented the principles of STOMP (stopping over-medication of people with a learning disability, autism or both) and ensured that people's medicines were reviewed by prescribers in line with these principles. People received annual health checks.

We saw for a person that had received rapid tranquilisation, monitoring of their physical health after the dose had been given was completed.

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 people honest information and suitable support.

Staff knew what incidents to report and how to report them. Incidents were reporting using an electronic system. There had been no serious incidents on Adarna Ward in the 12 months prior to our inspection. Staff knew how to report serious incidents clearly and in line with policy.

The service had no never events.

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

Managers debriefed and supported staff after any serious incident.

Managers investigated incidents thoroughly. People and their families were involved in these investigations. Managers now ensured incidents were monitored more closely to understand themes and trends.

Staff received feedback from investigation of incidents, both internal and external to the service. Managers gave feedback in team meetings and in one-to-one supervision. Staff also had access to emails where information was shared amongst the team.

Staff met to discuss the feedback and look at improvements to people's care. There were monthly team meetings and staff were invited to share learning and suggest improvements.

Long stay or rehabilitation mental health wards for working age adults

Inadequate

Is the service effective?

Requires Improvement

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

Assessment of needs and planning of care

Staff assessed the physical and mental health of all people on admission. They developed individual care plans that were mostly reviewed regularly through multidisciplinary discussion and updated as needed. Care plans reflected people' assessed needs, but were not always personalised, holistic and recovery oriented.

Staff completed a comprehensive mental health assessment of each person either on admission or soon after.

People had most aspects of their physical health assessed soon after admission and regularly reviewed during their time on the ward. We did, however, find gaps in routine bowel monitoring for 3 people on the ward where it was not documented on several days if the people had opened their bowels. This was particularly important to ensure that the people were regularly opening their bowels and if not that action was taken to ensure this problem was rectified before the person suffered any complications.

Staff developed a comprehensive care plan for each person that met their mental and physical health needs. We reviewed 6 care records during our inspection and all contained a comprehensive care plan.

We found that care plans were kept up to date apart from one example where the care plan explained to a person that they would be at the hospital for 21 months. This time had now passed but the care plan had not been updated to reflect why the person was still on the ward or when their expected discharge now was. Due to the patient group that resided on Adarna ward, lack of clarity and uncertainty around discharge date could have a detrimental effect on the patient's wellbeing.

Care plans were mostly personalised, recovery orientated and holistic but they did not always promote strategies to enhance independence, or demonstrate evidence of planning and consideration of the longer-term aspirations for each person. We saw examples of communication plans / grab sheets in place for all person files we reviewed. These included key information about the person as well as their positive behavioural support plan. We reviewed one care plan for a person who was nearing discharge who had a pictorial care plan. The care plan showed a picture of a care facility they may have been moving to with a question next to it asking, "do you want to live here" and then a tick or a cross. This did not give the person any detail about the care facility, offer a visit to the facility or allow for any other options if the person was unsure. It was unclear how staff had communicated this potential move to the person other than through the use of this sheet. We also saw one person whose care plan had not been updated with the expected date of discharge, the care plan explained an estimated length of stay and this time frame had now passed.

Best practice in treatment and care

Staff provided a range of treatment and care for people based on national guidance and best practice. This included access to psychological therapies, there was also some support for self-care. However, we did not

always find people were actively encouraged with the development of everyday living skills and meaningful occupation. Staff supported people with their physical health for the most part and encouraged 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 people in the service and staff delivered care in line with best practice and national guidance. (from relevant bodies e.g. NICE) . There was access to psychological therapies and each person was able to access a minimum of 1 hour per week. Groups and individual therapy available on the ward were; cheer you up group (managing depression), DBT based therapies for self-esteem and assertiveness, which was adapted for autistic people. The consultant psychologist was also trained in eye movement desensitization and reprocessing (EMDR).

Staff completed people's positive behavioural support plans which included the identified care and support to support people in individualised person-centred ways. The lead psychologist was also the lead for positive behavioural support plans and the hospital aimed to complete these within 12 weeks of admission. These were present in all 6 care records we reviewed.

However, staff were not always working with people in person-centred ways that took account of their autism and/or in line with their positive behavioural support plans. We found that staff were not always working in an autism informed way despite having completed mandatory training on how to interact with autistic people. Examples of this that we saw included staff being noisy at times on the ward such as singing and shouting down the ward to each other and people, which could be quite distressing for people who were sensitive to noise, including people who we observed were wearing ear defenders due to noise. We also saw examples of staff telling people "in a minute" and then not returning for some time. Again, for autistic people who may take information quite literally, this may become a trigger. Members of the multidisciplinary team acknowledged that more could be done to ensure staff fully understood and always followed people's positive behavioural support plans.

Staff identified people' physical health needs and recorded them in their care plans. However, care plans were not always followed in relation to physical health and we saw 3 examples where patients required bowel monitoring charts to be completed daily. This had not happened on a number of occasions.

Staff made sure people had access to physical health care, including specialists as required. For example diabetes specialist nurse, dietician, epilepsy nurse and podiatry.

Staff were not always working in person-centred ways to ensure they met people's dietary needs. However, we did observe at mealtimes that not all people were called individually for meals to ensure they were aware food was available and ready to eat. We saw staff telling people in the main lounge area that food was ready but they did not visit all bedrooms to ensure that people who were in their bedrooms were called. We also saw some gaps in the completion of diet and fluid charts for people. Examples included one person who often did not sit down for meals, whose diet chart often stated "refused" but did not detail what was then done to ensure food was offered or eaten or to consider whether they had any unmet needs to enable them to sit and eat meals. Staff assessed those needing specialist care for nutrition and hydration. Access to a dietician was via a GP referral and we were able to see in patient records when this had been considered and completed as required. Staff helped people live healthier lives by supporting them to take part in programmes or giving advice. We saw evidence of people cooking with staff on a regular basis and the aim was to work towards independent cooking. The hospital had previously been a smoke free site and had reverted to allowing

smoking in the outdoor areas during the Covid-19 pandemic. There was nicotine replacement therapy available for people and we did see this prescribed for some people, but we did see several people spending long periods outside smoking during out inspection visit, at this time we did not see staff intervening to offer nicotine replacement or to discuss generally the benefits of reducing or stopping smoking.

Staff used recognised rating scales to assess and record the severity of people' conditions and care and treatment outcomes.

Staff used technology to support people. People had access to computers on the ward and some had their own games consoles in their bedrooms.

Staff took part in clinical audits, benchmarking, and quality improvement initiatives. We saw audits taking place for patient records, medicines, ligatures and the environment.

However, audits did not always ask the correct questions to ensure shortfalls were highlighted. For example, where we found paper records of risk assessments were out of date in comparison to the electronic record, the ward's care record audits had not identified this issue for 4 consecutive months.

Skilled staff to deliver care

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

The service had a full range of specialists to meet the needs of the people on the ward. This included a full-time consultant psychiatrist, mental health nurses, a speciality doctor, an occupational therapist and an assistant, a psychologist and an assistant, healthcare support workers, social workers, activity co-ordinators and a speech and language therapist.

At our last inspection, we found that staff did not all have specialist training on autism or learning disabilities. At this inspection we found that staff training in this area had improved.

Managers gave each new member of staff a full induction to the service before they started work. New staff also had access to 'grab and go' sheets for each person which included summary information about their communication needs and positive behaviour support plans.

Managers supported staff through regular, constructive appraisals of their work.

Managers supported permanent medical staff to develop through yearly, constructive appraisals of their work.

Managers supported non-medical staff through regular, constructive clinical supervision of their work. Clinical supervision for Adarna ward was at 87% at the time of our inspection.

Managers made sure staff attended regular team meetings or gave information from those they could not attend. Managers sent minutes out via email to those that could not attend.

Long stay or rehabilitation mental health wards for working age adults

Inadequate

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

Managers made sure staff received any specialist training for their role. We saw examples of staff completing training in sensory integration therapy, which is designed to help people with sensory-processing problems (including those with autism) cope with the difficulties they have processing sensory input.

Managers recognised poor performance, could identify the reasons, and dealt with these.

Multi-disciplinary and interagency team work

Staff from different disciplines worked together as a team to benefit people. They supported each other to make sure people had no gaps in their care. They had effective working relationships with staff from services providing care following a patient's discharge.

Staff held regular multidisciplinary meetings to discuss people and improve their care but there were delays in updating the appropriate record with decisions. We saw evidence of regular meetings with people. However, we did see that the use of paper and electronic records did mean there was sometimes a delay in multidisciplinary meeting minutes being uploaded onto the electronic system. Paper records were used during the meeting and these would then need to be scanned into the electronic system, we saw there had been a delay in this being completed meaning the most recent MDT meeting minutes were not always available in care records. We saw examples where MDT notes had taken up to 3 weeks to be uploaded, meaning the most recent MDT notes were not available to the team during this time.

Staff did not always make sure they shared clear information about people and any changes in their care, including during handover meetings. We attended a handover during our on-site inspection and reviewed handover sheets for the 5 days leading up to our inspection. Were able to see that each patient was discussed, including their detention status and observation levels. However, the individual risks of each patient and how to manage these, were not always discussed in detail, especially when there had been a recent incident with that patient. The handover records were hand written each day and did not contain any prepopulated information that were essential for staff to discuss. This could lead to different information being discussed each day and important areas such as risk being missed.

Ward teams had effective working relationships with other teams in the organisation.

Ward teams had effective working relationships with external teams and organisations. As many of the people on Adarna ward were not from the local area, we saw in care records and in particular the multi-disciplinary team meeting, that the ward staff maintained good communication with people' home teams including commissioners and care coordinators.

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 people' rights to them.

Long stay or rehabilitation mental health wards for working age adults

Inadequate

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. Training in mental health act awareness was mandatory and Adarna ward was 100% compliant at the time of our inspection.

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

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

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

People had easy access to information about independent mental health advocacy and people who lacked capacity were automatically referred to the service. There were posters in several areas on the ward to detail their contact number and how to get in touch.

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

Staff made sure people 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.

Staff did not always request an opinion from a Second Opinion Appointed Doctor (SOAD) when they needed to. We found that for one person on Adarna ward, they had been prescribed two medications in June 2023 under Section 62 (Section 62 allows for urgent treatment to be given to detained people). A SOAD should normally have been requested before Section 62 is used. However, we found that a SOAD had still not been requested to review the person's medication at the time of our inspection. This was addressed by the doctor during the inspection.

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

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

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

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

Good practice in applying the Mental Capacity Act

Staff supported people 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 people who might have impaired mental capacity.

Staff received and kept up to date with training in the Mental Capacity Act and had a good understanding of at least the five principles. Training was mandatory and was at 100% compliance at the time of our inspection.

Long stay or rehabilitation mental health wards for working age adults

Inadequate

There were no Deprivation of Liberty Safeguards applications made in the last 12 months. People were detained under the Mental Health Act as the legal framework to provide care and treatment in hospital.

There was a clear policy on Mental Capacity Act and Deprivation of Liberty Safeguards, which staff could describe and knew how to access.

Staff knew where to get accurate advice on the Mental Capacity Act and Deprivation of Liberty Safeguards.

Staff gave people all possible support to make specific decisions for themselves before deciding a person did not have the capacity to do so. Pictorial information was available and easy read versions if required.

Staff assessed and recorded capacity to consent clearly each time a person needed to make an important decision.

When staff assessed people as not having capacity, they made decisions in the best interest of people and considered the person's wishes, feelings, culture and history. The records we looked at showed that capacity assessments took place and people were supported to give informed consent to their care.

The service monitored how well it followed the Mental Capacity Act and made and acted when they needed to make changes to improve.

Is the service caring?

Requires Improvement

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

Kindness, privacy, dignity, respect, compassion and support

Staff did not always understand the individual needs of people and did not always support people to understand and manage their care, treatment or condition. However, people told us that staff treated them with compassion and kindness most of the time. They respected people' privacy and dignity.

Staff were mostly discreet, respectful, and responsive when caring for people. However, we observed that staff were not always sensitive to the needs of the people on the ward, despite having completed training around autism and learning disabilities. For example, we observed staff shouting and singing loudly on the ward when some people were sensitive to noise. We carried out a short observation framework for inspection (SOFI) and found that for the majority of our evening visit and the morning of our daytime visit, staff only interacted with people on a need led basis, for example when giving medication or handing out cups and cigarettes. During the afternoon of our daytime visit, we saw staff have more meaningful, positive interactions with people, such as discussions about people' hobbies, their childhood and interests.

Staff did not always give people help, emotional support and advice when they needed it. We spoke to people on the ward who told us that at times it was noisy and chaotic. We also heard noise from both the ward upstairs and the alarms ringing on the ward, as well as staff behaviours as mentioned above. At these times we saw people retreat to their bedrooms and some made use of ear defenders. Staff did not seek out these people to discuss what could be done to

assist, support or reduce distress. Care plans indicated that ear defenders should be used when the ward was noisy, but this did not address the issue of noise or ways to reduce it for these people. Three people told us they did not always feel safe on the ward and spent most of their time in their bedroom. This was due to other people, noise and lack of opportunity to engage in activities they enjoyed.

Staff supported people to understand and manage their own care treatment or condition for the most part. We saw care plans that showed evidence of patient involvement. We spoke to 6 people, only one told us they did not have a copy of their care plan. However, we did see 1 care plan where the person was given an expected discharge date and this time had now passed, the person remained on the ward and the care plan had not been updated to reflect this information and tell them why. We also saw one social story for a person who was nearing discharge. This contained information of a potential supported living accommodation and then asked the question "do you want to live here", it then gave a tick or a cross. This did not give the person enough information to understand the implications of this decision and allow them to make an informed decision.

Staff directed people to other services and supported them to access those services if they needed help. There was an advocate who visited the ward weekly. There was also information displayed about how to complain, support with issues such as housing and money and information about different groups in the local community.

People said staff treated them well and behaved kindly. No-one raised any concerns with us about staff behaviour or abuse and all people knew the name of their named nurse. However, some people did raise that they felt unable to approach staff other than their named nurse with their problems or to ask for help and they preferred to stay mostly in their bedrooms. During our inspection we observed that some people stayed in their bedrooms for most of the day. Two people told us they did not feel they had built up a good rapport with staff despite some of them being on the ward for some time.

People gave positive feedback about activities they enjoyed on the ward such as cooking, attending the gym, cinema trips and visits to the onsite tuck shop that was run by people.

Staff did not always appear to understand the individual needs of each person and therefore, did not always show warmth and respect. This included staff making unnecessary noise on the ward, not engaging in meaningful conversations with people, being task focused and not sticking to times for leaving the ward or repeatedly saying "in a minute" to people. However, we found that people described a good relationship with their own named nurse and details in care plans reflected personal preference of people as well as their interests and hobbies.

Staff felt that they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards people.

Staff followed policy to keep patient information confidential.

Involvement in care

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

Involvement of people

Long stay or rehabilitation mental health wards for working age adults

Inadequate

Staff introduced people to the ward and the services as part of their admission. There was a welcome handbook for new people. This was given out prior to admission when staff visited people at their previous placement so they could read this prior to arriving.

Staff involved people and gave them access to their care planning and risk assessments. All except 1 person we spoke to had been given copies of their care plan and they knew what information it contained.

Staff made sure people understood their care and treatment (and found ways to communicate with people who had communication difficulties). We saw positive examples of the use of pictures and social stories to make care plans more accessible for people. We also saw other information available in easy read formats such as rights for the mental health act, medicines information and complaints information.

Staff involved people in decisions about the service, when appropriate. People could give feedback on the service and their treatment and staff supported them to do this. We attended the patient council meeting on the second day of our inspection. People from all 3 wards at the hospital attended this meeting. At this meeting, staff listened to and acted upon people's views and opinions. People had put forward the idea of a new group called "the cheer me up group", and this was being discussed at the meeting. People also discussed ideas such as a new chill out space, a free barber they had attending the hospital and a keeping well group. All these ideas were from people which the service had acted upon and were in progress at the hospital.

Staff supported people to make decisions on their care in the main. However, we did see the examples given above where people care plans did not accurately describe discharge dates and decisions around care.

Staff made sure people could access advocacy services. The advocate visited the ward weekly and was present on the ward speaking to people during our inspection.

Involvement of families and carers

Staff did not always inform and involve families and carers appropriately.

We spoke to 7 carers of people on Adarna ward. All but 1 carer told us they felt their loved one felt safe on the ward. However, 6 out of 7 told us they felt communication from the ward could be improved whilst 4 out of 7 told us the ward and toilets and bathrooms used by people were not clean when they visited.

Staff did not always support, inform and involve families or carers. Out of the 7 carers we spoke to, 5 of them told us the service did not keep them as informed as they would like about their loved one. For example, carers told us that they were informed about a change after it had already been made, such as changes in care, medications, care plans and discharge plans. However, 2 carers felt that they had been involved and were kept up to date with relevant information.

Staff helped families to give feedback on the service. Carers told us who they would contact if they wanted to raise concerns and felt they were able to do this if needed.

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

Is the service responsive?

Long stay or rehabilitation mental health wards for working age adults

Inadequate

Requires Improvement

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

Access and discharge

Staff planned and managed patient discharge well. They worked well with services providing aftercare and managed people' move out of hospital. As a result, people did not have to stay in hospital when they were well enough to leave.

Bed management.

Managers regularly reviewed length of stay for people to ensure they did not stay longer than they needed to. The average length of stay for people on the ward was 15 months. The longest stay at the time of our inspection was 38 months and the newest person had been there less than 1 month. The people on the ward required a slower paced rehabilitation due to the complex nature of the people residing there. This did mean at times that people required a specialist placement following Adarna ward and availability of these placements could be scarce, particularly if people preferred to be nearer to home. This was the main reason for people remaining on the ward for longer periods of time than anticipated. There were 13 people on the ward at the time of our inspection. Once people reached a certain stage of their rehabilitation they could be also considered for transfer to Adarna House which was nearby and also run by Cygnet Healthcare provided more community focused rehabilitation.

The service admitted some out of area people due to the specialist type of service it provided and lack of similar facilities across the country. Most people were from the wider Lancashire area, but some were from further afield. If a person was not from the local area staff supported them, in line with their wishes, to have regular contact with family, friends or an advocate.

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

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

People were moved between wards during their stay only when there were clear clinical reasons, or it was in the best interest of people.

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

The psychiatric intensive care unit was upstairs in the same building if a person needed more intensive care.

Discharge and transfers of care

Managers monitored the number of people whose discharge was delayed and took action to reduce them. There were no delayed discharges on Adarna Ward at the time of our inspection.

Long stay or rehabilitation mental health wards for working age adults

Inadequate

People did not have to stay in hospital when they were well enough to leave, although staff / managers reported that finding and securing an appropriate, permanent discharge placement for people such as in a specialist unit or one that met the specialist requirements of some people did take some time.

Staff carefully planned people' discharge and worked with care managers and coordinators to make sure this went well. We saw evidence of discharge planning in care records and involvement of care coordinators and commissioners in patient meetings.

Staff supported people when they were referred or transferred between services.

The service followed national standards for transfer.

Facilities that promote comfort, dignity and privacy

The design, layout, and furnishings of the ward supported people' treatment, privacy and dignity. Each person had their own bedroom with an en-suite bathroom and could keep their personal belongings safe. There were areas for privacy, but these were not always quiet. The food was of good quality, but people could not make hot drinks and snacks at any time as they needed to ask staff for a cup from the office and this could lead to delays. When clinically appropriate, staff supported people to self-cater, although at the time of our inspection we did not see anyone cooking for themselves for all meals.

Each person had their own bedroom, which they could personalise. People had individual bedrooms which had a bed space and an en suite bathroom with a shower, toilet and sink. We saw people had personalised their bedspace with pictures, their own computers and other items from home.

People had a secure place to store personal possessions in their bedroom.

The wards noise and acoustics still did not meet people's sensory sensitivities. However the design, layout and furnishings supported people and their other sensory needs. At our previous inspection we raised with the provider that the noise levels both on the ward and coming from the wards above was distressing for people, especially those sensitive to noise. The provider had taken some action since the last inspection to try and reduce noise, this included soundproofing boards on the walls, installation of acoustic flooring to ward above, acoustic works to 5 of the bedrooms and also carried out a scoping exercise into the use of silent alarms. However, this had not been effective as there was still a lot of noise from the wards above and alarms were still sounding loudly at regular intervals. We were told by several patents that the noise on the ward distressed them and that for this reason they chose to spend long periods in their bedrooms whilst some also used ear defenders. The managers at the hospital were aware that this issue remained and following our inspection told us that the job to install silent alarms was due to be completed in April 2024. The environmental audit was due to be revisited in February 2024 to take into account the views of the current people on the ward. The room where people could meet with visitors in private was also noisy. One relative raised with us that the alarms sounded regularly in the visitor room and that this was also distressing for the people and family. However, there was a sensory room on the ward and lighting was kept low.

Staff used a full range of rooms and equipment to support treatment and care. There was a dining room, de stimulation area, sensory room and gym on the ward. There was also a smaller lounge and the main lounge. However, these rooms were not always quiet and there was often loud music playing in the main lounge area as well as the television. We did not see staff make any attempts to reduce this noise during our two day inspection.

Long stay or rehabilitation mental health wards for working age adults

Inadequate

The service had quiet areas. People could make phone calls in private; they were able to use the ward office, they also had access to their own mobile phones.

The service had an outside space that people could access easily. The outside space was stark and littered with cigarette ends. We saw people going outside to smoke at regular intervals and there was no separate space for people who did not smoke to get some fresh air. However, the door was always open and people could go in and out as they pleased.

People could make their own hot drinks and snacks, but people were dependent on staff to make drinks as cups and spoons were kept in the staff office and people needed to ask staff for these prior to making a drink. This meant when staff were busy, people were delayed in making their own drinks. This was not individually risk assessed and managed and was therefore a blanket restriction on the ward at the time of our inspection.

The service offered a variety of meals to people People we spoke to raised no concerns about the food.

People' engagement with the wider community

Staff did not always support people with activities outside the service, such as work, education and family relationships.

When we asked staff about opportunities for education and work, we were not told of any current opportunities on offer. At the time of our inspection, no people were engaging in any voluntary or paid work in the local community. When we asked staff about any links they had developed or what work previous people had engaged in, we were only given 1 example, a farm that people had visited that was open in the summer months only. It is recognised that due to people's needs on Adarna ward, it could be difficult for people to engage in work, either paid or unpaid. However, opportunities and links with potential services would have ensured that this was available to people if they wished to explore these opportunities. The occupational therapist was hoping to redevelop links with the community services after returning to work. Some patients did tell us about activities they enjoyed both on and off the ward. Examples given included attending the gym, going to the local coffee shop and attending the local shops. On the ward patients enjoyed cooking sessions.

Staff helped people to stay in contact with families and carers. Family relationships were encouraged and nearly all people we spoke to told us about them visiting family and loved ones and vice versa. This was accommodated by the ward in the visiting room or in the local community if leave permitted.

Meeting the needs of all people who use the service

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

The service could support and make adjustments for disabled people and those with communication needs or other specific needs. The ward was on ground level.

Staff made sure people could access information on treatment, local service, their rights and how to complain. We saw information on display on the ward at the time of our inspection.

The service had information leaflets available in languages spoken by the people. At the time of our inspection no people required this, however, staff told us and showed us how these were easily accessible if required.

Long stay or rehabilitation mental health wards for working age adults

Inadequate

Managers made sure staff and people could get help from interpreters or signers when needed. We asked staff about this and, although it was not required at the time of our inspection, they were able to tell us where they would access these services.

The service provided a variety of food to meet the dietary and cultural needs of individual people.

People had access to spiritual, religious and cultural support. There was a display on the ward wards which detailed information about different religions, traditions and beliefs. There was also a room available on site which people and staff could use, for example to pray or for some quiet time. There had been visits to the hospital by different religious representatives, they visited on a regular basis.

Listening to and learning from concerns and complaints

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

People, relatives and carers knew how to complain or raise concerns. All people and relatives we spoke to told us this.

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

Staff understood the policy on complaints and knew how to handle them.

Managers investigated complaints and identified themes. There were 17 formal complaints and 3 informal complaints on Adarna ward over the 12 months prior to our inspection. Themes included noise on the ward, staff attitude and staff management of peer to peer altercations. We could see that complaints raised were investigated appropriately and feedback given to people. Out of the 17 complaints on Adarna ward, 4 were upheld, 7 were partially upheld and 5 were not upheld.

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

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

Managers shared feedback from complaints with staff and learning was used to improve the service.

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

Is the service well-led?

Inadequate

Our rating of well-led went down. We rated it as Inadequate.

Leadership

Long stay or rehabilitation mental health wards for working age adults

Inadequate

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

The hospital had an experienced registered manager who understood the service and the needs of autistic people.

Leaders in the service were passionate about the care and treatment they were providing to people.

Leaders felt supported in their roles and that there were opportunities to develop in the organisation. Leaders engaged with people and were 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.

Staff understood the vision and values of the organisation. Managers described how the provider's vision and values were considered as part of the recruitment process to ensure that new staff entering the service represented the qualities expected of the organisation.

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.

Staff we spoke to told us that they enjoyed their job. Some staff had worked at the hospital for some time and told us they felt the local managers were supportive and accessible. Staff told us about opportunities for development and how they were supported to attend training relevant to their role. All staff told us the team on the ward worked well together and supported each other.

The service had undertaken a staff survey between March and April 2023. 58% of staff had responded (78 out of 134). The results of the survey were mixed, although staff rated the organisation and hospital highly for being able to raise concerns without fear of retribution. The areas that were highlighted as most needing to improve were staff satisfaction around pay, career progression and perceived lack of staffing. An action plan to address areas that had scored poorly or had decreased significantly since the last survey had been created.

Governance

Our findings from the other key questions demonstrated that governance processes did not operate effectively at team level and that performance and risk were not always managed well. There was significant failures in audit systems and processes, in terms of both identifying and mitigating risk. Some audits did not ask the correct questions in order to identify risk and therefore, actions were not taken.

Long stay or rehabilitation mental health wards for working age adults

Inadequate

The service did not operate an effective system to assess, monitor and mitigate risks relating to the health, safety and welfare of service users who may have been at risk. Where they existed, systems and processes were not effective in fully mitigating the risks found

The provider had an external pharmacy provider who completed monthly audits of the medication management processes and clinic room on Adarna Ward. However, we found that these audits were not effective in identifying issues and even when issues were identified, these were not always acted upon. “The provider had an external pharmacy provider who completed monthly audits of the medication management processes and clinic room on Adarna Ward. However, we found that these audits were not effective in identifying issues and even when issues were identified, these were not always acted upon. Furthermore, the provider completed their own internal medicnes audits, which were not provided at the time we asked for them but later provided as part of our factual accuracy process, but again these did not identify the issues we found during our inspection. The outcome of this was that during our inspection we found several issues relating to medicines and the clinic room.

This included the fridge temperatures being out of range on several occasions with no actions taken. The audit of the clinic room did not identify when the fridge temperature had been recorded as high. In addition, there was a large amount of out-of-date equipment in the clinic room, several by over 2 years which had not been identified by any relevant audit to mitigate the risk that service users may be given treatment with out-of-date medicine supplies.

There were gaps in recording of bowel monitoring for a person who was prescribed clozapine on Adarna ward. This should have been completed daily and we found bowel monitoring was completed ad hoc with gaps of up to 7 days.

We found that there was one incident on Adarna Ward where the respective responsible clinician had completed Section 62 urgent requests for two different people that were completed in June 2023 and were not on the people current T3 (A T3 certificate is used for authorising medical treatment where a person does not or cannot consent to treatment for mental disorder).Neither the medicines or the Mental Health Act Audits identified or addressed the length of the section 62 being in place or the issue of whether a timely request had been made to the second opinion appointed doctor service

In addition to this, staff were not always completing appropriate accurate, complete and contemporaneous records in relation to medicines administration on Adarna ward. During the inspection, we identified a serious issue with the likely falsification of medicine records by registered staff working for the provider. During the site visit we identified shortfalls in the recording of the administration of correct medicines at the right times for some people and took photographic evidence. These issues were raised with the provider during the inspection. The provider sent a response to our feedback and submitted additional evidence. On reviewing this submission, we identified that gaps in medicines records had then been completed by registered staff retrospectively on 2 occasions for 2 different people. This included one registered staff signing for medicines retrospectively but had not been administered by them. Due to the limited range of medicines audits that the provider carried out, we were not assured that their systems and processes would identify this issue ordinarily.

The provider was also not mitigating the risk of using both a paper and electronic records system simultaneously. Senior leaders told us that the most up to date copy of each person's risk assessment should be in both the electronic and the paper record. However, we found that 4 out of 4 risk assessments we reviewed on the electronic records system were different to the one we reviewed in the paper records. All 4 were out of date by several months and we did not see evidence that the records audits completed by the provider had identified this issue. This meant that staff working on the ward who did not have access to the electronic records system, were not able to see the most up to date risks relating to the people.

However, the service had a clear organisational governance structure. On a local level, the service held a business meeting and clinical governance meetings monthly. Issues from these meetings fed into a senior governance meeting that was attended by the registered manager. This meeting was part of the organisational governance structure that meant issues could be escalated to senior managers of the organisation.

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.

The service had a local risk register which had last been reviewed in January 2024. Risks on the register included the las CQC inspection rating, handover information on Adarna ward and issues with delivery of pharmacy stock.

Staff described feeling confident and able to raise any concerns or risks identified within the service to managers.

At our last inspection we noted that the service had not always made notifications to CQC when required. We found this issue to be resolved at this inspection as appropriate notifications had been submitted when required.

Information management

Staff collected analysed data about outcomes and performance.

There was both an electronic and paper record system. We observed staff using the electronic system and they were all comfortable and were able to easily find information when requested.

Managers had access to performance reports and data which supported them in their awareness of risks and in understanding areas requiring improvement.

Engagement

The service held weekly community meetings for people to give them the opportunity to provide feedback on the service or to raise any concerns or issues. Staff could also provide updates to people during these meetings.

The service had patient, carer and staff survey forms that could be completed and submitted anonymously. Managers received the results of these surveys and used the results to consider any improvements or changes that were required.

Managers shared themes from feedback and reflected on the survey results within team meetings.

Learning, continuous improvement and innovation

The service was not participating in any research, national audits or accreditation.

Long stay or rehabilitation mental health wards for working age adults

Inadequate

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The service did not provide safe care. It did not manage medicines, medicine fridges and medical supplies safely and risk assessments were not always complete. The service did not ensure that systems for monitoring compliance with the Mental Health Act ensured that people only received medicines which they had consented to, or which had been correctly authorised by a Second Opinion Appointed Doctor. The service was using both a paper and electronic records system, we found that paper records did not contain the most up to date risk assessments for people in 4 out of 4 records we reviewed on Adarna ward. Medicine records were found to have been filled in retrospectively by staff when gaps were identified at our inspection. Patients who required bowel monitoring due to risks aorund medication they were taking were not being monitored as required. Staff were not all bare below the elbow in accordance with the provider's own policy. The environment was not always clean, we found food on the floor, staining on furniture, cigarette ends in the lounge and some of the furniture was ripped. People did not always feel safe Adarna ward and some people told us they did not feel they could approach staff when they needed to talk, despite being on the ward for some time.

Regulated activity	Regulation

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment The service did not ensure that the environment met the needs of people residing in the service, including their sensory needs. The environment remained noisy despite work carried out to soundproof the ward. There was a lot of noise from the wards above and patients felt this was detrimental to their mental health. Alarms rang out on the ward when there was incidents on other wards, and silent alarms had not yet been installed. We raised this at our last inspection.

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 There was significant failures in audit systems and processes, in terms of both identifying and mitigating risk. Some audits did not ask the correct questions in order to identify risk and therefore, actions were not taken. The service did not operate an effective system to assess, monitor and mitigate risks relating to the health, safety and welfare of service users who may have been at risk. The service did not ensure that there were robust systems and processes that effectively identified and addressed service quality issues. This included contemporaneous care records, medicine management, ward environments, risk assessments and MHA documentation. In addition audits that were carried out did not always ask the correct questions to identify issues and the service had not recognised this. The provider did not ensure that they mitigated the risk of running a paper and electronic based system simultaneously, to ensure that all paper based records were the most up to date version.

Regulated activity	Regulation

This section is primarily information for the provider

Requirement notices

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

Treatment of disease, disorder or injury

Regulation 9 HSCA (RA) Regulations 2014 Person-centred care

Care plans were not always up to date, of sufficient quality and did not always contain enough detail.

Blanket restrictions were in place on the ward that were not recognised in the blanket restrictions audit. This included the complete ban of the use of ceramic cups. Patients had to knock on the office door to ask staff for cups and spoons and this meant they could not always gain access to a drink when they wanted one. The restriction had not been individually risk assessed and was a blanket restriction.

The staff were not always working in an autism informed way. Staff on the ward were noisy, shouting down the ward to each other and to patients. At times language used was not in keeping with an autism informed environment.

This section is primarily information for the provider

Enforcement actions

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
Treatment of disease, disorder or injury Assessment or medical treatment for persons detained under the Mental Health Act 1983	Regulation 17 HSCA (RA) Regulations 2014 Good governance You are failing to operate effective systems or processes to ensure compliance with the requirements of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014 You did not effectively operate systems to assess, monitor and mitigate risks relating to the health, safety and welfare of service users who may be at risk. Wherethey existed, systems and processes were not effective in fully mitigating the risks found. Action we took: Warning notice.