Cygnet Hospital Harrogate

Quality Report

23 Ripon Road
Harrogate
North Yorkshire
HG1 2JL
Tel: 01423 500599
Website: www.cygnethealth.co.uk

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

Ratings

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

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

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

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

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

Summary of findings

Overall summary

We rated Cygnet Hospital Harrogate as **good** because:

- The ward environments were safe and clean. The wards had enough nurses and doctors to meet patients' needs. Staff assessed and managed risk well and followed good practice with respect to safeguarding. Use of physical restraint had reduced and was only used when other interventions had been unsuccessful.
- 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 audits to evaluate the quality of care they provided.
- The ward teams included or had access to a range of specialists to meet the needs of patients on the wards. Managers ensured that these staff received training, supervision and appraisals. The ward staff worked well together as a multidisciplinary team and with those external to the hospital who had a role in patients' aftercare.
- Staff understood and discharged their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005.
- Staff understood the individual needs of patients. Culture on the wards had improved and patients were mainly positive about staff approach. They supported patients to make informed decisions about their care and maintain relationships with families and carers.
- The service managed beds responsively, making decisions based on the existing patient group to maintain a good ward dynamic for staff and patients. Patients were discharged promptly once their condition warranted this.
- The service was well led and the governance processes ensured that ward procedures ran smoothly. The managers had overseen significant improvements within the hospital.

However,

- Staff on both wards did not manage medicines safely. Medicine cards demonstrated errors and omissions in prescribing, administering and documenting medicines. Physical health monitoring after rapid tranquilisation was not always carried out appropriately. Information from incidents, risk assessments and risk management plans were not always triangulated effectively, and level of harm was assessed inconsistently.
- Care records were not always reflective of allied health professional input or actions that had been taken to monitor physical health care. Good practice in data management was not maintained; paper records did not clearly demonstrate when later amendments had been made, and agency staff made patient record entries using regular staff members' accounts. Paperwork processes were complex and time-consuming for staff.
- Patients reported that some staff could be abrupt. Interventions took place in patients' bedrooms as there was not a suitable alternative. Evidence of staff application of the Equality Act was not consistent.

Summary of findings

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Good

Cygnet Hospital Harrogate

Services we looked at

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

Summary of this inspection

Background to Cygnet Hospital Harrogate

Cygnet Hospital Harrogate is a 36-bed independent hospital which provides in-patient care for people over the age of 18 years who are experiencing mental health problems. Patients are admitted from across England and the hospital provides care and treatment for informal patients and patients who are detained under the Mental Health Act 1983.

The hospital had a registered manager and a controlled drugs accountable officer in place at the time of the inspection.

A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered persons have the legal responsibility for the service meeting the requirements of the Health and Social Care Act 2008 and associated regulations. An accountable officer is a senior person within the organisation with the responsibility of monitoring the management of controlled drugs to prevent mishandling or misuse as required by law.

The hospital had two wards:

- Haven Ward, a 19 bed acute admission ward for men and women;
- Sanctuary Ward, a 17 bed acute admission ward for women.

Cygnet Hospital Harrogate has been registered with the Care Quality Commission since 15 November 2010. It is registered to carry out two regulated activities:

- treatment of disease, disorder or injury;
- assessment or medical treatment, for persons detained under the Mental Health Act (1983).

The hospital has been inspected on five previous occasions. The last inspection took place in July 2018, the hospital was rated requires improvement overall, the safe domain was rated as inadequate; the effective, caring and well led domains were rated as requires improvement, and the responsive domain was rated as good. The hospital did not meet six regulations of the Health and Social Care Act (Regulated Activities) 2014:

- Regulation 9, Person-centred care. The service did not facilitate meaningful activities and therapy for patients seven days a week. Care was not appropriate to patients' needs or reflective of the hospital's statement of purpose.
- Regulation 10, Dignity and respect. Patients were not always spoken to with kindness when the staff were under stress. Staff did not always ensure the privacy of the patients as patient confidentiality was not upheld at nurses' stations.
- Regulation 12, Safe care and treatment. The service was not assessing the individual risk to the health and safety of patients on admission as most patients were placed on 15-minute observations. Staff and patients did not always have timely access to a doctor for medical help. The service was not doing all that was reasonably practicable to mitigate patient risks as observations were not being consistently carried out or recorded. Patients' allergy information was not consistently being recorded. The hospital was not ensuring that medicines were supplied in sufficient quantities to ensure the safety of patients or to meet their needs, patients reported a delay in receiving physical health medicines on admission. The service was not ensuring the safe management of medicines as they were not carrying out physical monitoring following the use of rapid tranquilisation in line with the provider policy.
- Regulation 13, Safeguarding service users from abuse and improper treatment. There were blanket restrictions in place on both wards that were not necessary to prevent, or not a proportionate response to, a risk of harm posed to or by the patients. Informal patients were deprived of their liberty upon entering the service as they were not able to leave the hospital building unaccompanied.
- Regulation 17, Good governance. The governance systems in place were not entirely effective. The service did not assess, monitor and improve the quality and safety of the services provided to patients through their auditing processes. The systems in place

Summary of this inspection

did not fully assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk following serious incidents.

- Regulation 18, Safe staffing. Sufficient numbers of suitably qualified, competent, skilled and experienced persons were not deployed on the wards, section 17 leave was cancelled and patients did not receive regular one to one time with their named nurse. Staff did not receive sufficient support within the clinical supervision structure.

We reviewed all of these breaches in regulation during the inspection. The provider had made significant improvements in all domains, but still needed to make improvements in relation to medicines management under Regulation 12. Medicines were not always prescribed, administered, managed or documented correctly and appropriately. Physical health monitoring following rapid tranquilisation was not consistently carried out in line with Cygnet policies.

Our inspection team

The team that inspected the service comprised of one CQC inspector and two specialist advisors, both of whom were registered mental health nurses.

Why we carried out this inspection

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

How we carried out this inspection

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

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

Before the inspection visit, we reviewed information that we held about the location and asked a range of other organisations for information.

During the inspection visit, the inspection team:

- visited both wards at the hospital, looked at the quality of the ward environment and observed how staff were caring for patients;
- spoke with six patients who were using the service;
- spoke with both ward managers and the clinical manager;
- spoke with 14 other staff members; including doctors, nurses, assistant psychologist, activity coordinator, volunteer and social worker;
- attended and observed one patient meeting and four multi-disciplinary meetings;
- collected feedback from 14 patients from 21 comment cards;
- looked at six care and treatment records of patients;
- looked at eight post rapid tranquilisation physical health monitoring forms and four restraint forms;
- carried out a specific check of the medication management on both wards; and
- looked at a range of policies, procedures and other documents relating to the running of the service.

Summary of this inspection

What people who use the service say

During the inspection we spoke with six patients and received feedback from 14 patients who completed comment cards.

Patients reported that they found the environment comfortable and clean. They said that there was a positive atmosphere and they felt safe on the wards. They were complimentary of the facilities and said that the food was of a very high quality.

Patients spoke mainly in positive terms regarding the staff, stating that they were “amazing”, “compassionate” and “caring”, and they felt that staff were invested in patients’ wellbeing. However, some patients said that staff approach was inconsistent, and while they were positive about the majority, some staff could be abrupt.

Patients reported that there was always a staff member available on the ward and that activities and leave had not been cancelled. Many patients were engaged in activities during the inspection and reported that they had enjoyed the therapy and activity groups and found these to be effective. They stated that activities were conducted seven days a week and they were able to inform the timetable.

Patients reported that they had been given information regarding their medicine and treatment choices and had been involved in these decisions. All but one reported that they had easy and timely access to a doctor.

Patients were given opportunities to give feedback on the service in surveys and within community meetings. They felt that they could report complaints or concerns without fear of repercussions. Patients who had made complaints said their feedback had been welcomed and they had received a response to their concerns.

One patient informed us that the positive staff approach that we observed during inspection was reflective of their experience throughout their admission, and that staff had not altered their behaviour in response to our visit.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Requires improvement 

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

- Staff across both wards had not correctly completed patient medicine cards; prescription information was not always completed appropriately and there were errors in the recording and administering of medicines.
- Staff had not consistently carried out post rapid tranquilisation monitoring in line with provider guidance. The service had not identified one patient's medicine administration as rapid tranquilisation.
- Two patients were not given medicine to manage their physical health needs as these were out of stock and had not been ordered in a timely manner.
- Two of the six risk assessments we reviewed had not been updated promptly in response to a change in risk, and two risk management plans had not been amended to include management of a change in risk. The service did not always categorise level of harm in a consistent way.
- There were data management concerns in some records. It was not clear in paper documents when amendments had been made or by whom. Agency staff did not have their own log in details to access electronic records and recorded entries on regular staff members' accounts. This posed a risk as it would not be easy to identify which member of staff had carried out which interventions.

However:

- All wards were safe, clean, well equipped, well furnished, well maintained and fit for purpose.
- The service had improved staffing levels and had enough nursing and medical staff, who knew the patients and received basic training, to keep patients safe from avoidable harm.
- Staff assessed and managed risks to patients and themselves and followed best practice in anticipating, de-escalating and managing challenging behaviour. Staff used restraint only after attempts at de-escalation had failed. The ward staff participated in the provider's restrictive interventions reduction programme.
- 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.

Summary of this inspection

- The wards had a good track record on safety. 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.

Are services effective?

Good

We rated effective as **good** because:

- Staff assessed the physical and mental health of all patients on admission. They developed individual care plans, which they reviewed regularly through multidisciplinary discussion and updated as needed. Care plans were personalised, holistic and recovery-oriented.
- Staff provided a range of care and treatment interventions suitable for the patient group and consistent with national guidance on best practice. They ensured that patients had good access to physical healthcare and supported patients to live healthier lives.
- Staff used recognised rating scales to assess and record severity and outcomes. They also participated in clinical audits, benchmarking and quality improvement initiatives.
- The ward teams included or had access to a range of specialists to meet the needs of patients on the wards. Managers made sure they had staff with a 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.
- 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 teams within the organisation and with relevant services outside the organisation.
- 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 supported patients to make decisions on their care for themselves. They understood the provider's policy on the Mental Capacity Act 2005 and assessed and recorded capacity clearly for patients who might have impaired mental capacity.

However:

Summary of this inspection

- Care plans did not effectively document the involvement of allied health professionals or reflect physical health care interventions.

Are services caring?

Good

We rated caring as **good** because:

- There were notable improvements in staff approach to patients on the ward and patients reported that most staff treated them with compassion and kindness.
- Patients had regular one to one interventions, activities and Section 17 leave with staff and reported that staff made time for them.
- Staff involved patients in care planning and risk assessments, and actively sought their feedback on the quality of care provided. They ensured that patients had easy access to independent advocates.
- They understood the individual needs of patients and supported patients to understand and manage their care, treatment and condition.
- Staff informed and involved families and carers appropriately and supported patients to maintain their relationships.

However:

- Some patients said that a small number of staff would speak to them in an abrupt manner.
- Some staff did not display a working knowledge of the Equality Act and care records did not refer to one patient in their preferred name and pronoun.

Are services responsive?

Good

We rated responsive as **good** because:

- Staff managed beds well. This meant that a bed was available when needed and that patients were not moved between wards unless this was for their benefit. Discharge would only be delayed for clinical reasons.
- The design, layout, and furnishings of the service generally supported patients' treatment, and communal areas had been decorated with murals. Each patient had their own bedroom with an en-suite bathroom and could keep their personal belongings safe.
- There were areas off the ward for patients to meet family and carers.
- The food was of a good quality and patients could make hot drinks and snacks at any time.

Summary of this inspection

- The service met the needs of patients who used the service. Staff helped patients with communication, advocacy and cultural and spiritual support.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team and the wider service.

However:

- Staff had to undertake one to one therapeutic interventions and physical examinations in patients' bedrooms as there were no other appropriate or dedicated spaces for this on the wards.

Are services well-led?

Good

We rated well-led as **good** because:

- Leaders had the skills, knowledge and experience to perform their roles. They had a good understanding of the services they managed and were visible and approachable for patients and staff.
- The hospital manager and clinical manager had led significant service improvements since the last inspection, and staff were positive about the impact of this.
- Staff knew and understood the provider's vision and values and how they were applied in the work of their team.
- Staff felt respected, supported and valued. Morale had significantly improved, particularly on Haven ward following the appointment of a new ward manager. They felt able to raise concerns without fear of retribution.
- Staff reported that the service provided opportunities for career progression and additional training.
- Our findings from the other key questions demonstrated that governance processes had improved at ward level and that performance was managed well.
- Ward teams had access to the information they needed to provide safe and effective care and used that information to good effect.
- Staff engaged actively in local and national quality improvement activities.

However:

- Patient documentation processes were complex and lengthy, costing staff time and leading to errors in documentation.

Detailed findings from this inspection

Mental Health Act responsibilities

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

Staff showed good understanding of the Mental Health Act 1983 and the Mental Health Act Code of Practice and could describe the Code of Practice guiding principles. All staff had completed the mandatory training module. The service had accessible policies and could seek support from their Mental Health Act administrator or managers if they required support.

Staff stored copies of patients' detention papers and associated records correctly and staff could access them when needed. At the last inspection we had concerns that section 17 forms (permission to leave the hospital) had not been completed correctly. At this inspection, we found all of the section 17 leave forms had been completed appropriately. Staff prioritised facilitating section 17 leave and said it would rarely be cancelled.

Patient detention paperwork was regularly reviewed and audited by the Mental Health Act administrator. The service also had a contract with a pharmacy who conducted weekly audits of patients' medicines cards to ensure compliance with the Act. Non-compliance with the Mental Health Act was discussed within integrated governance meetings.

Staff explained to each patient their rights under the Mental Health Act in a way that they could understand. Patient records demonstrated that patients had been informed of their rights within the appropriate timeframes. Informal patients were listed as having escorted leave at the last inspection, which was contrary to the Code of Practice. This was no longer the case at this inspection; informal patients understood their rights and the service displayed posters to tell them they could leave the ward at any time.

Patients had easy access to information about independent mental health advocacy and patients who lacked capacity were automatically referred to the service. The hospital had increased their access to advocacy and received support from an independent mental health advocate twice weekly.

Mental Capacity Act and Deprivation of Liberty Safeguards

Staff showed a good understanding of the Mental Capacity Act 2005. Training in the Act was mandatory for staff and 97% of staff had completed this. There was a clear policy on Mental Capacity Act and Deprivation of Liberty Safeguards and staff stated that they knew who to approach for support in applying the Act.

Staff assessed and recorded capacity on an ongoing basis and was decision specific. Capacity and consent to treatment was assessed as a multidisciplinary team at patients' weekly ward rounds and was clearly recorded. Staff reported that they always assumed patients had capacity and would support patients to make specific decisions for themselves. When a patient was assessed as not having capacity, staff informed us that they would take into account patients' wishes, feelings and culture. The service had links with an independent mental capacity advocate who attended the ward weekly to provide support to patients.

Overview of ratings

Our ratings for this location are:

Detailed findings from this inspection

	Safe	Effective	Caring	Responsive	Well-led	Overall
Acute wards for adults of working age and psychiatric intensive care units	Requires improvement	Good	Good	Good	Good	Good
Overall	Requires improvement	Good	Good	Good	Good	Good

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

Good

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

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

Requires improvement

Safe and clean environment

The wards were within a period building and the layout did not allow for clear lines of sight to observe patients in all parts of the wards. The service mitigated this by using observation mirrors and closed-circuit television which covered internal and external communal areas throughout the hospital.

Staff completed and regularly updated thorough risk assessments of the hospital areas. They had an environmental risk register that identified areas of concern with action plans attached or detailed existing measures that mitigated the risk. Each ward had a ligature risk map and ligature cutters located within the staff office. Some areas within the hospital contained ligature points (a ligature point is a place to which patients intent on self-harm might tie something to strangle themselves). In response to concerns from our previous inspection the bannisters in communal areas had been replaced, the service had also updated their ligature risk assessment to include the outside areas.

The ward ligature risk assessments had been updated in response to incidents on the ward with actions being implemented promptly by the hospital; such as the replacement of all patient en-suite doors, which had been completed on Sanctuary ward at the time of inspection and had been ordered for Haven. Incident forms had an action plan section to identify areas that the service could learn from. In response to an incident that had occurred during the month of inspection, an action had been created to update the ward ligature risk assessment; the clinical manager had emailed it as a lesson learnt locally as well as informing Cygnet at a corporate level.

Sanctuary was a female only ward and adhered to the guidance on eliminating mixed sex accommodation. Haven was a mixed sex ward and met the requirements outlined in guidance regarding mixed sex accommodation. Both wards provided patients with single rooms with en-suite facilities.

Managers and staff were aware of the requirements for same sex accommodation. Staff informed us that male and female bedrooms were placed on different ends of the main bedroom corridor, which was situated directly opposite the nurses' station. There was also a smaller separate corridor that we were informed would be reserved for either males or females depending on the gender split, this was supported by our findings during inspection. The ward had a designated female only lounge located on the female end of the corridor. The service had strict admission criteria for the ward to safeguard patients. The service could evidence that when safeguarding concerns had been raised they had discharged male patients to a male only ward, transferred female patients onto the Sanctuary ward, and put appropriate measures in place to safeguard patients while waiting for discharge. Patients who required greater observation or had higher vulnerability could be placed in bedrooms opposite the nurses' office, these bedrooms could be allocated to patients of any gender.

All staff carried personal infrared transmitter alarms. We were informed by staff that there had been an incident of a staff alarm not sounding because it had not been charged

overnight; this concern had been echoed within a corporate alert. The service had implemented an intermittent closed-circuit television review in order to check that alarms had been charged correctly, they reported that there had been no further incidents since that time. Patients had nurse call alarms within their bedrooms, there was evidence within patient records and incident forms of patients using these to summon assistance.

Both wards were equipped with accessible resuscitation equipment and emergency drugs that staff checked daily, as evidenced within records. Both ward clinic rooms were small and did not have room for an examination couch. Medicines were dispensed through a hatch. Haven's clinic room appeared to be overstocked, Sanctuary's was tidy and appropriately stocked. The controlled drugs were checked daily and signed for appropriately, including occasions when no controlled drugs were being stored. The fridge temperatures were checked daily and appropriate action had been taken when out of range, though Haven ward had not been checked on four occasions between August and October 2019.

Ward areas were clean, well maintained, well furnished and fit for purpose. All patients spoken with during inspection reported that the service was clean and comfortable. Some patients stated that communal areas, such as the patient kitchen, could be left untidy and that staff responded promptly to this. This was supported by observations during inspection, cleaning records were also up-to-date and domestic staff were visible on the wards. All staff had completed their infection control training and staff were observed to follow the provider's infection control policy, such as handwashing.

Safe staffing

The service had increased staffing figures since the last inspection. Between 01 July 2018 and 30 June 2019, the number of substantive staff on Haven ward was 24 and Sanctuary was 27, an increase of eight staff members overall. The level of sickness had reduced; both wards had sickness levels of under 3% for the period. Managers supported staff who needed time off for ill health. We were informed of times that managers had supported or encouraged staff to have a period of absence following incidents. The service continued to have a high turnover of staff, 18 members of staff had left the service in the same period. Various reasons for this were cited, including staff involved in pending internal investigations and staff leaving for promotions in alternative services. The service had run robust recruitment campaigns in order to replace those staff members. In July 2019 the hospital had reported five nurse vacancies and four health care assistant vacancies; at the time of inspection, two of the nurse positions had been filled and interviews for health care support workers were scheduled for that week.

The service had enough nursing and support staff to keep patients safe. The wards had enough staff on each shift to carry out any physical interventions safely and respond to incidents. At the last inspection it was felt that the wards were not adequately staffed to ensure safety on the wards. Since that time, Cygnet Hospital Harrogate had increased the number of staff allocated to both the day and night shifts on both wards, and consistently sought to staff the ward to a higher level than the figure indicated by their staffing matrix. Day shifts were allocated six staff and night shifts were allocated five; both day and night shifts were allocated two nurses. Managers calculated and reviewed the number and grade of nurses and healthcare assistants for each shift. They met daily to discuss staffing levels for that day and the upcoming week, planned activities on the ward and reviewed any incidents, to consider whether additional staff should be sought or whether the existing allocation could be redistributed to provide support.

Between 30 September 2019 and 03 November 2019, both wards maintained staffing levels in line with their staffing matrix and no ward was reduced by more than one staff, according to their preferred staffing levels, at any time. There were no instances when both wards were below their preferred allocation at the same time. Additionally, Sanctuary ward was often staffed over allocation. Seven staff were allocated to 20 day shifts despite having no patients on close observations during that period, evidencing that the ward manager could adjust staffing levels daily to take account of case mix.

The service continued to use high rates of bank and agency staff. Between 30 September 2019 and 03 November 2019 they filled 142 shifts with agency staff and 80 shifts with bank staff. Shifts were also filled using staff overtime and by bringing in staff from other hospitals within the Cygnet group. The ward managers had been counted in the numbers on some occasions as well, both were registered mental health nurses.

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

Good

At the last inspection there was concerns that high agency use had impacted upon patient care. The ward rotas evidenced that they sought agency staff that were familiar with the ward and block booked them to provide consistency. The service had also increased their bank provision since the last inspection. Managers made sure all bank and agency staff had a full induction and understood the service before starting their shift. We were informed by agency staff that staff had been accommodating and supportive, they reported that having a second nurse allocated to shifts had built their confidence on the wards.

A qualified nurse was present in communal areas of the ward at all times and most patients reported that staff were available and that they had regular one to one sessions with staff. The care records reviewed indicated that all patients had one to one engagement with multiple members of staff every day, staff also recorded when this had been offered but declined by the patient within the daily notes.

All of the patients spoken with reported that they had not had escorted leave or activities cancelled. This was supported within patients' care records as well as observation during inspection. Staff reported that leave could, on occasion, be cancelled as a result of ward acuity but that they would always endeavour to prioritise facilitating leave. They also stated that they tried to ensure as many patients were able to use section 17 leave as possible, meaning that duration could be reduced for some individuals, but ensuring that others' leave was still facilitated. Staff that worked in the therapy department were not counted in ward numbers and facilitated leave and activities. Patients were asked to bring any escorted leave requests to the morning meeting so they could be factored in to the shift. In the morning meeting we observed staff offer an escorted walk to patients who were new to Harrogate to be able to familiarise themselves with the local area. The ward manager for Sanctuary also informed us that they facilitated group walks some weekends.

The service had enough day-time and night-time medical cover and a doctor was available to go to the ward quickly in an emergency. The service hired three staff grade doctors and two consultants. At the last inspection, concerns were raised regarding the availability of doctors and their response time. The service had changed their doctor provision since this time and reported significant improvements. We were informed by patients and staff that they could access support from a doctor quickly. The service had altered their doctor on call provision and we were informed that doctors would respond to a psychiatric emergency within 30 minutes out of working hours, as per national guidance. The service incident data from 01 September 2019 to 31 October 2019 showed no recorded incidents of delayed access to medical assistance. The doctors were given mobile phones to ensure that staff could contact them promptly when they were not on the ward. The consultants were now employed by the service and were no longer locum staff, though two of the staff grade doctors were locum staff, one of whom worked part time.

Staff had completed and kept up-to-date with their mandatory training. All training modules had been completed by 92% of staff or more, including management of violence and aggression, immediate life support and health and safety. The mandatory training programme was comprehensive and met the needs of patients and staff. Managers monitored mandatory training and alerted staff when they needed to update their training. Staff spoken with during inspection were aware of modules that were approaching their renewal date and reported that training was easy to access. Ward rotas evidenced staff being given time outside of the staffing numbers in order to access training days.

Assessing and managing risk to patients and staff

During inspection we reviewed six care records. Staff completed comprehensive risk assessments for each patient on admission using a recognised risk assessment tool. Four of the records reviewed had been updated following any incident or change in presentation. One patient's risk assessment had not been updated to reflect a change in risk following threatening behaviour towards others on the ward. Another had been updated on 20 October 2019 and 28 October 2019, incidents had occurred on three occasions prior to the incident that was updated on 28 October 2019. All of the incidents were then reflected within the patient's risk assessment, but there had been a delay in it being added to the file.

Patient risk was assessed on an ongoing basis. Staff were notified of any updates during handover. The wards then conducted a multidisciplinary meeting with nurses, doctors and allied health professionals to discuss any incidents

that had occurred within the last 24 hours and changes in presentation. Risk was then also reviewed at the patient's weekly ward round. A new administrative role had been introduced to the hospital, they had recently begun auditing incident data to ensure that the information was recorded in patients' risk assessments and actions were recorded within patients' risk management plans.

All patients had a risk management section of their care plan, which identified three progressing levels of intervention. All but one record, which documented that the patient did not wish to be involved, reflected patient preferences. For example, that if restraint was required as a last-resort intervention, they would prefer that female staff carried it out. Additionally, not all patients had restraint listed as their highest-level intervention; one patient had theirs listed as an assessment of their access to leave. Of the six records reviewed, four had risk management plans that addressed the risks identified within their risk assessments. However, two had not been updated in coordination with new incidents that had been recorded within the patients' risk assessments.

At the last inspection there was concern that patients were not individually risk assessed when allocating patients' observation levels on admission. During this inspection all patients had a documented reason applied to the determined observation level appropriate to their care need. Staff told us that patients' observations could be increased by nursing staff but required review by a doctor to be reduced. At the last inspection we also noted that observation records were not completed in line with guidance. All patients' observation records were reviewed during inspection and had been completed correctly with no omissions. The service had introduced a regular audit of the observation records by the nurse in charge. Any errors were then reported as an incident. Between 01 September 2019 and 31 October 2019 there had been two recorded incidents of lapses in the observation procedures.

Staff applied blanket restrictions on patients' freedom only when justified and gave patients an explanation when this was in place. A number of blanket restrictions had been identified at the last inspection, all of these had been resolved appropriately; for example, there was no longer set times for smoking and both wards had access to cutlery and crockery. The hospital had a reducing restrictive practice group where restrictions were discussed. Blanket restrictions were also discussed within team meetings, where they were referred to as "rogue rules".

The hospital had an air lock at the entrance and both ward doors into the hospital building were usually unlocked. At the time of inspection one ward was locked temporarily to ensure patient safety and there was a sign on the door explaining this to patients. Informal patients knew that they could leave the ward freely and the service displayed posters to tell them this. Informal patients and detained patients that had been given unescorted leave were issued with yellow cards that they could present to reception in order to be let through the air lock. Reception staff were only present during working hours, ward staff would let patients through the air lock outside of these times.

The service had a list of prohibited items that were not permitted on the unit and they kept these items securely. This list was included in patient welcome packs and information was kept on the wards. Staff reported that they followed Cygnet policies and procedures when they needed to search patients or their bedrooms for prohibited items to keep them safe from harm. Staff searched patient belongings on their arrival to the ward. We reviewed the incident data from 01 September 2019 to 31 October 2019. the service recorded five occasions when they had conducted room searches. There was evidence within two incidents that staff had requested permission to search informal patients' belongings and acted in accordance with their decisions. Three other incidents did not specify whether permission to conduct the search was sought; one stated that the patient was told that staff would request that domestic staff open their safe if the patient did not open it for them, after which the patient complied. On all occasions room searches had been carried out in response to incidents.

Levels of restrictive interventions had reduced since the last inspection. They recorded fewer incidents of restraint within twelve months (169) than they had recorded in six months (191) at the time of the last inspection. Managers informed us that they hoped to reduce this further by engaging in the provider's reducing restrictive practice programme. Between 01 July 2018 and 30 June 2019 Haven

ward recorded 72 incidents of restraint involving 34 patients, 15 of which resulted in the use of prone restraint. Sanctuary recorded 97 incidents of restraints involving 72 patients, six of which resulted in the use of prone restraint.

The service had had three incidents between 01 January 2019 and 30 June 2019 in which staff had inappropriately used restraint. The service conducted investigations into these incidents and disciplinary action was taken where appropriate and lessons learnt were shared with all staff. Following these incidents, a member of management attended incidents to supervise and provide support. When a manager had not been present for an incident, the clinical manager reviewed the incident on the service's closed-circuit television system. Staff said that this heightened level of oversight had led to a hesitance in staff applying the use of restraint, which managers had observed when monitoring incidents. Managers provided staff with debriefs in order to address this and provide reassurance that incidents were being reviewed to ensure good practice, not to criticise individuals; both staff and managers reported that practice had improved since this time.

Restraint information was collated and reviewed within integrated governance meetings. Lessons learnt were then disseminated through team meetings and supervision, within which restraint was a standing agenda item. Staff and managers told us that they made every attempt to avoid using restraint, instead using de-escalation techniques, and restrained patients only when these failed and when necessary to keep the patient or others safe. We reviewed eight restraint records during inspection. Of these, two did not record whether staff or the patient had been offered a debrief. All had documented that verbal de-escalation had been attempted, except one, in which case it would not have been appropriate.

We reviewed seven records of rapid tranquilisation during inspection. There had been concerns raised at the last inspection regarding the completion of rapid tranquilisation forms. The service had implemented supervision and additional training to staff since that time and there were improvements in the documents reviewed. For example, respiration rate was being documented and staff were recording when patients had refused interventions. Three of the documents reviewed were completed correctly. However, there was still concerns with the other forms reviewed. One had continued monitoring the patient at hourly intervals when the patient had fallen asleep, but national guidance and the provider's policy states: "monitoring should occur every 15 minutes if the British National Formulary maximum dose has been exceeded or the service user appears to be asleep or sedated". One form had hourly intervals noted from 16:50 until 21:50, but monitoring had stopped at the 18:50 interval, with the later times crossed out, indicating that the time intervals had been completed in advance and not at the times that the observations had been conducted. The same form also stated that the "patient had been breathing normally for a period of four hours", though the latest interval documented was two hours following the medicine being administered. One record was delayed in conducting the hourly observation on three of the ten recorded intervals, by 55 minutes, 20 minutes and 15 minutes respectively. Another record was delayed by 15 minutes for the final observation.

In addition to this, there was one restraint form dated 07 October 2019 stapled to a post rapid tranquilisation monitoring form for the same patient from 04 October 2019. The incident report number had been edited on one form as it had been assumed that they referenced the same incident. This administrative error had not been noticed when reviewed by the administrator or the manager. Staff were unable to find the correct corresponding forms as post-rapid tranquilisation monitoring had not been undertaken for one of the incidents. We reviewed the patient's daily notes and it was documented that staff had been instructed by their manager that they were not required to carry out physical health monitoring after the administration of the intramuscular medicine as it was prescribed as "when required" medicine and not rapid tranquilisation. The National Institute for Health and Care Excellence definition of rapid tranquilisation is: "the use of medication by the parenteral route (usually intramuscular or, exceptionally, intravenous) if oral medication is not possible or appropriate and urgent sedation with medication is needed". On both occasions the patient had had medicine administered in response to an incident; as such, physical health monitoring should have been carried out. Additionally, if the medicine had been administered as "when required", clinical guidance still states that "close observation is required until fully recovered from sedation".

The hospital did not have a seclusion room and would seek to transfer patients who would require seclusion to a psychiatric intensive care unit. There was one incident

between 01 July 2018 and 30 June 2019 during which a patient was secluded on the ward while staff awaited police assistance. There were no quiet areas or reduced stimulus rooms on the wards and staff reported that they would aim to seclude patients in their bedrooms where possible, or an isolated area separate from the other patients.

Safeguarding

Staff knew how to recognise and report abuse and could give examples of how to protect patients from harassment and discrimination. All staff had completed safeguarding training, of the staff eligible for the higher level (level 3) training, 92.3% were up to date with their training. Staff knew how to recognise adults at risk of or suffering harm and worked with other agencies to protect them. During inspection, staff undertook safeguarding discussions about how they could utilise the assistant psychologist and social worker to put appropriate support in place for a patient that they had concerns about.

Staff knew who to inform if they had concerns and how to make a safeguarding referral. (A safeguarding referral is a request from a member of the public or a professional to the local authority or the police to intervene to support or protect a child or vulnerable adult from abuse. Commonly recognised forms of abuse include: physical, emotional, financial, sexual, neglect and institutional. Each authority has their own guidelines as to how to investigate and progress a safeguarding referral.) The service had an internal safeguarding lead as well as a corporate contact that they could approach for advice or support. The service had employed a social worker who assisted staff and patients with safeguarding.

Staff followed clear procedures to keep children visiting the ward safe. The service had two visitors' rooms located on the ground floor of the building, accessed via key fob, containing comfortable seating and games. Children were not permitted to enter the wards.

We reviewed the incident data from 01 September 2019 to 31 October 2019. The hospital recorded that they had approached the local authority safeguarding team on eight occasions for a range of different concerns, seven of these referrals were declined by the local authority as they did not meet its threshold. The remaining incident was suitable to be considered for safeguarding had been investigated and appropriate action was taken by the provider.

Staff access to essential information

All patient records were stored securely, either on the computer or within a locked office. Patient daily notes and care plans were recorded electronically and all regular staff could access them easily. Agency staff did not have access to the computer system, staff reported that regular agency staff members would be logged into a staff member's account and they would write their name at the start of their entry for the patient's daily notes. While this did reduce the administrative tasks for staff, allowing agency staff to use a staff member's account does not comply with good data management and there is a risk of entries being made without a clear audit trail to identify who has made them.

Patient risk assessments were completed within a word document which was not stored within the patient's care record, though their risk management plan was. Patient consent to treatment was documented alongside their medicine card. Patient care plans were printed and held in a paper record. Patient care plans could be transferred easily between different Cygnet wards, if patients were being discharged externally they would take their paper file.

The manner in which incident records were completed raised concerns. Incidents in which restraint and rapid tranquilisation were used created a large administrative task for staff. Staff were required to complete three paper documents plus an additional one if a debrief had taken place with patients or staff. They were then required to type the incident in the patient's electronic notes and make an amendment to the patient's risk assessment. Records were then checked by an administrator and a manager to ensure that they had been completed correctly. Changes were made to the forms. For example, a tick being crossed out and a separate box being ticked, or additional comments being added to the form. However, it was not always clear when these changes had been made and who by. There was one record in which amendments had been initialled by the person who had made them, but this was not a consistent approach. Having multiple paper records for the same incident also increased the chance of administrative error, as had happened when a restraint report from 07 October 2019 was stapled to a post rapid tranquilisation monitoring report from 04 October 2019.

Staff commented that incident recording was an overly complex process that took them a long time. Managers

were aware of this and had created an administrative role who checked the documentation to ensure staff had triangulated the information correctly. They were also in the process of creating an electronic incident reporting system that they hoped would make the process simpler and shorter for staff.

Medicines management

Staff had policies and processes to follow when administering, prescribing and storing medicines. Staff informed us that medicines were checked twice daily and discussed daily within the morning staff meeting. Patients told us, and records demonstrated, that patients were provided with advice and information regarding medicines. Patients were involved in a weekly medicine review within ward round, they could also request to speak to a doctor within the week. Staff told us that medicines could be ordered from their associated pharmacy weekly.

Staff reviewed the effects of each patient's medicine. Patients' physical health monitoring was carried out daily unless otherwise specified, a member of staff was allocated at the start of the day to conduct these observations. In the medicine cards reviewed, medicines had been prescribed to levels within the British National Formulary guidance and patients' behaviour was not controlled by excessive and inappropriate use of medicines.

Medicines were stored securely on the wards and according to manufacturers' instructions. Nurses checked the fridge temperatures daily, this had been missed on four occasions between 01 August 2019 and 30 October 2019 on Haven ward, but staff had documented that they had taken appropriate action when the temperature had fallen out of range.

A pharmacist visited the wards weekly to conduct an audit of the clinic room standards, medicine cards and compliance with the Mental Health Act. They produced a weekly report of any errors and areas for improvement. The service reported that between 01 January 2019 and 30 June 2019 the service had had 18 errors: seven administration errors, two errors during preparation, two medicine refusals, four prescription errors and three stock discrepancies. We reviewed the incident information for two incidents between 01 September 2019 and 31 October 2019 in which medicine had been incorrectly administered. On both occasions the doctor was notified and advice was sought, the patient was notified of the error and physical observations were carried out.

We were informed by managers that where medicine errors were attributed to a staff member, a reflective account was written and the incident was discussed through supervision with their line manager. Managers produced a monthly report which was discussed within governance meetings to explore any trends or additional actions that needed to be taken. Ward staff conducted a review of their medicine management within team meetings and engaged in reflective practice. Haven ward had introduced a new system whereby nurses were not to be disturbed by anyone while dispensing medicines, this was to reduce the possibility of medicine errors and instances of staff not signing patients' medicines cards correctly by removing distractions.

At the previous inspection we raised concerns that patient allergy information was not always recorded and that patients had reported that they had not had access to their physical health medicine. We reviewed 23 medicine cards during inspection, all had noted patient allergy information. However, there was still some concern over stock levels and the documentation of this. Two patients' physical health medicine had not been administered as it was out of stock, one on two occasions and one on seven occasions. The latter patient was recorded as having refused, but we were informed by a staff member during inspection that it had not been administered because the medicine, which was a controlled drug, was unavailable.

There were other concerns found within the patient medicine cards reviewed. Two patient cards had incidents whereby medicine had not been administered and not signed by the staff member. There was one card where medicine had been administered but not signed for on three occasions, and another card that had been signed but not dated. One had not been signed by the staff member on nine occasions where medicine was recorded as refused. One patient was administered medicine on two occasions when the prescription had not been signed by the prescriber and there was no start date recorded, this was raised to managers during inspection and an incident

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Good

form was created. Another patient was administered intramuscular medicine, but the medicine chart was unclear on the dose, and it should have been clarified prior to administering.

Track record on safety

Managers took part in serious case reviews and made changes based on the outcomes. The service submitted details of three serious case reviews between 01 July 2018 and 30 June 2019. One of these was a serious choking incident, one was the inappropriate use of restraint and the other was a near miss self-harm incident. All three were subject to an internal investigation and had informed changes within the hospital. For example, the investigation into the incident of a patient choking found that the patient's physical health form had not been completed on admission and there was no record of additional attempts being made to complete this with the patient. There had also been a perceived fault with the defibrillator, which was rectified by using an alternative defibrillator; however, it was later found that there was no fault with the machine and this may have been due to human error. In response, the provider stated that all staff should be trained in immediate life support, including health care support workers who had previously been trained in basic life support. They also reviewed the multidisciplinary team morning meeting to ensure outstanding actions are revisited every morning until they have been completed.

Reporting incidents and learning from when things go wrong

Staff knew what incidents to report and how to report them. Staff raised concerns and reported incidents and near misses in line with provider policy. We reviewed the incident data from between 01 September 2019 and 31 October 2019. In this time period the service had recorded 119 incidents. The service collected the incident details, action taken, outcome, severity, action plan and whether restraint was used and, if so, what type. Incidents were categorised into different types, such as self-harm, data protection breaches, medication errors, absconsions and violence to staff. Most of the incidents had been recorded clearly, with actions taken and an appropriate level of harm attributed. However, there were six incidents that had a lower severity level assigned that was not consistent with the level of harm recorded for similar incidents. Two patients had self-harmed with noted wounds; two patients required oxygen to be administered following a physical healthcare incident and one patient had seriously ligatured and lost consciousness. All of these were recorded as "no harm / negligible". Another patient had been admitted to hospital to have their appendix removed, this was categorised as "minor".

Managers investigated incidents thoroughly, utilising an investigator from elsewhere within the organisation where appropriate, and notified those involved of the outcome and provided feedback. Staff reported that they were involved in reviews and investigations. The service had a lessons learnt log which is sent electronically and printed out for the staff room and offices, to increase visibility. These were discussed further within team meetings and staff supervision. Staff were able to give examples of recent learning, such as ensuring that staff effectively monitor the contents of parcels that patients receive. Learning from incidents that had happened elsewhere within the organisation was also included in the information provided to the teams.

Staff reported that managers debriefed and supported staff after any serious incidents. Staff stated that they would also receive phone calls the following day and managers gave examples of times they had encouraged staff to take time off following serious incidents. Of the eight restraint records reviewed, all but two recorded whether a debrief had been offered to staff and patients. The month prior to inspection, the assistant psychologist had approached some patients to complete an analysis of the incident as patients were declining debriefs when they had been offered shortly after incidents. We were informed by the clinical manager that they hoped to introduce this analysis as the new debrief model and to train staff in how to implement it. They hoped that this would ensure patients were offered a second opportunity for a debrief and increase uptake.

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

(for example, treatment is effective)

Good

Assessment of needs and planning of care

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Good

During inspection we reviewed six patient records. Patient records were documented in both paper and electronic formats. Staff completed a comprehensive mental health and physical health assessment of each patient either on admission or soon after. Patients' physical health was regularly reviewed during their time on the ward. Two patient records evidenced patients being supported to have additional physical health tests completed and referrals to external services where necessary. The physical health care plan was not reflective of the interventions that had been carried out for one of these patients, it was recorded within their daily notes. Staff were carrying out interventions appropriately.

Staff developed a comprehensive care plan for each patient that met their mental and physical health needs. Care plans were reviewed as a multidisciplinary team within the patient's weekly ward round and were updated when patients' needs changed. Care records evidenced that a holistic range of patients' needs were being met and were recovery-orientated. All patients had input from allied health professionals, to address different aspects of their care needs. Staff were supporting a patient to access spiritual support within the community. However, while this was evident within the patient's notes, this was not reflected within the patient's care plans. Staff support for LGBT+ patients was also not reflected within care records; observations during inspection showed that staff used patients' chosen names and pronouns, but this was not mirrored within patient care records.

All of the care records included evidence of the patient's voice, with quotes and information about what support strategies they found to be useful. Some of the earlier paper copies of the care plans had been written on and amended by patients. One record had minimal amount of personalisation, staff had documented that attempts had been made to include the patient but they did not wish to be involved.

Best practice in treatment and care

All patients on both wards had their physical observations (blood pressure, pulse, respirations and temperature) taken daily; the hospital also had use of an electro-cardiogram machine. There was evidence of the pharmacists' side effect monitoring scale being used to monitor patients' responses to medicine. Where staff had identified a need for additional physical health monitoring; namely food and fluid, fasting blood glucose monitoring completed, and increased regularity of physical observations; these had been completed in line with the recommendations.

The service had made significant improvements to the treatment options available to patients. At the time of the last inspection the provider's statement of purpose did not match the care provided as the staff team did not contain any allied health professionals. The service was also not providing therapies and activities seven days a week, which was not in line with national guidance. Since that time, the service has hired a social worker and an assistant psychologist and were hoping to develop the allied health professional team further. The therapy department's provision had extended to cover weekends and ward staff were supported to carry out activities in the evenings, such as film nights.

Staff followed National Institute for Health and Care Excellence guidance to inform patients' treatment plans and medication options. Patients were assessed for suitability for support from members of the multidisciplinary team, including the therapy department, within their assessment and initial ward round and referred if appropriate.

The therapy department provided activities and therapies to patients seven days a week. The programme varied on a weekly basis, patients decided the week's itinerary in a planning and expectations meeting with the therapy department every Monday. Activities consisted of exercises such as creating sweet trees, self soothe boxes and teddies out of socks. Therapeutic interventions included anxiety management, breathing skills, mindfulness and crisis management. Patients that were not comfortable with attending activities in a group setting could also have one to one sessions, which were facilitated by the therapy department manager. Patients spoke very highly of the therapy department and of the positive impact that this had had on their recovery.

The social worker assisted patients with housing, financial and employment support. They also supported patients in maintaining relationships with family members and involving carers with their treatment planning. The assistant psychologist role had only been in place for three months and was still in development. They were involved in patient risk formulations and working with patients in a

one to one setting to have a deeper understanding of what had caused the risk to develop, sustaining factors and positive things that can act as a protective element. They were hoping to introduce some group work as well.

The service monitored patient outcomes using recognised rating scales, the Health of the Nation Outcome Scales and the non-forensic Mental Health Clustering Tool, for all patients admitted to the ward. At the time of inspection, the clinical manager was involved in a project to amend a monitoring scale utilised elsewhere within the organisation, to make it applicable to an acute ward setting.

Patients were supported to live healthier lives. They provided advice on weight management and the ways in which medicines could impact upon weight management. The service provided healthy meal options, and patients had access to healthy snacks, such as fruit. Patients were invited to take part in walking groups into town or to local gardens. The service also facilitated weekly yoga and fortnightly massage sessions within the therapy department.

Smoking cessation advice was displayed on notice boards. Advice and nicotine replacement was available to patients. There were two designated smoking areas, one was in a shelter at the front of the hospital and the second was within the enclosed courtyard. The service only reported one incident of a patient smoking indoors between 01 September 2019 and 31 October 2019.

Senior staff followed an annual audit programme to monitor the quality and safety of the service. Examples of audits included the management of violence and aggression, complaints, patient records, reducing restrictive practices, and rapid tranquilisation monitoring. Ward level staff also completed regular audits including observation records, and environmental audits. Each month, managers participated in an integrated governance meeting to discuss audit outcomes and review associated action plans.

Skilled staff to deliver care

The service employed a range of specialists to meet the needs of the patients on the wards. Disciplines within the hospital included mental health nurses, health care support workers, staff grade doctors, consultant psychiatrists, activity coordinators, therapy manager, assistant psychologist and social worker. Staff spoke positively of the impact that the increased multidisciplinary approach had had on patient care. The allied health professional input was under further review at the time of inspection; some staff suggested that the service would benefit from this expanding further to provide additional psychological input or an occupational therapist. At the time of inspection, managers had offered a former patient training to become an expert by experience for the service.

Managers ensured staff had the right skills, qualifications and experience to meet the needs of the patients in their care, including bank and agency staff. Staff said that they had also been supported to access further training, such as phlebotomy, all staff attended a four-day course regarding managing personality disorders, health care support workers were assisted to complete nurse associate training. Managers said that any training requested would be considered, they had recently sourced a course in wound care following feedback from staff. Staff said that if they wanted to pursue further qualifications and could demonstrate how it would benefit the service, they felt confident that the service would fund it. Staff who were pursuing further education were also supported, for example through flexible rotas and shifts. Two nurses were completing an NVQ level 5 in leadership and management in health and social care at the time of inspection.

Managers gave each new member of staff a full induction to the service before they started work. Staff were given a week on the ward supernumerary, during which they shadowed someone in post. New starters were asked to complete a self-assessment induction checklist that was then reviewed by the ward manager. Preceptorship nurses were given a corporate six-month training plan, which could be extended up to a year to ensure staff felt confident in all areas. They were assigned a nurse and provided with additional supervision from managers. The programme also gave the nurses opportunities to attend local programmes that gave guidance and discussed areas of interest. The service had links with local universities and supported student nurse placements. One of the preceptorship nurses we met during inspection had applied for the role following her student placement at the hospital.

Managers supported staff through regular appraisals of their work. The appraisal rates for Haven was 92% and 100% for Sanctuary. Staff gave us differing timeframes to describe the regularity of clinical supervision, we were

informed they took place monthly, every two months, quarterly and every six months in different interviews. The provider supervision policy states that all staff should receive clinical supervision on a monthly basis. The supervision records documented that clinical supervision rates were over Cygnet's target of 90% for both wards. The clinical manager conducted an audit of this to ensure that monthly supervision was maintained. Supervision could take different forms, including team meetings, debriefs as well as formal supervision. In order for supervision to be documented as completed, a record of the interaction needed to be completed and signed by the participants. At the last inspection we had concerns about the supervision process. While there was still some lack of clarity with staff regarding clinical supervision, staff reported that they felt supported by the current structure and could request additional supervision to be facilitated when they felt it was required.

Both the social worker and assistant psychologist received internal managerial supervision; they received clinical supervision from staff of the same discipline who worked at neighbouring Cygnet hospitals. The social worker reported that they had both internal managerial supervision and external clinical supervision monthly. The assistant psychologist received external clinical supervision fortnightly and internal managerial supervision quarterly. The therapy department conducted internal managerial supervision monthly. Ward doctors received supervision from the consultant psychiatrists, we were informed that this happened on an ad hoc basis.

Staff had access to monthly team meetings and could access team meeting minutes for meetings they had been unable to attend. Learning needs that had been identified for the staff group and opportunities for development were discussed within team meetings. Individual training needs were discussed within appraisals and supervision and staff were given the time and opportunity to develop their skills and knowledge. Managers recognised and addressed poor performance and were able to give examples of instances where they had provided support to manage this concern or followed disciplinary procedures in response.

Multi-disciplinary and inter-agency team work

Staff shared information about patients and any changes in their care at the start of each shift during handover meetings. The wards also conducted a daily multidisciplinary meeting Monday to Friday, all of the allied health professionals including the consultant psychiatrist attended the meeting to discuss incidents over the previous 24 hours, any changes in presentation and review patients' leave.

Staff held multidisciplinary meetings on week days to discuss patients and improve their care. For the ward rounds we observed, the consultant psychiatrist, staff grade doctor and a nurse were present, patients had been invited but only one was able to attend the full meeting. Allied professionals were not always able to attend if they were facilitating interventions, but reported that they would try to attend ward rounds for patients whose care they were involved in. The patients discussed on the day of inspection were all new admissions.

The hospital had links with other hospitals within the organisation and reported that they would support patient transfers where applicable, such as patients who required admission to a psychiatric intensive care unit. Some staff from a neighbouring hospital had been working on the unit as bank staff at the time of inspection. The hospital also maintained working relationships with external organisations, for example working with commissioners and community teams to support patients' plans for discharge.

Where the service was unable to address the patient's needs, we were informed that staff were able to refer to external services. Managers told us that they had good links with physical healthcare professionals. They had access to a local GP service and could request support from diabetes nurses and district nurses, who attended the hospital to discuss treatment options with staff and patients. Staff told us that when patients were admitted with long term physical health concerns, they would liaise with the patient's home team to ensure that they continued with the existing treatment plan.

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

Staff showed good understanding of the Mental Health Act 1983 and the Mental Health Act Code of Practice and could describe the Code of Practice guiding principles. All staff had completed the mandatory training module. 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.

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Good

Staff stored copies of patients' detention papers and associated records correctly and staff could access them when needed. At the last inspection we had concerns that section 17 forms (permission to leave the hospital) had not been completed correctly. At this inspection, we found all of the section 17 leave forms had been completed appropriately. Staff made sure patients could take section 17 leave when this was agreed with the consultant and said that the duration of leave may be reduced, but it would be rare that it was cancelled.

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 administrator was and were able to ask them for support. When they were unavailable the service could also access support from an administrator at a neighbouring Cygnet hospital. Patient detention paperwork was reviewed by the administrator on admission and they conducted monthly audits of patient records to ensure they complied with guidance. The service had a contract with a pharmacy who conducted weekly audits of patients' medicines cards and their compliance with the Act, and produced a weekly report.
Non-compliance with the Mental Health Act was discussed within integrated governance meetings.

Staff explained to each patient their rights under the Mental Health Act in a way that they could understand, repeated as necessary and recorded it clearly in the patient's notes each time. Patient records demonstrated that patients had been informed of their rights within the appropriate timeframes. Informal patients knew that they could leave the ward freely and the service displayed posters to tell them this. Informal patients were listed as having escorted leave at the last inspection, which was contrary to the Code of Practice. Guidance on informal patients' rights was redistributed to staff by managers and this practice was no longer happening at the time of this inspection.

Patients had easy access to information about independent mental health advocacy and patients who lacked capacity were automatically referred to the service. The hospital had increased their access to advocacy and now received support from an independent mental health advocate twice weekly. We were informed by the ward manager for Sanctuary that the advocate had attended a community meeting with the patients that week.

Good practice in applying the Mental Capacity Act

Staff showed a good understanding of the Mental Capacity Act 2005. Training in the Act was mandatory for staff and 97% of staff had completed this. There were no Deprivation of Liberty Safeguards applications made between 01 January 2019 and 30 June 2019. There was a clear policy on Mental Capacity Act and Deprivation of Liberty Safeguards, which staff could describe and knew how to access. Staff stated that they would approach the hospital doctors, managers or the social worker for support in applying the Act.

Staff reported that they always assumed patients had capacity and would give patients all possible support to make specific decisions for themselves before deciding a patient did not have the capacity to do so. Staff assessed and recorded capacity to consent clearly and this was decision specific. Staff said that they assessed capacity on an ongoing basis and would discuss any perceived changes within the morning meeting. Capacity and consent to treatment was assessed as a multidisciplinary team at patients' weekly ward rounds. The capacity to consent to treatment form was attached to every medicines card reviewed during inspection.

When a patient was assessed as not having capacity, staff informed us that they would take into account the patient's wishes, feelings and culture. The service had links with an independent mental capacity advocate who attended the ward weekly to provide support to patients.

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

Good

Kindness, privacy, dignity, respect, compassion and support

At the previous inspection, concerns were raised regarding staff approach to patients when the wards were busy. Observations during this inspection showed a significant improvement. Staff were observed to interact with patients in a kind, respectful and natural way. Staff gave patients help, emotional support and advice. All of the care records reviewed detailed that patients had had regular one to ones with staff. One patient stated that "staff always make time for me when I've needed it".

This observed improvement in staff approach was reflected within three of the six patient interviews, patients stated staff were "caring and motivated" and another said staff were "always respectful and polite". The remaining three gave mixed feedback, describing some staff in very positive terms like "amazing", and others in more negative terms. One patient summed this up by stating "some staff are nicer to me compared to others, but it is improving". We received 21 comment cards from 14 patients, 12 patients made reference to staff attitude. Six gave universally positive feedback, and stated staff were "fantastic", "treated me kindly" and "made me feel so welcome". Four of the patients gave mixed feedback and said that "some staff were excellent" or "certain staff are outstanding" but that others could be "abrupt" or it "depends on their mood". Two of the patients that provided feedback in comment cards made only negative remarks about the approach of a staff member. Staff and patients reported that they felt confident to raise concerns to management and were able to give examples of when they had done so.

At the previous inspection there had been concerns about patient confidentiality being upheld. Since that time the service had created a new office space on Haven ward and made improvements to the Sanctuary office. Staff were observed to maintain patient confidentiality throughout the inspection. No patients raised concerns about staff discussing confidential information in communal areas. This was also mirrored within the community meeting we attended during inspection. When patients broached topics that may be of a sensitive nature, staff respectfully stopped patients from detailing the matter further and stated that they would discuss it outside of the meeting. Five of the patients spoken with said that staff always knocked before entering their bedroom, one patient said this had not happened on three occasions. During inspection staff were observed to knock on patient doors prior to entering the room to conduct observations.

All staff had completed their training in equality and diversity. Most staff spoken with demonstrated a good knowledge of the Equality Act and how to protect patients with protected characteristics from discriminatory or abusive behaviour. During one interview a member of staff did not use accepted terminology or describe an accepted approach regarding people with protected characteristics. When a staff member did not use a patient's preferred pronoun in the nursing office, staff confidently and appropriately challenged this. This was raised during feedback to the service, the staff member has since done additional diversity training. Staff on the ward were observed to talk to and refer to patients using their preferred names and pronouns. However, this was not reflected within care records. One patient's care plan and risk assessment had not been amended to reflect their preferred name or pronoun; and their daily notes alternated between different names and pronouns.

Staff understood and respected the individual needs of each patient including their cultural, social and religious needs. There was evidence within a patient's care record that they had been supported by staff to attend a local church service on multiple occasions. The hospital also had a multifaith room with religious texts and a prayer mat with compass. The service provided a variety of food to meet the dietary and cultural needs of individual patients. Patients were complimentary of the food choices and said the hospital catered to dietary requirements.

Involvement in care

Staff introduced patients to the ward and their services as part of their admission. They were given a ward orientation and provided with a welcome pack with the information in, so patients could refer back to it when they had had time to settle in to the environment. The social worker had produced an updated carers' leaflet providing information about the service, their processes, the area and what they can expect. Within the community meeting we observed, staff invited patients to participate in an escorted tour of the local area to orientate them to the town as well as the hospital.

The ward rounds attended during inspection detailed the patient perspective. Two of the four patients invited had attended their ward round, though one patient was discharged back to their local area so left early. Staff were observed to approach the patient with kindness and respect throughout and gave the patient time to give their perspective, their treatment preferences and their goals. Staff supported patients in discussions about their diagnosis and explained their medication and treatment plans. One patient's family relationships were discussed and consent was sought for their relative to attend the next meeting to be involved in treatment decisions.

Patients' perspective was evident in care plans and where it was not evident, it had been recorded that the patient had declined involvement. Staff were able to evidence that they

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

Good

had supported patients to ensure that care had been provided in line with their communication needs. One patient's Mental Health Act rights had been provided to them in three different languages. The service was also accessing an interpreter service to attend the patient's ward round.

The service did not support patients to create advanced decisions but did use advanced decisions that had been created prior to admission to inform care, where clinically appropriate. Patients had weekly access to an independent mental health advocate, one visited each ward and patient records evidenced that patients regularly met with them. Staff reported that they had increased carer involvement to advocate for patients' preferences if they did not have capacity to do so. They had introduced a new process that was reviewed within the morning staff meeting, there was now a checklist to ensure that carers had been contacted, where consent had been given by the patient. During inspection, staff were seen to contact a carer to discuss a patient's care and treatment and provide updates.

Patients could give feedback on the service and their treatment and staff supported them to do this. The most recent patient survey had been conducted in January 2019, the service scored highly within the organisation in areas such as feeling safe, the environment and trust in nursing staff. Staff involved patients in decisions about the service, when appropriate. At the time of inspection patients had been involved in decorating the corridor into the therapy department with a 'tree of hope', they had put their handprints and written a personal message of hope. We were also informed that patients had been invited to a meeting to discuss restraint reduction but it had very poor attendance. The service had an action point to introduce an expert by experience role and to invite them and carers to discuss ways to reduce restrictive practice. At the time of inspection, we were informed by a volunteer that they had been offered training to become an expert by experience for the service.

We were informed that the social worker had been instrumental in improving links with families and carers, and supporting patients in maintaining their relationships. All of the patients spoken with that wished for their loved ones to be involved in their care and treatment reported that they had been. Staff reported that one barrier to carer involvement was when patients were out of area, they tried to think of solutions to incorporating carers into treatment decisions. We were told that ward rounds had been rearranged to accommodate carers who were travelling long distances. On the day of inspection, a carer had been contacted by phone to ensure their perspective was included within ward round discussions. Family visits were observed to be facilitated on both wards and patient records demonstrated that detained patients were considered for escorted leave with family members where appropriate. During inspection the staff team were in discussions about referring a patient for family therapy to improve their family relationships following discharge. Staff also reported that they supported patients to move away from relationships if there were safeguarding concerns.

There was evidence that staff assisted patients with maintaining relationships within the service. For example, a patient's care record detailed that they had been considered for transfer to another ward, but had remained on Haven ward as they had developed strong working relationships with staff members, and it was felt that it was in their best interest to continue treatment there.

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

Good

Access and discharge

The average bed occupancy for Haven ward was 96% and Sanctuary ward was 94% from 01 January 2019 to 30 June 2019. The Royal College of Psychiatry states that optimum bed occupancy to deliver high standards of care in acute settings should not exceed 85%. Within this period the service had a high number of patients admitted from other parts of the country, with 218 patients having been admitted from areas more than 50 miles away. The hospital did not reserve beds for patients living in the 'catchment area'. The service informed us that they prioritised patient need over patient location and would accept patients from anywhere in the country if there was not a suitable bed for them closer to home.

The service had a part-time bed manager located within the hospital, they worked in conjunction with a nurse from one of the wards. Out of the bed manager's working hours,

the nurse allocated to bed management for that shift would take the lead of admissions and were able to seek advice from the on-call manager if they required additional support. Staff informed us that they felt supported to make a decision about patient suitability and did not feel any pressure to admit patients if they felt it would not be a suitable placement. During inspection we witnessed a nurse take a bed management call, they asked additional questions regarding patient risk and felt that the patient may not be suitable for the current patient group on the ward. They spoke with the ward manager and they supported the nurse in declining the patient's admission. At the time of inspection, the hospital had had a period of accepting clients with a lower presentation of self-harm, this was to allow the patient group and staff to recuperate following a period of higher acuity on the wards.

Managers regularly reviewed length of stay for patients to ensure they did not stay longer than they needed to. The average length of stay was low for both wards. Haven ward had an average length of stay of 25 days and Sanctuary's was 17 days. They recorded that no patients had had a delayed discharge between 01 January 2019 and 30 June 2019. The service had employed a social worker since the time of the last inspection, they had provided assistance with patients' housing, employment and finances. Staff planned patients' discharge and worked with care managers and coordinators. Discharge was discussed as a multidisciplinary team within patient ward rounds. In the ward round observed during inspection, patients were invited to be present (though two engaged in activities instead), carers were invited, and the patient's community mental health team were involved where applicable.

Staff supported patients when they were referred or transferred between services. Staff told us that patients would be moved to a different unit or discharged at a time most suitable for the patient. The exception being if there was a clinical need for them to be moved immediately or if they had been recalled to a local hospital, which the patient's home team would arrange, often at short notice.

Managers informed us that due to the short admission period of most patients, it was rare that overnight leave was facilitated. However, should a patient go on overnight leave, the wards did not use these beds for other patients, and there was always a bed available for patients should they return to the ward. Staff told us that patients would not be moved between the wards of the hospital unless clinically necessary to do so for the safety of the patient or other patients on the ward. For example, a patient had been transferred to Sanctuary when there had been a safeguarding concern raised while on Haven ward, and it was felt that an all-female ward would be a more appropriate environment for them.

The service had five patients who were readmitted back to the ward within 90 days of discharge between 01 January 2019 and 30 June 2019, all of these patients were on Sanctuary ward. Managers informed us that they would seek a psychiatric intensive care unit within patients' local areas but had links to wards within other Cygnet hospitals should patients require additional support. Staff reported that it was rare that they would have delayed access to these services and that the majority of patients would be transferred within 12 hours.

The facilities promote recovery, comfort, dignity and confidentiality

Each patient had their own bedroom with an en-suite shower room with toilet, which they could personalise with items from home. As most patients were on the wards for a limited period, many did not have a lot of possessions with them. Patient bedrooms had a safe in which they could store their personal belongings. Patients were also given keys to their bedrooms, which had been introduced following the previous inspection. The wards had a cordless phone that patients could take to their bedrooms to make phone calls in private. Haven ward had lost theirs the day of inspection and allowed a patient to use the office phone for a conversation with their care coordinator.

Patients told us the food was a very good quality and they were able to access food according to their dietary requirements. Patients had kitchens on the ward where they were able to make hot drinks and snacks at any time and were not dependent on staff.

Informal patients and detained patients risk assessed for unescorted leave were allocated yellow cards to give them access to outdoor areas. Since the last inspection the service had built a secure courtyard, this was only accessed under the supervision of staff. It was utilised for patients who were a risk of absconsion to be able to have access to fresh air and for patients to use in the evenings if they wished to, as the hospital grounds and the smoking shelter joined a busy road and a lot of pedestrians passed in the evenings.

The communal areas of both wards had been decorated with high quality murals by an artist who had links with the service. At the time of inspection, they were painting a corridor on Sanctuary ward. They had approached patients within the community meeting to get their input into the design. A 'tree of hope' had been painted on the corridor up to the therapy department that had hand prints with patient messages of hope written on them. The artist hoped to decorate the courtyard once the mural on Sanctuary was completed.

Neither of the wards had a quiet space for patients to access or utilise for one to one interventions with staff. Haven ward had a ladies' lounge, but interventions were discouraged to take place there and it was only available to female patients and staff. We were informed that interventions with staff took place in patient bedrooms. Neither clinic room was large enough for an examination couch so physical examinations, when necessary, also took place in patient bedrooms. Staff reported that they had raised the lack of therapeutic space on the ward as a concern but it had not been actioned. This had also been raised as a concern at the last inspection, and while there had been substantial improvements to the ward environments, it had not been addressed at the time of inspection.

The hospital had a dedicated therapy space, this was situated off the wards. Music played throughout the day and had space for group therapies and one to one therapies. The service was in the process of changing one of the offices in the department into a space that could be used for one to one interventions with the assistant psychologist and social worker as there was no dedicated space for this at the time. The service had two rooms where patients could meet with visitors in private. These were situated off the ward and also served as meeting rooms for multidisciplinary meetings and tribunals. We were informed that the allied professionals occasionally used these for patient interventions when they were available.

Patients' engagement with the wider community

Staff supported patients with activities outside the service, such as work, education and family relationships. The social worker assisted patients in accessing work and education opportunities and developing contacts. They attended patients' ward rounds where applicable to discuss the patient's requirements and how they would be able to assist them with their needs.

Staff supported patients in orientating them to the local area and facilitated local walking groups. There were leaflets and posters in communal areas and patient induction booklets gave information about local services, such as support groups. Staff reported that due to the limited duration of stay and the number of out of area patients the ward supported, patients rarely engaged in these types of services, and staff more regularly assisted patients to access a local gym and church.

Meeting the needs of all people who use the service

The service could support and make adjustments for disabled people and those with communication needs or other specific needs. The hospital had disabled access. Sanctuary was on the ground floor and there was a lift to Haven ward, which is situated on the first floor. The lift required a fob to enter and could be accessed by staff when required. The hospital placed female patients with mobility difficulties on the ground floor. There were restrictions within the admission criteria to discount male patients with mobility concerns, to ensure the hospital complied with fire regulations.

Staff made sure patients could access information on treatment, local services, advocacy services, their rights and how to complain. The service was able to provide treatment information and leaflets in alternative languages and had access to interpreters and sign language services. At the time of inspection, a patient required translation services, their Mental Health Act rights had been provided in English and two other languages at their request. The ward had also requested the presence of an interpreter for the patient's next ward round. They had done this at the request of the patient and against the advice of the patient's commissioners, who had said the patient had a strong understanding of English.

Patients had access to spiritual, religious and cultural support. Staff reported that they supported patients to access a local church and synagogue. There was evidence within a patient's care record that they had been accompanied by staff to local church services within the community. The hospital also had a multifaith room with religious texts and a prayer mat with compass. This had recently been moved out of the main building to allow for renovations of the therapy department, but staff informed us that there were plans to move it back into the main building once work was completed. The service provided a variety of food to meet the dietary and cultural needs of

individual patients. Patients' welcome booklets had information about how to access a local LGBT+ group, local religious organisations and support groups within the community.

Listening to and learning from concerns and complaints

Patients knew how to complain and raise concerns. The service displayed how to complain in communal areas. Staff encouraged patients to raise any concerns or feedback during the weekly community meetings, which staff as well as ward managers attended wherever possible. Staff understood the policy for complaints, they knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint. Staff spoken with demonstrated a good understanding of the duty of candour. This was also demonstrated within incident information, which listed that patients had been notified and apologies were given following medicine errors.

All patients spoken with stated that they felt safe to raise any concerns with staff, one stated "staff welcome it". Three of the six patient spoken with during inspection reported that they had made complaints during their admission. Two stated that they had received an appropriate response from management, one felt that their complaints had not been consistently listened to by the ward manager. Staff reported that patients who raised concerns or complaints were protected from discrimination and harassment. Those who had made complaints felt that they would feel safe to raise further complaints with the service.

Most complaints were raised as low-level concerns and dealt with locally, without being logged as a formal complaint. The organisation's complaint structure requires that the patient is asked whether they are satisfied with the outcome of the complaint. Any patients that were not satisfied with the outcome were then informed of how to escalate their complaint, this information was also available in posters on the wards. The service received four complaints in writing between 01 September 2019 and 31 October 2019. All were investigated appropriately, and the patients received feedback of the outcome and any actions that had been taken from the ward manager. Three were managed locally and documented as withdrawn, one was not upheld. In all cases it was noted that the patient was satisfied with the outcome. It was documented that staff who had been identified, discussed the complaint in supervision and general learning was shared within team meetings.

The service also discussed compliments within the integrated governance meetings. Between 01 September 2019 and 31 October 2019, they had received 12 compliments, in written and verbal format. Most of the compliments were regarding the care received on the ward and three made particular reference to the therapy department. All compliments received were shared with the staff members identified and successes were celebrated. All complaints and compliments were reviewed by the clinical manager and discussed within integrated governance meetings. Any themes or trends were shared with the corporate lead for improving patient experience.

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

Good

Leadership

Managers had a good knowledge of the service they managed and could explain clearly how the teams were working to provide high quality care. Managers had implemented significant improvements to the service and the quality of care provided since the last inspection. They were aware that there were still areas for improvement and had action plans in place to try to address these.

Managers had the skills, knowledge and experience to perform their roles. Managers used their knowledge base to improve staff knowledge and patient experience. For example, the Haven ward manager had been educated in treatment of patients with personality disorders and used this experience to assist staff in understanding the reasons behind patients' presentation and the appropriate way to respond.

Ward managers, the clinical manager and the hospital manager were visible in ward areas. Ward managers

attended multidisciplinary meetings and spent time on the wards with staff. Both managers had plans to move their office onto the ward area in order to increase this visibility further.

Staff gave universally positive feedback regarding service managers. The hospital manager and clinical manager had been determined and proactive in addressing the concerns raised at the previous inspection, and had led significant improvements within the hospital. Staff gave particularly complimentary feedback about the impact that the clinical manager had had on the service and staff team. There had also been a change in ward manager on Haven ward, and staff reported that this had led to improvements in morale and support on the ward.

Most patients spoken with gave positive feedback about managers and were observed to talk in a comfortable and familiar manner with them during inspection. However, there were some concerns raised by three patients regarding a senior member of staff.

Leadership development opportunities were available, including opportunities for staff below team manager level. Two nurses were being supported to complete an NVQ level 5 in leadership and management in health and social care. Staff appraisals included conversations about career development and how this could be supported. Managers had responded to feedback from health care support workers about a lack of development opportunities and supported staff to access nurse associate training. They also introduced three senior health care support worker positions on each ward. However, many of the staff members who had been offered this position went on to achieve additional promotions and had left the service. The hospital was looking to fill these vacancies at the time of inspection.

Vision and strategy

The provider had updated their core values in October 2018. These were:

- Care – We listen to each other and care for each other. We care deeply about everyone who is part of the Cygnet community.
- Respect – We treat people fairly as individuals. We understand the strength that lies in our diversity. We ensure people have the ability to support to make a positive difference.
- Empower – We empower people to make informed decisions and forge their own path. We encourage people to take every opportunity.
- Trust – Forming the basis of our therapeutic and working relationships we work hard to build and maintain trust.
- Integrity – Guided by a strong moral code, we act with the best intentions and for the right reasons; making person-centred decisions based on individual assessment.

Staff knew and understood the provider's vision and values and how they were applied in the work of their team. The values were visible on posters and computer homepages. Managers informed us that the values were integrated into the job roles and the importance of them was emphasised from induction; the managerial supervision structure also assessed staff against the provider's values. Managers used the terminology during interviews to discuss ward improvements. For example, the Haven ward manager stated that they wished to "empower" the nurses to make decisions; the clinical manager said that they had made difficult decisions in order to maintain the "integrity" of the service.

Staff were not involved in creating the organisation's values. We were informed that staff were told in an email that the organisation's values had been changed. The senior leadership team then conducted a road show to discuss them with staff. Staff reported that they were not involved in the provider strategy but did feel able to influence change at a service level. Staff reported that they felt management "listened", "respected" and "welcomed" their input into service development.

Culture

All staff reported that they felt respected and valued, including agency staff who reported that staff had welcomed them onto the ward. We were informed by staff of all grades that they felt that their opinions and feedback would be valued.

There had been a substantial improvement in staff morale since the last inspection, particularly on Haven ward. Staff reported that there had been improvements to the "culture" on the ward and that they received greater managerial support. All staff reported that they felt positive about working for the provider and their team, saying that they enjoyed their roles, and that it was a happy staff team.

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

Good

Some staff previously reported that they would not feel able to raise concerns. All staff spoken with during this inspection reported that they would feel safe to report concerns to managers without fear of retribution. Staff knew how to use the whistle-blowing process and information was available in staff areas to remind staff of this process.

Managers dealt with poor staff performance when needed, providing support to improve performance or taking disciplinary action where necessary. Staff and managers informed us that in response to an investigation into incidents of restraint being used inappropriately, staff had become hesitant when applying restraint techniques. Staff reported that managers acknowledged and addressed staff fears appropriately and provided support through debriefs.

The service ran a Christmas awards ceremony to recognise success within the service. Individuals were nominated for awards such as "biggest contribution to the hospital", which was awarded to the clinical manager in recognition of the number of improvement projects they had been involved in.

Staff reported that teams worked well together, that there was strong working between the different disciplines and that when they came across difficulties, managers offered support.

The service had low levels of sickness on the wards, both reported figures of under 3%. Staff were supported to take time off when ill or following difficult incidents. Staff reported that they were offered debriefs after serious incidents and that managers would call them to check on their welfare the following day if they were not on shift.

Governance

The hospital had systems and procedures to ensure that wards were safe and clean; that there were enough staff to maintain safe care and treatment and facilitation of patient leave and activities; that incidents were managed safely; that care plans were holistic and up to date; and that incidents were reported, investigated and learnt from.

There had been notable improvements to the quality of governance processes since the last inspection. Mental Health Act paperwork had been completed in line with guidance, consent to treatment was recorded appropriately, observation records had been completed in line with policy, and all mandatory training modules had been completed by over 90% of staff.

However, while there had been improvements to the quality of physical health monitoring post rapid tranquilisation, there was still omissions or errors in four of the seven records reviewed. Patients' medicines cards contained multiple errors and some prescribing information had not been completed appropriately. There was some improvement required in incident documentation to ensure level of harm was consistently assigned to incidents and that patient risk records were updated appropriately. Data management processes also required improvement to ensure that it was clear when paper records had been amended and who by, and to give agency staff an appropriate means of making patient entries, without using regular staff accounts.

There was a clear framework of what must be discussed at a ward, team or directorate level in team meetings to ensure that essential information, such as learning from incidents and complaints, was shared and discussed. Staff had implemented recommendations from reviews of deaths, incidents, complaints and safeguarding alerts at the service level.

The hospital had clear governance structures in place. Staff undertook or participated in local clinical and environmental audits. Managers sought the support of their administrator to collate information from the local audits to inform discussion within the monthly combined integrated governance meeting and medical advisory committee meeting. Managers monitored compliance with the local audits using an overarching local action plan; this collated required actions, the person responsible and an anticipated date for this to be completed by. Actions were red amber green rated according to level of completion in relation to the anticipated completion date. This document was reviewed within the local integrated governance meeting to ensure that audits had been actioned appropriately.

Analysis from local governance meetings was shared at regional meetings within the organisation, such as the regional clinical governance group, nurse practice development group and positive and safe group. Relevant learning was also shared with steering groups to inform ongoing areas of development and change. Combined

learning from the regional meetings was then fed into the corporate operational governance meetings and committees. Information was cascaded both up to the board level and back through to the ward level using this process. The local governance meetings had a standing agenda item to discuss the corporate lessons learnt log. The local governance minutes from June 2019 included information about a new risk disseminated from the corporate lessons learnt, and July 2019 included information disseminated at the regional nurse practice development group.

Staff understood the importance of working relationships being established with other teams, both within the provider and externally, to meet the needs of the patients.

Management of risk, issues and performance

Managers were able to make requests for funding to make environmental improvements to maintain patient safety. They had built an enclosed courtyard for patients to access, to limit the possibility of absconsion. They were also in the process of replacing all of the en-suite bathroom doors at the time of inspection, this work had been completed on Sanctuary ward and ordered for Haven ward. In response to feedback from the last inspection they had also remove the balustrades from the staircase in communal areas.

The hospital had a local risk register, which fed into the corporate risk register. One of the incident reports we reviewed had an action plan to escalate a new ligature risk up to a corporate level. The hospital manager and clinical manager were the only staff who had access to the local risk register. Staff told us they could submit items to the local risk register through discussions with managers. The local risk register had eight risks listed which were monitored within governance meetings monthly. The local risk register had been amended to include new ligature risk information following an update from the corporate risk register about an incident at a different Cygnet hospital. Senior managers could escalate concerns to the corporate risk register, after discussion with the corporate risk manager, and access this register for reference. The corporate risk register contained risks from multiple Cygnet locations.

Information management

Staff had access to the equipment and information technology needed to do their work. They had access to necessary physical health monitoring equipment, including an electro-cardiogram machine. Staff had access to enough computers to complete patient records. The telephone system worked well and staff were able to provide patients with a cordless phone that they could take to their room for private phone calls.

Staff maintained data confidentiality in relation to patient records, which were maintained securely. Staff recorded patient information in both paper and electronic format. The electronic recording system had only recently been introduced and did not allow for patient information to be collated easily in one place. For example, patient care records, risk management plans and daily notes were recorded within the provider's software. However, risk assessments and admission information was located within a word document stored separately in the ward's shared drive. Mental Health Act paperwork and documents relating to restraint, incidents, and physical health monitoring were kept in paper format.

Under the current format, staff were required to fill in three paper documents and update four electronic records, that were kept within two different computer programmes, for an incident involving restraint and rapid tranquilisation. This was a time consuming and burdensome task for staff. The main area that staff reported they wished to be improved upon, was the amount of time they spent completing paperwork. The senior management team were aware of staff frustrations with the technology. The clinical manager was part of a steering group that had implemented a lot of changes to the care record programme, such as changing the format to make the content more patient focused. Managers planned to make all patient records electronic and to implement an electronic incident recording system to streamline the process for staff.

The service was able to evidence that they made notifications to external bodies as needed. They also documented when referrals to local safeguarding structures had been declined.

The service had access to two ward clerks, a Mental Health Act administrator, a bed manager and two clinical administrators. One of the clinical administrators was new to role and had taken on some additional tasks to support the management team. They were responsible for collating

all of the key performance indicators and audit information required for review within the monthly integrated governance meetings. This task had previously been the responsibility of the clinical manager.

Engagement

Staff were informed about changes implemented by the provider and the services they used in team meetings and emails from management. Patients were notified of changes within community meetings.

Patients and carers had opportunities to give feedback on the service they received in a manner that reflected their individual needs. They were invited to take part in patient satisfaction surveys. Community meetings were held weekly and provided a forum for patients to give feedback on the service. The standing agenda items included: progress since last meeting, what was positive and what could be improved upon, ward-based activities and reducing restrictive practice. Senior service managers were visible within the hospital and ward managers attended the patients' weekly community meeting where possible. Patients and carers could meet with members of the service's management team.

Managers and staff had access to feedback from patients, carers and staff and used it to make improvements. They had "you said, we did" boards in communal areas. They gave examples of service developments that had been made, such as having activities over the weekends and evenings.

We were also informed that patients had been invited to a meeting to discuss restraint reduction, but it had had very poor attendance. The service had an action point to introduce an expert by experience role and introduce them and carers to discuss ways to reduce restrictive practice. At the time of inspection, we were informed by a volunteer that they had been offered training to become an expert by experience for the service.

Learning, continuous improvement and innovation

The hospital did not have Accreditation for Inpatient Mental Health Services at the time of inspection. Sanctuary ward had implemented Safewards and had many of the underlying principles and structures in place within the daily running of the ward; such as mutual expectations, a get to know me board and a "PRN box", which had different equipment in that patients could use to help ease their level of agitation prior to requesting "as required" medication. Safewards had been scheduled to be implemented on Haven ward but the senior health care support worker, who had been assigned as the Safewards lead, left the organisation, so a later training date had been arranged.

Managers were able to make requests for environmental improvements to be made in order to improve patient experience as well as patient safety. Requests were rated in order of priority, which would determine the timeline in which they could be introduced, so high risk items would be prioritised. However, the organisation had funded the creation of a larger office on Haven ward to support patient confidentiality. They had also supported the staffing figures being increased for each shift and the introduction of allied health professionals to the multidisciplinary team. Staff informed us that they had requested for a quiet room or intervention space to be created on the wards but that this had not been successful.

Staff were given the time and support to consider opportunities for improvements and innovation, and this led to changes. For example, staff had received a four-day training course in personality disorders and another course had been secured for a nurse to train staff in wound care in November 2019. The clinical manager was involved in a number of steering committees to improve care records and amend a patient outcome measure to suit an acute ward environment.

Senior nurses took part in an organisation-wide nurse practice development group, which provided an opportunity to share lessons and good practice. The service had secured positions for three nurses to take part in a nursing development programme, this was for preceptorship and registered nurses. It provided learning and guidance on care planning, managing challenging behaviours, specialist knowledge on treating patients who have autism, a personality disorder or learning difficulties.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure medicines are prescribed, administered and managed appropriately; that documentation is completed accurately, and that patients have access to all appropriate medicines during admission.
- The provider must ensure that physical health monitoring following rapid tranquilisation is carried out in line with Cygnet policies.

Action the provider SHOULD take to improve

- The provider should ensure that risk information is updated promptly and reflected within patient records, and that level of harm following incidents is classified consistently.
- The provider should ensure that patient care records are reflective of the care provided, detailing therapies received and physical health monitoring plans.
- The provider should ensure that they comply with data management guidance; ensuring that any later amendments to paper documents are clearly signed and dated, and agency staff are not making entries on regular staff computer profiles.
- The provider should ensure that all staff demonstrate a strong understanding of the Equality Act and that patient records are reflective of this.
- The provider should ensure that patients are able to have interventions in a setting other than their bedrooms.
- The provider should ensure that they continue with plans to make patient documentation a more concise process for staff.
- The provider should continue with improvements to the culture on the wards, to ensure that there is a consistent staff approach towards patients.

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 **How the regulation was not being met:** Care and treatment was not provided in a safe way for patients as staff did not consistently demonstrate the proper and safe management of medicine or post rapid tranquilisation physical health monitoring. **This was a breach of regulation (12) (2) (g)**