Cygnet Hospital Ealing

Quality Report

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

Ratings

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

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

Letter from the Chief Inspector of Hospitals

I am placing the service into special measures due to its failure to provide a safe environment for patients receiving treatment for eating disorders. We had previously issued the provider with warning notices (November 2018), but it did not respond robustly and was still in breach of the regulations when we returned on this inspection.

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

Professor Ted Baker

Chief Inspector of Hospitals

Overall summary

Due to the concerns we found during this inspection, we used our powers under section 31 of the Health and Social Care Act to take immediate enforcement action and placed a number of conditions on the provider's registration. This meant that the provider could not admit patients to Sunrise Ward until improvements had been made. The imposition of conditions also serves as a ratings limiter for the key questions of safe and well-led for the hospital overall.

We rated Cygnet Hospital Ealing as **inadequate** because:

- The provider was not delivering safe care. Patients were at high risk of avoidable harm on Sunrise Ward. Four patients had self-harmed during a two-month period when they were being observed on a 1:1 basis by staff. There were shortfalls in the management and recording of some medicines.
- Some nursing staff on both wards did not have experience and were not offered adequate training to enable them to care for patients with an eating disorder or personality disorder. The multidisciplinary team on Sunrise Ward had completed appropriate assessments and care plans, but the nursing team was too disorganised to implement them reliably.
- On Sunrise Ward some nursing staff spoke to patients in an off-hand manner and did not display kindness or compassion, although patients on New Dawn Ward said staff were kind.
- Sunrise Ward did not offer a therapeutic environment for patients with eating disorders Nationally recommended psychological therapies were not available and some nursing staff had no insight into how to work with patients around meal times and snacks. There was a lack of weekend activities on both wards.
- Some parts of the building were poorly maintained. For example, the patient alarms and the lift.
- The service was not well led. There had been a high turnover of senior staff within the hospital and, whilst posts had been covered for most of the interim period, this was impacting adversely on the nurse leadership. Staff on both wards reported instances of bullying. Patients on both wards complained about a lack of timely feedback when they raised any issues. The provider had appropriate systems in place to monitor quality and safety, but no one was systematically checking that they were being used or looking at what needed further follow up.

Summary of findings

- The provider had not made all the necessary improvements from the previous inspection in November 2018. The provider's self-assessment said that the work had been completed. We concluded that, although some improvements had been made to paperwork, this had not led to a consistent improvement in practice. This failure was linked to the ongoing leadership changes which meant that the oversight was not in place.

However:

- New Dawn Ward had a permanent ward manager in place and was better managed than Sunrise Ward.
- Most clinicians within the multidisciplinary team were working hard to build good working relationships internally and externally. They were using clinical tools and guidance appropriate for their professions on both wards and they were participating in clinical audits.
- Patients' mental and physical healthcare needs were assessed on admission and regularly monitored. Referrals were made to specialists when required.
- All permanent staff received annual appraisals and most staff received regular supervision, although it did not always cover all relevant issues.
- Discharges were well planned in conjunction with patients' local health and care teams.
- There was sufficient space for all the on-ward activities to be carried out; a range of rooms were available.
- Patients had access to independent advocacy and staff carried out their duties in line with the Mental Health Act and the Mental Capacity Act.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Specialist eating disorders services	Inadequate 	We rated the eating disorder service as inadequate because: The provider was not delivering safe care. Patients were at high risk of avoidable harm. Issues identified at our focused inspection in November 2018 had not been fully addressed. The provider had informed us that they were no longer in breach of the regulations, but this was incorrect although some improvements had been made in a few areas. The ward was not well-led. In particular, the management and oversight of the nursing team was very poor.
Personality disorder services	Requires improvement 	We rated the personality disorder service as requires improvement because: There were shortcomings with the physical environment, medical equipment and controlled drugs which were not well managed. Systems in place to monitor the quality of the service and drive improvements were not always effective.

Summary of findings

Contents

Inadequate

Cygnet Hospital Ealing

Services we looked at: Specialist eating disorder services, Personality disorder services

Summary of this inspection

Background to Cygnet Hospital Ealing

Cygnet Hospital Ealing, Ealing has two wards.

Sunrise Ward is a seventeen bed ward for women over 18 with complex eating disorder with co-morbid conditions. The service offers psychological therapies as well as support and care relating to physical and mental health. At the time of our inspection there were eight patients on the ward.

New Dawn Ward is a specialist service for women over 18 who have diagnosed personality disorders. It has nine beds and predominantly offers a dialectic behaviour therapy treatment model. At the time of our inspection there were eight patients on the ward.

Many of the bedrooms within the hospital are shared. We were informed that the provider is actively considering how to eliminate shared rooms.

The service is registered to undertake the following regulated activities:

- Care and treatment for persons detained under the Mental Health Act 1983
- Treatment for disease, disorder or injury

The Care Quality Commission carried out a focused unannounced inspection of Sunrise Ward only in November 2018. We inspected key questions in safe, caring and well-led. This inspection was undertaken in response to concerns raised by staff and patients. Following that inspection, we carried out enforcement action to ensure improvements were made to the safety and management of the service. We issued two warning notices in relation to regulation 12 (safe care and treatment) and regulation 17 (good governance) of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014. We did not re-rate the service as we only checked specific issues.

The service was in breach of regulation 12, safe care and treatment, because it did not have sufficient staff on duty to carry out one-to-one observations; there was a high use of agency staff; staff did not keep up-to-date and accurate records of patient care and treatment and one-to-one observations were not being recognised as a restrictive intervention.

The service was also in breach of regulation 17, good governance, because its governance systems were not effectively identifying issues or monitoring actions to improve the service. This was a continuing breach from the previous inspection.

The provider was also found to be in breach of regulation 10, dignity and respect. Patient and carer feedback indicated that patients were not consistently listened to or provided with compassionate care by all staff.

The Care Quality Commission last carried out a comprehensive inspection of this hospital in May 2017. At that inspection we rated the service as 'good' overall. We did not rate the ward for patients with a diagnosis of personality disorder as, at that time, we did not rate this specialist service. At that inspection the provider was found to be in breach of two regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulation 10, dignity and respect, as we received poor feedback about the quality of care for patients.

Regulation 17, good governance, because learning from incidents was not discussed in staff meetings and there was little evidence that issues raised in staff meetings or patient community meetings were used to drive improvements in the service.

The service did not have a registered manager at the time of inspection and there had been no permanent ward manager on Sunrise Ward for over a year.

Our inspection team

The team which inspected this service comprised of three CQC inspectors, one inspection manager, two assistant

Summary of this inspection

inspectors and two specialist advisors. One was a nurse with experience in eating disorders services and the other a nurse with experience in looking after people with a personality disorder.

Why we carried out this inspection

We inspected this service as part of our comprehensive mental health inspection programme and to follow up on the warning notices served in December 2018 and breaches of regulations from the November 2018 and May 2017 inspections.

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.

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 eleven patients who were using the service
- spoke with three carers for patients on Sunrise Ward
- spoke with the ward manager on New Dawn Ward
- spoke with the clinical nurse manager, regional operations director and interim hospital manager
- spoke with 28 other staff members; including consultant psychiatrists, doctors, nurses, occupational therapist, healthcare assistants, clinical psychologist on New Dawn Ward, assistant psychologist on Sunrise Ward, student nurses, group facilitator, administrator and social worker
- spoke with an independent advocate
- attended and observed two multi-disciplinary ward round meetings
- attended and observed one hospital morning meeting and a discharge teleconference for a patient on Sunrise Ward
- looked at eight care and treatment records of patients
- carried out a specific check of the medicine management on both wards
- looked at a range of policies, procedures and other documents relating to the running of the service
- observed a lunchtime meal and attended a post-meal support group.

What people who use the service say

During the inspection we spoke with 11 patients and three family carers. The family carers were for patients on Sunrise Ward. Feedback from patients was varied with a mixture of positive and negative comments about staff attitude and the service they received. On New Dawn Ward patients said staff were kind. However, two patients on New Dawn said that confidentiality was not always maintained by staff.

On Sunrise Ward, patients reported that some staff did not treat them with compassion and kindness. They also

Summary of this inspection

told us that staff fell asleep during one-to-one observations, their feeds were delayed and agency and bank staff made inappropriate comments about food and portion sizes.

All patients reported that concerns they raised at community meetings were not addressed in a timely manner.

We received mixed feedback from carers in relation to the attitudes of staff. Two carers told us that most staff were caring and kind, but one carer told us that some staff were abrupt in their manner on the telephone.

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The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Inadequate

The Notice of Conditions, served under section 31 of the Health and Social Care Act limits the rating that can be awarded for safe across the hospital as a whole.

We rated safe as **inadequate** because:

- There was a poor track record on safety on Sunrise Ward, with four incidents of patient self-harm taking place in two months when the patients concerned were meant to be under close observation. Due to the disorganisation of the nursing team on Sunrise Ward, we concluded there was an ongoing risk and took the step of requiring the ward to cease admissions immediately.
- Staff did not fully mitigate risks associated with the layout of both wards. Whilst there was a ligature risk assessment in place, there was a lack of clarity about responsibility for managing the risk of the ligature anchor points. Outstanding actions on the ligature risk assessment did not have specific completion dates.
- There were long-standing maintenance issues on New Dawn Ward with no date for repair. Patient alarms had been out of order for some time and patients said they could not easily call for help at night. The sluice room on Sunrise Ward was used as a storage cupboard for patient belongings so could not be used for disposing of human waste. Sunrise Ward clinic room was disorganised, some medical and clinical equipment was dispersed around the ward. This impacted on the timing of some patients' nasogastric feeds as staff struggled to find the equipment required. Some items were beyond their use-by date and the blood glucose machine had not been calibrated within the last year. The Sunrise Ward nursing office was chaotic, and this impacted on the ability of staff to find clinical and non-clinical information in a timely way. Information was dispersed between different systems and this was an issue on both wards.
- The service had enough nursing and medical staff, but the nursing team on Sunrise Ward was not deployed to best effect or well-inducted. There was high use on this ward of agency

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staff who may not know the patients. Staff turnover at the hospital was running at 22% which impacted on continuity of care and the level of staff experience in respect of the patient groups.

- Whilst the assessment and management of risk had improved on Sunrise Ward with robust written plans in place, they were not being implemented during one-to-one observations of patients so risks remained. Patients told us that staff frequently fell asleep.
- Nursing staff on Sunrise Ward did not follow the provider's policy on recording in relation to controlled drugs. There was a similar issue on New Dawn Ward; in addition, on New Dawn one of two oxygen cylinders was empty and emergency medicines were dispersed rather than kept in one convenient place; this could cause treatment delays.
- Sunrise Ward simply stopped using members of agency staff if they had been implicated in an incident in any way. There was no evidence of feedback to the agency or any wider learning opportunities for the staff team to reduce similar incidents in future.
- There was no evidence of the duty of candour being applied when a serious incident had taken place on Sunrise Ward, but this was not the case on New Dawn Ward.

However:

- Both wards were clean and well equipped. Shared bedrooms were in use within the hospital, but the provider was considering how to eliminate them.
- Over 83% of permanent staff on Sunrise Ward and 88% on New Dawn Ward had completed their mandatory training.
- There had been improvements in the recognition and review of restrictive interventions. Blanket restrictions were only used when appropriate. However, post-incident debriefs did not always take place as planned on Sunrise Ward due to the disorganised nature of the ward.
- Staff had training on how to recognise and report abuse. They were working with external bodies to identify themes and issues.
- Staff regularly reviewed the effects of medications on each patient's physical health.

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Are services effective?

Requires improvement 

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

- Whilst there was some good practice by individual staff members on Sunrise Ward, this was undermined because the ward did not provide a therapeutic environment for patients with eating disorders. Evidence-based recommended psychological therapies were not available on Sunrise Ward and the disorganised nursing team was unable to reliably deliver nasogastric feeds on time.
- Some members of the Sunrise Ward nursing team did not have experience or training in supporting patients with an eating disorder. For example, they lacked insight into the implications of not delivering feeds, meals or snacks in a timely way. Patients were left distressed and there was a risk to their health.
- Some staff on New Dawn Ward said they had not received any training in personality disorders; it was not included in the training provided.
- Nursing staff induction was minimal on Sunrise Ward, but more comprehensive on New Dawn Ward.
- Staff on New Dawn Ward avoided discussing personal matters in supervision as they were not assured of confidentiality.
- It was not always clear from the records whether clinical supervision included discussions that helped staff to maintain or improve their clinical performance had taken place.

However:

- Staff assessed the physical and mental health of all patients on admission. They developed individual care plans with patients, which they reviewed regularly through multidisciplinary discussion and updated as needed.
- A range of psychological interventions and support was available to patients on New Dawn Ward.
- Since the last inspection, the multidisciplinary team on Sunrise Ward had been joined by a dietician with experience in eating disorders, which increased the range of specialists that patients had access to.
- The multidisciplinary team on each ward had effective working relationships with staff from services that provided aftercare and engaged with them to plan patient discharges.

Summary of this inspection

- Some recommended clinical tools and guidance for working with patients with eating disorders were being used by relevant staff members and clinical audits were taking place with follow up action plans if required. The same applied to New Dawn Ward where patients with personality disorders were treated.
- Staff ensured that patients had good and timely access to physical healthcare and patients' physical health was regularly monitored.
- Permanent staff members received regular supervision.
- Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice and discharged these well. Staff explained patients' rights to them.
- Staff supported patients to make decisions about 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.

Are services caring?

Inadequate

We rated caring as **inadequate** because:

- Patients and former patients of Sunrise Ward independently told us some staff did not treat them with compassion and kindness. We noted the consistency of the concerns raised over the last ten months. However, patients on New Dawn Ward said staff were kind.
- On Sunrise Ward we observed that nursing staff communication with patients was perfunctory.
- Two patients on New Dawn Ward said confidentiality was not always maintained by staff.
- Patients complained they were bored at times, particularly at weekends when there were few planned activities.
- Patient feedback was invited on both wards but was not reliably responded to in a timely manner.

However:

- Patients' privacy and dignity on Sunrise Ward had improved; due to the low number of patients, no patients were sharing rooms and the use of male staff on one-to-one observations had reduced.

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- Staff on both wards involved patients in care planning and risk assessment. They ensured that patients had easy access to independent advocates.
- Staff informed and involved families and carers appropriately.

Are services responsive?

Requires improvement

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

- The service could not be relied upon to treat concerns and complaints seriously, to investigate them thoroughly and feedback consistently to patients and staff members. There was little analysis of complaints to identify and address themes.
- The hospital lift was subject to breakdowns which impacted on patients with mobility needs and those who were meant to avoid burning calories through exercise.

However:

- Staff planned and managed discharge well on both wards. They liaised well with services that would provide aftercare and Sunrise Ward staff were working with NHS England to overcome obstacles to discharge.
- Staff supported patients to external medical appointments and if they required admission to a general hospital.
- Patients' access to food and drink on Sunrise Ward was planned on an individual basis with the dietician. Patients on New Dawn Ward praised the food.
- Advocacy and cultural and spiritual support were available to patients.

Are services well-led?

Inadequate

The Notice of Conditions, served under section 31 of the Health and Social Care Act limits the rating that can be awarded for well-led across the hospital as a whole.

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

- The service was not well led. A newly appointed permanent hospital manager and ward manager had both decided not to take up their posts which meant the provider was still working to find replacements. An interim hospital manager and ward manager were in place but could not provide the long-term

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stability. This was impacting adversely on the nurse leadership and on Sunrise Ward the nursing staff were working in a chaotic manner and struggling to meet the complex needs of the patients.

- The provider had not made all the necessary improvements from the previous inspection in November 2018. However, their self-assessment said that the work had been completed. This failure was linked to the ongoing leadership changes which meant that the oversight was not in place.

- Staff knew and understood the provider's vision and values, but they were not consistently applied to the work of the Sunrise Ward team. They were better applied on New Dawn Ward.

- Staff on Sunrise Ward felt they were not respected, supported and valued. New Dawn staff felt the organisation did not value them. Some staff told us there was a blame culture within the hospital and individuals had been bullied.
- Our findings from the other key questions demonstrated that governance processes operated ineffectively at ward level and that performance and risk were not consistently well-managed.
- Sunrise Ward's nurses' office was very disorganised, so records were not easily found and could be hard to follow. The dispersed record system also meant information was hard to find on New Dawn Ward.
- Feedback from staff and patients was not always responded to in a timely way or at all.

However:

- Sunrise Ward had participated in a national accreditation scheme for eating disorders.
- There was good leadership within some professions.

Detailed findings from this inspection

Mental Health Act responsibilities

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

Staff had undertaken specific training related to the use of the MHA.

All necessary paperwork relating to the MHA was in order, including treatment authorisation forms. There was a MHA administrator at the hospital who had oversight of the administration of the MHA. They also provided advice and support to ward staff.

Patients received information about their rights under the MHA and could access the support of an Independent Mental Health Advocate (IMHA) if they needed to. Staff referred patients to the IMHA or patients could contact them themselves; their details were displayed for patients to refer to.

Mental Capacity Act and Deprivation of Liberty Safeguards

Staff had undertaken specific training related to the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS). At the time of our inspection, no patients were subject to authorisations of their deprivation of liberty.

Staff we spoke with had a good understanding of the MCA and were able to give us examples of how it was used in practice.

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Specialist eating disorder services	Inadequate	Requires improvement	Inadequate	Requires improvement	Inadequate	Inadequate
Personality disorder services	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement	Requires improvement
Overall	Inadequate	Requires improvement	Inadequate	Requires improvement	Inadequate	Inadequate

Inadequate

Specialist eating disorder services

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

Are specialist eating disorder services safe?

Inadequate

Safe and clean environment

Safety of the ward layout

- Staff carried out regular risk assessments of the care environment. Responsibility for this was assigned to a staff member during each handover.
- The layout of the ward meant that staff could not easily observe patients. The ward was on two levels. Staff assessed risks to patients and staff arising from the layout of the ward and mitigated these through individual patient risk assessment, the observation of patients and regular security checks. Closed-circuit television was in use in the corridors and communal areas. Where individual patients were identified as being at risk, increased observations, including one to one support were used.
- There were ligature anchor points on the ward and staff mitigated most of these risks adequately. The provider had completed a ligature risk assessment in November 2018. However, risks remained because outstanding actions did not have specific completion dates. There was also a lack of clarity about responsibility for managing the risk of the ligature anchor points. Some risks, such as bedroom radiator casings, were to be "managed locally", however the risk management plan did not specify how this would be done or who was responsible for this. Some information was not clear, for example, the assessment described ligature points in bedroom 1A, but the actions described related to bedrooms 7 and 9.
- Ligature cutters were available in the office. Staff knew where to locate them in the event of an emergency.
- The provider completed an annual fire inspection in November 2018 and a fire risk assessment in September 2018. The provider had completed all actions required. Staff carried out bi-weekly fire alarm tests. The provider had held a fire evacuation drill in December 2018.
- All staff carried alarms to summon assistance from colleagues if needed. We observed staff responding promptly to any emergency alarm calls. There were alarms in patients' bedrooms, however these had not been working for some time.

Maintenance, cleanliness and infection control

- Patients were provided with care in clean and hygienic environments. All areas we inspected were visibly clean, had good furnishings and were well-maintained. The ward had full time domestic staff.
- Cleaning records were up to date and demonstrated that the ward areas were cleaned regularly.
- Staff adhered to infection control principles, including handwashing. Disposable gloves, aprons and liquid gel were available on the ward. Staff carried out infection control audits to monitor and assess the risk from infection. However, we found that staff were not able to access the sluice room as it was overflowing with patient belongings, clutter and other items which had been stored. It was not clear where staff could dispose of human waste safely to prevent infection.

Clinic room and equipment

- The ward had one treatment room with a couch. Staff weighed patients, took bloods and inserted nasogastric tubes in this room. Equipment in the treatment room was visibly clean. All equipment except the blood glucose machine had been calibrated within the last year. This meant that staff could not be sure the blood glucose machine was working correctly.
- Emergency equipment and medicines were stored in the nursing office and checked regularly to ensure they were within date and fit to use.
- The ward clinic room was located on the ground floor. Staff stored and dispensed medicines from this room. The clinic room was untidy and disorganised, for example a substantial quantity of disposable medical equipment, such as swab kits, needles and water for injection were past their expiry date and were mixed in with disposable medical equipment which was not past its expiry date. This meant that there was a risk that items could not be located easily and that out of date supplies might be used in error.
- Clinical and medical equipment was dispersed in different rooms throughout the ward and this demonstrably delayed nasogastric feeding for some patients at scheduled times. For example, replacement drinks and nasogastric feeds were stored in the occupational therapy kitchen and treatment room. During our inspection we observed the nurse leave the ward to obtain a nasogastric feed from the occupational therapy kitchen. We found half a bag of feed in the treatment room. The member of staff reported that the patient would have the remaining feed later in the day.
- At the time of our inspection there were no hoists or other specialist equipment in use. Pressure-relieving mattresses and top-up mattresses were easily accessed for individual patients, if required, to prevent the risk of pressure ulcers developing.

Safe staffing

Nursing staff

- The hospital used a staffing matrix to estimate the number of staff required per shift. The tool identified the number of staff required according to the number of patients admitted to the ward. We checked the rota contained the required number of nursing staff and that the shifts had been covered. The written record corresponded with the requirements laid out in the matrix.
- On Sunrise Ward there were 11 whole time equivalent (WTE) registered nursing posts, and 22 (WTE) health care assistant posts. Two nursing posts and one healthcare assistant post were vacant at the time of the inspection. The clinical manager reported that the two nursing posts had been recruited into and start dates were due to be confirmed by the human resources department.
- There was a high turnover of staff. The hospital reported that 11 staff had left Sunrise Ward since March 2018. Staffing vacancies and the high use of one-to-one observations were identified as a concern on the hospital's risk register. The total staff turnover rate for the hospital between the period of March 2018 to February 2019 was 22%.
- The overall staff sickness rate during the 12 months leading up to our inspection was 4.7%. One member of staff was on long-term sick leave.
- At our previous inspection in November 2018, we found that there were insufficient qualified, experienced nurses on duty, who had the skills to work with patients with eating disorders. At this inspection we found that while there were sufficient registered nurses on duty they did not all have the skills to work with patients with eating disorders. For example, two patients reported that their nasogastric feeds were regularly delayed. The registered nurses did not understand the impact of this on the individual patients.
- Staff were not effectively deployed or supervised on the job. We heard from three staff that the ward was chaotic and the shifts poorly planned. Two staff reported that there were delays with the administration of nasogastric feeds. These delays then impacted on how the patients spent the rest of their day and caused them emotional distress. Patients had raised concerns about delays in the community meetings.
- At our previous inspection, we found that there were insufficient staff to carry out one-to-one observations. At this inspection we found improvements had been made. We reviewed staff duty rotas for the previous three months and found that sufficient staff were on duty to carry out one-to-one observations.

- Despite this, five staff reported there was a problem with staff accessing breaks, particularly when an incident had occurred. Two patients told us that staff appeared to be on one-to-one observations for up to five hours without a break. Community meeting minutes also detailed this area of concern from patients.
- Any staff shortages were responded to appropriately. The ward used regular bank and agency staff to cover shifts. A number of agency staff were on short term contracts so that continuity of care could be provided. Information provided by the hospital showed that 873 shifts had been filled by bank and agency staff for the period 1 December 2018 to 28 February 2019. The high numbers of bank and agency staff were due to the frequent use of one-to-one observations.
- Induction arrangements were in place for bank, agency and permanent staff but we found that one newly registered member of nursing staff had not been inducted to the ward, patients or other staff. This staff member had just been told to undertake on-line training and read files. This was not a robust introduction to the service and there was a risk that patients' individual needs would not be known and the staff member would feel unsupported.
- A member of staff was present with patients in communal areas at all times.
- Staffing levels allowed patients to have regular one-to-one time with their primary nurse. This was confirmed by patients we spoke with.
- Staff shortages rarely resulted in staff cancelling escorted leave. Leave was only cancelled if there was a change in the patient's presentation.
- There were enough staff to carry out physical interventions, such as restraint. During our inspection we observed staff from the other ward responding to emergency alarm calls on Sunrise Ward. This ensured that ward staff received additional support.

Medical staff

- There was adequate medical cover day and night and a doctor could attend the ward quickly in an emergency. There was one part-time consultant psychiatrist who worked four days a week, a full-time specialty doctor and a junior doctor who worked three days a week. Cygnet operated an out of hours on-call duty rota. A duty doctor could attend quickly in the event of a medical emergency. These doctors were associate specialists in mental health. Consultants were available on-call out of hours.

Mandatory training

- Staff had received and were up-to-date with appropriate mandatory training. Staff completed mandatory training in areas which included basic and intermediate life support; prevention and management of violence and aggression; food hygiene; infection prevention and control; information governance; health and safety; equality and diversity and the Mental Health Act. Compliance with mandatory training across the hospital was above 85% except for basic life support which was 83%.

Assessing and managing risk to patients and staff

Assessment of patient risk

- Staff completed a risk assessment for each patient upon admission and updated this regularly. Individual patient risks were discussed at daily handover, hospital meetings and multi-disciplinary meetings. Staff used a recognised risk assessment tool; the 'short term assessment of risk and treatability'.

Management of patient risk

- At our previous inspection, we found that patients' risk assessments and management plans and daily risk management plans did not reflect the current risk of the patient. At this inspection we found improvements had been made. The inspection team reviewed four patient risk management plans prepared by members of the multidisciplinary team. All four were up-to-date and reflected the current risk presented by the patient and the plans to mitigate the risks presented. Staff included details of the specific risks the patient presented in the risk assessments. For example, some patients presented specific risks in relation to water loading, self-harm and re-feeding syndrome.
- The multidisciplinary team identified and responded to changing risks to, or posed by, patients. For example, they were responsive in applying the Mental Health Act in respect of a patient who required nasogastric feeding due to the increasing risk of the patient refusing food, fluids and medicines. Staff met daily and discussed individual patient risk and management plans during

handovers and morning hospital meeting. The multidisciplinary team reviewed risk assessments using a traffic light system (red, amber, green). Some of this work was undermined by poor nursing practice.

- Patients were placed at risk of receiving unsafe care and treatment because nursing staff did not follow procedures for the safe observation of patients. In the nursing office the engagement and observation competency folder contained the names of only six healthcare assistants, confirming those people had read and understood the provider's observation policy. Yet the staff rotas indicated at least 15 agency or bank staff had worked on the ward in the previous three months.
- Five patients independently told the inspection team that nursing staff had fallen asleep whilst undertaking continuous observation of patients within the previous week. The observation records for three patients on the 11 June 2019 which should have been updated every 15 mins were not completed for two hours. On four occasions in March and April 2019, patients had harmed themselves whilst being continuously observed by nursing staff. The provider had decided not to use those agency staff again. There was no record of learning from these incidents or dissemination of learning to the nursing team to minimise future incidents of patients' self-harm.
- Staff applied blanket restrictions on patients' freedom only when justified. For example, bathrooms were locked during and immediately after mealtimes to keep patients safe and to meet their needs. This prevented patients from water loading prior to their meal or purging following their meal.
- There were policies and procedures for searching patients. Staff were able to describe changes that had been made to searching patients' post after a patient received contraband items in the mail.
- Staff adhered to best practice in implementing a smoke-free policy. The hospital did not permit smoking anywhere on the hospital site. The service offered nicotine replacement therapy to patients who requested it.
- Notices were displayed on the ward explaining to informal patients about their right to leave.

Use of restrictive interventions

- At our previous inspection, we found that staff on the ward did not recognise one-to-one observations as a restrictive practice, reviews of one-to-one observations were not documented and information from the hospital-wide clinical governance meetings regarding restrictive interventions was not shared in ward operational meetings. At this inspection we found some improvements had been made. Patient care records clearly documented the review of use of restrictive interventions. These were also reviewed in the multidisciplinary meeting and recorded.
- For the period 1 September 2018 to 28 February 2019 there had been 19 incidents of restraint involving five different patients. One of the incidents of restraint was performed in the prone position and had resulted in the use of rapid tranquilisation. When restraint incidents were reported details were given about the duration of the restraint and which position the restraint was performed in.
- We spoke with the restrictive interventions lead for the hospital who told us most staff had undertaken training related to reducing the use of restrictive interventions. This included the use of a 'pod'; a type of bean bag to ensure physical restraint was undertaken as safely as possible. Work was also taking place to ensure debriefing following incidents when restraint was used was more embedded into the way the service operated. Any restrictive interventions in use were reviewed daily with the multidisciplinary team.
- Staff were aware of and understood the provider's restrictive interventions reduction programme. The provider audited the use of restrictive interventions. Restraint incidents were discussed in the daily safety meeting.
- Staff reported that they used physical interventions as a last resort if verbal de-escalation failed.

Safeguarding

- Between 30 April 2018 and 30 April 2019 there were 17 safeguarding notifications received by CQC for the whole hospital.
- Staff were trained in safeguarding, knew how to make a safeguarding alert and did that when appropriate.
- Staff could give examples on how to protect patients from harassment and discrimination.

- Staff knew how to identify adults and children at risk of or suffering significant harm. Staff told us they would raise concerns initially with the nurse in charge or hospital social worker who would notify the local authority if the matter met the threshold for referral.
- Children were not allowed to visit the ward but could visit family in a friends and family room located on the ground floor.
- The provider had been working closely with the local authority safeguarding team and NHS England in relation to a number of safeguarding concerns raised by patients. These related to staff attitude, inappropriate restraint and self-harm incidents whilst under observation. The local authority was making enquiries about on-going themes in relation to people's safety.

Staff access to essential information

- The provider did not ensure that staff had easy access to all the essential information needed to deliver safe care and treatment. Staff kept a mixture of electronic and paper records; these were held in various places. During our inspection, due to the disorganisation of the nursing office, information was not easy to access. Staff spent a long time looking for information we requested, for example, the staff duty rotas. This meant that there was a risk that information needed to provide safe patient care was not immediately accessible.
- We saw nursing staff recorded patients' vital signs on paper. With the overflowing muddled heaps of paper in the nursing office we could not be confident that these were filed or uploaded to the relevant patient's record in a timely way. Medics told us they shared this concern.

Medicines management

- Patients were placed at risk of unsafe care and treatment because staff did not follow the provider's medicine policy in relation to the recording of controlled drugs. From 6 May 2019 until the date of inspection, there were at least 23 occasions when only one nurse had documented in the controlled drugs register that they had checked the stock balance, or administered a controlled drug, to a patient. This was not in accordance with the provider's medicines policy which required a second staff member to witness this. There was one occasion, documented retrospectively, when a patient was administered a controlled drug without any signature of a staff member. There were at least 10 entries in the controlled drugs register where stock balances of medicines had been changed, and not separately recorded or signed by a member of staff. The documentation of controlled drugs and the way errors were recorded did not minimise the risks of administration and was not in accordance with the legal requirements in section 20(c) the Misuse of Drugs Regulations 2001.
- The provider had an agreement with an external pharmacy organisation to supply medicines and pharmacy services to the hospital. We reviewed all eight medicine administration charts on the ward and found that patients received the right medicines at the right dose at the right time. The ward stored medicines securely in clinic rooms and recorded temperatures for medicine fridges and the clinic room itself. Medicine audits were carried out, however the audit process had not identified shortfalls with the recording of controlled drugs.
- Staff reviewed the effects of medicine on patients' physical health regularly in line with NICE guidance.
- All staff who administered medicines completed a competency assessment with the clinical nurse manager to ensure they could administer medicines safely, but some were still not following best practice in relation to controlled drugs recording.

Track record on safety

- Between 12 March 2018 to 5 February 2019, the service reported 13 serious incidents for Sunrise Ward. These related to self-harm (7), allegations of abuse (2), information governance breach (1), violence towards staff (1), unexplained injury (1), accident (1).
- The hospital clinical manager had oversight of all incidents, serious incidents and investigations, but there was little evidence to show how this information had been used to promote improvements.

Reporting incidents and learning from when things go wrong

- Staff we spoke with knew what incidents to report and how to report them. Incidents were reported using a paper-based system. They were then uploaded onto the electronic system.

Inadequate

Specialist eating disorder services

- At our previous inspection we found that staff working on the ward did not have opportunities to learn from incidents, audits, complaints and feedback to improve practice on the ward. At this inspection we found some improvement, but further improvements were required. We reviewed five completed serious incident investigation reports. We saw that issues were reviewed and some potential learning was identified. However, in two of the incidents, which related to patients harming themselves while on close observations, the members of staff had worked for an agency and had simply not been used again by the provider. It was not clear in the investigation reports that the agency had been informed and whether permanent staff had had the opportunity to learn from the incidents. This meant that processes to learn from incidents were not effective or embedded to improve the service.
- Staff reported they received feedback from the investigation of incidents, both external and internal to the service via a newsletter and staff emails. For example, following an incident at another Cygnet hospital, staff had moved the emergency equipment into the nurses' office for ease of access. After a self-harm incident on the ward staff were informed of a patient hiding a blade in their lip balm. However, we saw that where incidents had been investigated, they were not consistently raised in operational meetings at the ward level. For example, an incident which took place in April 2019, with an investigation completed in May 2019, was not discussed in the staff team meeting in June 2019. The investigation report recommended staff should be more aware of a specific risk and the implementation of a management plan to minimise the risk of recurrence. It was not clear how this information had been disseminated to staff working on the ward.
- We reviewed five completed serious incident investigation reports. The reports did not show whether the provider had applied the duty of candour which requires the provider to be open, transparent and give patients and families a full explanation when things go wrong. For example, in one of the incidents a patient had suffered significant harm. The hospital accepted responsibility in relation to the actions of an agency nurse, however, there was no evidence of an apology being offered to the patient.
- Four staff reported that they did not always receive a debrief after a serious incident. This was mainly due to the lack of nursing leadership, poorly planned shifts and the busy ward environment. This affected staff morale and left staff feeling unsupported, as they were unable to reflect on their experience and identify opportunities for improvement.

Are specialist eating disorder services effective?

(for example, treatment is effective)

Requires improvement

Assessment of needs and planning of care

- We reviewed four patient care and treatment records. Staff completed a comprehensive physical and mental health assessment soon after admission. Initial assessments were comprehensive, outlined the presenting problem, risks, physical health condition and plan of care.
- Staff assessed and supported patients with their physical health needs and worked collaboratively with specialists when needed. Comprehensive physical assessments were completed and plans for on-going monitoring of health conditions and healthcare investigations were developed. This included close and regular monitoring of blood samples, heart rate, pulse, urine tests, temperature, weight monitoring and electrocardiogram (ECG). An ECG checks the hearts rhythm and electric activity and is important to ensure patients receive the right medication. Bone density scans were completed for patients who needed them.
- Staff developed care plans that met patients' identified needs. Care plans were personalised, holistic, recovery-oriented and regularly reviewed. All patients we spoke with confirmed they were involved in the development and review of their care plan. Three out of the four care plans were updated. One care plan had not been updated to reflect the change in risk or Mental Health Act status.

Best practice in treatment and care

- People were at risk of not receiving effective care or treatment that met their needs. Staff did not always

provide a range of care and treatment interventions suitable for the patient group. Patients and staff described the absence of evidence-based psychological treatment to minimise patients' distress and risks related to patients' eating disorders and patients' self-harm. Eating disorder-focused cognitive behaviour therapy, psycho-education, eating disorder-focused psychodynamic therapy and cognitive behaviour therapy addressing patients' self-harm were not provided, although they are recommended by the National Institute for Health and Care Excellence (Self harm in over 8's: long term management, 2011; Eating disorders: recognition and treatment, 2017). Patients in the service did not receive support with understanding their distress, thoughts, behaviour and coping mechanisms.

- We received negative feedback from patients about the psychology provision on the ward. One patient reported that they did not have regular planned sessions, another reported they had requested a new therapist, a third patient reported that groups were regularly cancelled.
- However, we found that staff did use the 'Management of really sick patients with anorexia nervosa' (MARSIPAN) guidelines. The MARSIPAN tool is approved by the Royal College of Psychiatrists and Royal College of Physicians and helps staff to carry out safe re-feeding, risk management and monitoring.
- Staff ensured that patients had good access to physical healthcare, including access to specialists when needed. Staff worked closely with the general hospital. This included referrals to cardiologists, gastroenterologists and other specialists as required.
- Since the last inspection the service had appointed a dietician with a background in eating disorders. The dietician carried out a nutritional and hydration assessment for each patient on the ward to ensure that individual needs were identified and they prepared meal plans to meet them, this included nasogastric feeding when appropriate.
- Staff used recognised rating scales to assess and record the severity and outcomes for patients as their treatment progressed. For example, health of the nation outcome scales (HONOS), the model of human occupation screening tool (MOHOST) and the Eating Disorder Questionnaire (EDQ).
- Staff used technology to support patients effectively, for example, the medical team could access blood test results promptly.
- Multidisciplinary team members participated in clinical audit. Staff carried our regular audits on care plan documentation, risk assessments, nutrition, the care plan approach (CPA) and health and safety. When shortfalls were identified, action plans were in place to ensure that improvements were made.

Skilled staff to deliver care

- Staff from the full range of mental health disciplines provided input to the planning and delivery of patient care and treatment. This included, consultant psychiatrist, doctors, nurses, nursing assistants, occupational therapists, social worker, clinical psychologist and dietician.
- Not all staff had the right skills and knowledge to meet the needs of the patient group. For example, there was a lack of nursing leadership and psychological therapies provision was not in line with best practice guidance. Two patients told us they did not always receive their nasogastric feeds on time. From our observations we found that the nursing staff on duty did not understand the impact of delayed feeds and incorrect snacks on the patients.
- Many of the staff had worked at the hospital for a number of years and had experience of working with people with eating disorders. The consultant, specialty doctor and dietician had specialist expertise in working with people with eating disorders.
- Staff confirmed that they received regular clinical supervision sessions and an annual appraisal to discuss their learning and development, work performance and any issues they had in relation to their role at the service. The service reported that 96% of staff had received supervision between 1 March 2018 and 28 February 2019. We reviewed supervision records for three staff. Two out of the three records were brief and contained minimal information on training, clinical

practice or patient care. The quality of the supervision records was variable and there was a risk that supervision was not used to promote or develop clinical practice and skills.

- Staff reported that they did not have access to regular team meetings until recently. Staff reported that reflective practice sessions no longer took place and there was no opportunity to reflect on their work and learn from each other. We requested team meeting minutes from Sunrise Ward and were provided with six sets of minutes for meetings which had taken place since January 2019. There were no minutes provided for any meetings in May. Minutes were taken using a template which included items such as medicines management, incidents and lessons learnt. We saw examples of learning from incidents which had taken place in other Cygnet services and in an NHS trust.
- The percentage of staff that had had an appraisal in the last 12 months was 88%.
- All permanent registered nursing staff were specially trained to safely carry out nasogastric tube insertion and enteral feeding. Three agency nurses had also been trained to carry out the procedure. Despite this, patients told us their nasogastric feeds were often delayed.
- Staff working on the ward could access eating disorders training on-line. The provider offered a nursing preceptorship programme for newly qualified nurses and supported nurses with their revalidation.
- Poor staff performance was not dealt with promptly and effectively. Staff and patients had reported concerns about the poor behaviour and attitude of a member of the multi-disciplinary team which continued to impact on the ward.

Multidisciplinary and inter-agency team work

- At our last inspection, we found that there was a split in the staff team between nursing staff and other members of the ward multidisciplinary team. At this inspection some staff reported that there had been few improvements. For example, all disciplines now attended the multidisciplinary team meetings. Despite this, some staff and patients continued to report on the dysfunctional relationships within the multidisciplinary team and between the multidisciplinary team and the nursing team. An external facilitator had recently been brought in to address the rifts and improve team dynamics.
- Staff held regular and effective multidisciplinary meetings on the ward to review patient care and treatment plans, medicines, risk and discharge planning. Patients were invited to attend the meeting. We observed one meeting and saw that patients were provided with opportunities to feedback on their care, treatment and future goals.
- Staff shared information about patients at effective handover meetings within the team and at each shift change. The ward had a morning meeting each day which was attended by members of the multidisciplinary team. Key information on each patient was shared, including changes in patient presentation and risk. This ensured that all staff had up-to-date information on each patient so that they could be cared for safely. However, due to the disorganisation of the nursing team, they could not be relied upon to put this information to good use.
- Most multidisciplinary staff worked together and with other health and social care professionals to deliver effective care and treatment. Care co-ordinators attended regular care programme approach meetings. Staff reported that they had good relationships with the GP, commissioners and local authority social services. We observed a professionals' meeting in relation to discharge planning for a patient; this showed that all necessary staff were involved and it considered the individual needs and circumstances of the patient.

Adherence to the MHA and the MHA Code of Practice

- All staff had training in the Mental Health Act (MHA). Staff were trained in and had a good understanding of the MHA, the Code of Practice and the guiding principles. This was part of mandatory training.
- Staff had access to administrative and legal advice on the implantation of the MHA and its Code of Practice. Staff knew who their MHA administrators were. The service had a full-time corporate MHA lead who provided support for the MHA administrator at the hospital.

Inadequate

Specialist eating disorder services

- Staff had easy access to the MHA policies and procedures and to the Code of Practice. Policies were available on a shared drive where staff could access them.
- Patients had easy access to information about independent mental health advocacy. Patients told us advocates visited the ward regularly.
- Staff explained to patients their rights under the MHA in a way that they could understand, repeated it as required and recorded that they had done it. We saw evidence that patients signed to confirm they had their rights read and understood them.
- At our previous inspection, we found that Section 17 leave was not accurately reflected in patient records. At this inspection we found improvements. Individual leave arrangements were clearly recorded in patient records. Staff ensured that patients were able to take Section 17 leave (permission for patients to leave hospital) when this had been granted.
- Staff stored copies of patients' detention papers correctly and they were available to all staff that needed to access them. Patients' detention papers were stored in the patients' files.
- Staff completed quarterly MHA audits by selecting random files of detained and informal patients on both wards to ensure all paperwork and procedures complied with the MHA and Code of Practice.

Good practice in applying the MCA

- 100% of staff had completed training in the Mental Capacity Act (MCA).
- Staff had a good understanding of the MCA and the five statutory principles.
- There were no patients subject to the Deprivation of Liberty Safeguards (DoLS) at the time of our inspection.
- The provider had a policy on the MCA, including DoLS. Staff were aware of the policy and had access to it.
- We saw detailed capacity assessments relating to consent to treatment.
- The hospital social worker provided day-to-day advice to the staff team on the MCA.
- Staff supported patients to make decisions and always assumed they had capacity to do so in the first instance. When patients lacked capacity, staff made decisions in their best interests, which recognised the importance of the person's wishes, feelings, culture and history.

Are specialist eating disorder services caring?

Inadequate

Kindness, privacy, dignity, respect, compassion and support

- At our previous inspection, patients provided negative feedback about the service, in particular they noted poor staff attitude. This continued to be of concern during this inspection. Patients told us that staff had poor attitudes and they did not feel they were treated with dignity or respect. For example, one patient told us that staff were abrupt in their manner and would talk loudly in a patient's bedroom whilst they were trying to sleep. Two patients reported that agency staff made insensitive and inappropriate comments about portion sizes and the appearance of their food in front of other patients. They found this experience to be humiliating, critical and unsupportive. The service had recognised that this was an issue and had introduced a one-page document called 'the very minimum you need to know'. This provided quick guidance on how best to support patients at meal times. Bank and agency staff were expected to read this before supporting patients and sign to say they had done this.
- We noted that these complaints about nursing staff were very similar to concerns raised by former patients which had led to our focused inspection in November 2018. There had been remarkable consistency in what patients had told us over the last ten months.
- Throughout the inspection we did not observe nursing staff communicating with patients in a therapeutic manner to assess and minimise patients' risk behaviours. Nursing staff members' communication with patients was perfunctory and care plans were not reliably implemented.
- At our previous inspection, patients told us that they were concerned about male staff carrying out

one-to-one observations which meant that they had to ask for female members of staff to use the toilet. At this inspection we found improvements. We did not find this to be an issue during this inspection.

- At our previous inspection, patients reported they had been given no choice about who they shared rooms with and said their privacy was compromised when the patient they shared with needed one-to-one observation. At this inspection we found improvements, the service had introduced a protocol regarding the use of shared rooms. Where people required one-to-one observations they were not placed in a shared room. At the time of our inspection there were eight patients on the ward. None of them were sharing a room.
- Patients reported that the multidisciplinary team helped them understand and manage their care, treatment and condition. Patients were actively involved in planning their care and recovery goals. They participated in discussions about their care during multidisciplinary team ward rounds.
- Staff supported patients to access other services including physical health specialists. For example, during our inspection staff were actively supporting a patient to attend an appointment at a general hospital.
- All five patients reported that they did not feel safe on the ward. They described staff falling asleep on one-to-one observations. One patient reported they had managed to self-harm whilst they were on observations the previous week. We saw that there had been other similar incidents reported. While the hospital had carried out investigations it was not clear that learning had been embedded.
- Nursing staff did not always understand the individual needs of patients. They had not considered the impact of delayed nasogastric feeds and snacks and the effects of inappropriate comments about food for the individual patient.
- Staff said they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards patients. However, they were not confident that they would be listened to and action taken.

Involvement in care

Involvement of patients

- Staff used the admission process to inform and orient patients to the ward and to the service. Patients received a 'service user handbook' on admission. This provided information about the ward, the roles and responsibilities of each member of staff, therapies available, safeguarding and how to complain. One patient reported they were involved in revising the handbook with staff so that more information could be included. The service also had a brochure on their external website.
- Staff involved patients in care planning and risk assessment. This was clear in the care records and risk assessments we reviewed. All five patients confirmed they met with their primary nurse weekly to discuss their care plan and participated in multidisciplinary ward rounds.
- Staff did not involve patients in decisions about the service. While Cygnet had a 'People's Council' which sought to involve patients across the country, this was not a development that had reached Cygnet Hospital Ealing. This lack of input had been raised in previous inspections of the service. Patients were not routinely involved in developing the service on Sunrise Ward, for example, patients were not involved in staff recruitment. However, we found patients had been involved in developing the ward brochure. Previously the provider had told us they were recruiting a patient representative with experience of eating disorders in order to be more inclusive of this patient group. There was no news of this development.
- Patients could give feedback on the service at weekly community meetings chaired by an independent advocate. At our previous inspection, we found issues raised by patients during community meetings were not responded to in a timely manner. At this inspection we found that some improvements had been made but further improvements were required to ensure that patients' reasonable concerns were listened to and acted upon. For example, patients reported that snacks and feeds were delayed and staff members were being left on one-to-one observations for several hours without a break. Management response to the patients was that these issues were due to 'allocation planning' and no further action would be taken. This did not resolve the issues raised.

Inadequate

Specialist eating disorder services

- All patients had access to the support of an advocate, who visited the ward twice weekly to speak with patients.

Involvement of families and carers

- Families and carers were actively involved if patients wanted them to be. When patients requested their participation, family members were invited to ward rounds where they could contribute to decisions about care and treatment. We spoke with three carers following our inspection. They reported that there were no carers' groups or community meetings involving families and carers active on the ward. However, the service had produced a 'carers handbook' to provide carers with useful information in recognition that not all carers were locally based. The handbook contained information about eating disorders and names and contact details of the multidisciplinary team on Sunrise Ward. It also contained information on where carers could access support for their own needs, such as a telephone helpline or their local carers' forum. One carer told us that they had not received the handbook and had to ask for written information.
- We received mixed feedback in relation to the attitudes of staff. Two carers told us that most staff were caring and kind, but one carer told us that some staff were abrupt in their manner on the telephone.

Are specialist eating disorder services responsive to people's needs?

(for example, to feedback?)

Requires improvement

Access and discharge

Bed management

- From September 2018 to February 2019, the ward had an average bed occupancy of 90%.
- The average length of stay for current patients on the ward was 416 days. Two patients had been on the ward for over three years.
- There was always a bed available for patients returning from overnight leave. Patients were only moved if this was required on clinical grounds. For example, if they required admission to the local general hospital.
- When patients were moved or discharged from the ward, this happened during the day so that the necessary professionals and families could be involved.
- Following our inspection in November 2018, the provider voluntarily stopped admissions to Sunrise Ward in January 2019 in consultation with NHS England. These had recommenced in May 2019 as the provider had been assured by local management that improvements in the quality of care had taken place.

Discharges and transfers of care

- Staff planned for patients' discharge, including good liaison with their care co-ordinators and care managers, to ensure a smooth transition.
- Three patients were subject to delayed discharges. The delays were due to non-clinical reasons. The hospital was working closely with NHS England and local clinical commissioning groups (CCGs) to find suitable placements which would meet the individual needs of each patient. Two patients told us that they felt frustrated by delays in being discharged from Sunrise Ward. One patient told us that they felt that they were becoming institutionalised and were keen to move back into the community.
- Staff supported patients during referrals and transfers between services, for example, during our inspection we saw that staff went with a patient who was transferred to the local general hospital due to a deterioration in their physical health.

The facilities promote recovery, comfort, dignity and confidentiality

- The ward had three single bedrooms and the other bedrooms were each shared by two patients. At the time of our inspection there were eight patients, so patients did not have to share rooms with other patients. All bedrooms had en suite facilities.
- Patients could personalise their bedrooms and most chose to do so with photographs, pictures and personal items.
- Patients could securely store their possessions.

- The ward had a full range of rooms, including a clinic room, treatment room, dining room, lounge, activity rooms and meeting rooms. Patients could use the visitors' room to meet family and friends.
- All patients were able to make phone calls in private and had access to mobile telephones.
- Patients had access to a large balcony they could access with staff supervision to get some fresh air. The service facilitated short walks for patients, when appropriate, each day.
- Availability of drinks and snacks was considered on an individual basis and were agreed as part of patient meal plans.
- Patients could access a range of therapeutic and recreational activities during the week, some were facilitated jointly by the occupational therapist and assistant psychologist. However, all five patients told us that they were often bored due to the lack of activities offered at the weekends. Community meeting minutes we reviewed also reflected this feedback. Staff were not able to tell us what plans were in place to address this.

Meeting the needs of all people who use the service

- The service made adjustments for patients with mobility issues. The ward had a lift to ensure that people with mobility issues could access the ward. Whilst we heard from patients on New Dawn Ward that the lift was regularly out of order, patients on Sunrise Ward did not raise these concerns. Throughout our inspection we observed patients using the stairs rather than the lift. This enabled them to burn more calories and demonstrated to us that staff did not have a good understanding of eating disorders as there was no evidence that patients were encouraged to use the lift instead of the stairs.
- Staff ensured that patients could obtain information on treatments, local services, patients' rights, and how to complain. This information was displayed on notice boards.
- The information provided was in a form accessible to the particular patient group according to each patient's needs.
- Staff made information leaflets available in languages spoken by patients when requested.
- Staff could access interpreters or signers when needed.
- Patients had individualised meal plans prepared by the dietician to meet their dietary needs.
- Patients had access to spiritual, religious and cultural support and could access a multi-faith room on the ground floor. Patients who wished to access specific religious services were facilitated to do so as part of their care plan.

Listening to and learning from concerns and complaints

- The hospital's compliance assistant managed complaints for both wards. In 2018, the provider received 28 complaints for the whole hospital. Learning from complaints was included in the staff monthly newsletter. However, the provider did not have an overall analysis of the total complaints broken down by ward and themes. This meant that there was a risk that potential learning from complaints was not optimised to provide a better quality of service.
- Patients knew how to complain or raise concerns. Patients told us that they would ask the advocate to help with any complaints they wanted to make. Two patients had used the advocate to assist with their complaint. Information about how to make a complaint was displayed on the ward and was included in the patients' welcome pack.
- Staff on the ward did not handle complaints appropriately. Three patients told us they did not feel listened to by staff or management in relation to concerns or complaints they raised. One patient told us some staff were more responsive than others to complaints, they gave an example of a verbal complaint they had raised being dismissed by a staff member. Another patient had escalated their complaint to the hospital manager as they did not receive a response to their initial complaint from the interim ward manager. This meant that we could not be assured that complaints and concerns were addressed and responded to in a timely manner.
- At our last inspection, we found that staff did not routinely record informal complaints to obtain an insight into emerging issues. We found this was still the case during this inspection.

Inadequate

Specialist eating disorder services

Are specialist eating disorder services well-led?

Inadequate

Leadership

- The service was not well-led. There were concerns about the lack of provider oversight as issues and concerns identified at our previous inspection in November 2018 had not been fully addressed, despite the provider informing us they were fully compliant in addressing breaches of regulation.
- We found significant shortfalls in the nursing leadership on Sunrise Ward; this had impacted on the delivery of high quality care. There was an absence of visible and effective nursing leadership on the ward. There had not been a substantive ward manager for more than one year. There was an absence of leadership in regard to areas of work such as the organisation of the nurses' office and clinic room, managing naso-gastric feeds in a timely manner, promoting good practice in relation to one-to-one observations of patients and record keeping, including those relating to controlled drugs.
- There had been changes in the leadership within the hospital and on a regional level since our last inspection in November 2018. This had impacted on the quality of the service provided on Sunrise Ward. The hospital director no longer worked at the service. Prior to the interim hospital director starting work, the clinical services manager had been acting up as the hospital director in addition to their clinical nurse manager role. They also managed another small hospital site. This meant that there had been a significant period where there had not been sufficient supervision, support and oversight for the hospital during a period where significant challenges and concerns had been identified and raised, including two warning notices from CQC.
- The provider had started to make changes to the management of the hospital. An experienced interim hospital manager had been in post for five weeks at the time of our inspection, as had the regional operations director and interim ward manager. A new hospital director had been recruited and was due to start in July 2019 alongside a substantive ward manager. After the inspection we were advised that the prospective hospital director and the prospective ward manager had withdrawn so the hospital faced a continuing period of uncertain leadership. Staff and patients spoke positively about the small changes the interim hospital director had made. They said they felt listened to and found the post holder to be approachable.
- The consultant psychiatrist, who had been in post since November 2018, was actively working to improve the clinical model and was in discussion with NHS England regarding the service specification. They had also been working on the staff approach to the treatment ethos on the ward and had held service development groups so staff could discuss proposed changes.

Vision and strategy

- The provider's senior leadership team had successfully communicated the provider's vision and values to the frontline staff in this service. Posters were displayed throughout the hospital and information for staff was also available on the intranet.
- Staff knew and understood the provider's vision and values and how they were applied in the work of their team. However, the provider's values were not always promoted in practice. For example, we heard consistent feedback from patients that staff fell asleep whilst carrying out one-to-one observations and patients reported lack of involvement in the service and not feeling listened to. There was little evidence of values in action.
- Staff had the opportunity to contribute to discussions about the strategy for their service, especially where the service was changing. For example, at service development meetings led by the consultant psychiatrist.

Culture

- Staff did not feel respected, supported or valued. There was not a positive culture on Sunrise Ward; staff morale was low and staff reported there continued to be a bullying culture within the hospital. We asked the provider to investigate this when we gave verbal feedback at the end of the inspection. They advised that they would follow it up through their human resources department.

- At our previous inspection, we asked the provider to address the culture and morale within the ward team. This included improving multidisciplinary working relationships and promoting professionalism. At this inspection we found some improvements had been made, however further work was required. Since February 2019 an external facilitator had been commissioned to work with the staff team on Sunrise Ward. The team met with them every fortnight. Staff reported that some areas of multidisciplinary working had improved, for example, all disciplines now attended the ward round. However, five staff reported that a culture of blame continued on the ward. They gave examples of bullying by a member of senior staff, including being shouted at and being told that they would be managed out of employment when patient incidents occurred.
- Staff did not always feel actively engaged or empowered. We received negative feedback about team working on the ward. Some staff continued to report on the split between nursing staff and the other members of the multidisciplinary and described low levels of staff job satisfaction. Newer members of the multidisciplinary team reported that any new ideas they wanted to introduce were dismissed by long standing staff. Healthcare assistants reported that shifts were chaotic and tasks not properly allocated, this impacted on patients not receiving their feeds on time and staff not being able to take a break. Bank staff reported they preferred to work on New Dawn Ward.
- Staff did not feel able to raise concerns without fear of retribution. Examples given were staff being targeted by their supervisor; this included allegations of bullying when they raised concerns about the supervisor's clinical practice.
- Staff knew how to use the whistleblowing process. Posters were displayed throughout the hospital with contact details of the provider's whistleblowing service.
- Poor staff performance was managed through supervision and obtaining support and advice from the interim hospital director and the provider's human resources department. However, three staff reported they had raised concerns about the poor behaviour and attitude of a member of staff which hospital management had not obviously addressed. They reported the poor performance of this member of staff impacted on the care and treatment patients on Sunrise Ward received. Patients had also raised concerns about the performance of the staff member. Whilst the provider had a duty of confidentiality to the member of staff concerned, they had not provided any form of assurance to the person's colleagues or patients so it was assumed the matter was not being dealt with. This contributed to poor morale on the ward.
- Staff appraisals included conversations about career development and how it could be supported. Staff had received a regular annual appraisal in the last year.
- Staff had access to support for their own physical and emotional health needs through an occupational health service. The hospital provided an employee assistance programme for permanent staff and their family members or partners to access additional support such as counselling, legal and financial advice.

Governance

- The provider's systems were not operated consistently or effectively to monitor and improve the quality of the service, or people's experience of receiving care. At our previous inspection in November 2018, we identified governance as an area of concern. This resulted in the provider being served with a warning notice (regulation 17 good governance), alongside another warning notice for safe care and treatment (regulation 12). In January 2019 the provider informed CQC that it had addressed and completed the actions required to ensure safe care and treatment and that they were on schedule to complete actions to improve governance by the beginning of February 2019. Following the November 2018 inspection, the provider voluntarily stopped admissions to Sunrise Ward. Admissions to the ward had recommenced in May 2019 in consultation with NHS England.
- Despite the provider's assurances we found they had not taken sufficient action to respond to the serious concerns raised at our previous inspection of this service. Most of the concerns we raised during this inspection were directly repeated from previous inspections of this service.
- At this inspection, we found while the provider had made some improvements, effective systems were still not in place to ensure that one-to-one observations were being carried out safely. Robust nursing leadership

was not provided on the ward to ensure patients received care and treatment in a timely manner. There was unsafe management of controlled drugs which had not been identified. There was a failure to follow up on actions identified at team meetings and patient community meetings and a lack of effective and cohesive team work. This meant that governance arrangements were not sufficiently robust to ensure good quality outcomes for people using the service.

- We checked the action plan the provider submitted following the previous CQC inspection. We saw that the key issues were identified and tracked. This meant there was a system in place to review ongoing actions. However, the service had not taken any steps to evaluate the success or sustainability of the changes made. For example, to improve the culture and morale of the staff team, there was an action to set up reflective practice meetings for some staff, but there were no associated outcome measures. This meant that there was a risk the action may be identified as complete when it had not had an impact in terms of changing the ward and hospital culture.
- 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. Monthly integrated governance meetings were held and attended by ward managers and senior staff within the service. A standardised agenda was in place which covered key areas of performance, such as the use of restrictive interventions, use of rapid tranquilisation, complaints, feedback from community meetings and an update on the current risk register. However, there were still shortfalls in practice in some of these areas.
- Staff had implemented some recommendations from reviews of incidents, complaints and safeguarding alerts at the service level. For example, staff had been reminded of the provider's search policy after contraband items had been posted to a patient. We were not assured that this was always done consistently, particularly in relation to complaints as patients said some staff were dismissive of them.
- Staff undertook or participated in local clinical audits. The audits were sufficient to provide assurance and staff acted on the results when needed. However, audits had not picked up on some issues, such as controlled drugs documentation.
- Staff understood the arrangements for working with other teams, both internally and externally, to meet the needs of the patients. Some internal relationships were strained.

Management of risk, issues and performance

- At our previous inspection we found that the risk register and CQC action plan did not accurately reflect the work being carried out to improve the ward. At this inspection we found some improvements, but further improvements were required. For example, the risk register dated March 2019 showed completion dates for all actions as March 2019, although some actions were still ongoing and not completed, such as those related to staffing.
- The hospital used monthly integrated governance meetings and quality assurance meetings to assess information from sources such as investigations, incidents, complaints and the staff representative group. This information formed the basis for developing recommendations and identifying learning to be shared with staff. Local governance structures linked to the organisation's governance framework. Items from the risk register fed into the corporate risk register for the provider. Key messages did not always reach staff in a timely way.
- The service had plans for emergencies. A business continuity plan included all the telephone numbers for use in an emergency. There were also contingency plans covering foreseeable incidents such as bad weather, severe staff shortage, infectious diseases and serious disruption to information technology and telephones.

Information management

- The service collated information about patient care. The data was used to improve the quality of patient care and the understanding of service needs, but the impact of this was patchy.

- Managers had access to information to support them with their management role. This included information on the performance of the service, staffing and patient care. Managers were able to compare their service with other services run by the provider.
- Staff had access to the equipment and information technology needed to do their work. The information technology infrastructure, including the telephone system, worked well and helped to improve the quality of care.
- Information governance systems included safeguards to protect the confidentiality of patient records. Electronic information was protected by passwords. Patient records were kept in the nurses' office. However, there were so many piles of paper in the nurses' office we were not assured that all personal information was secure.
- In theory, the information required to deliver patient care was available and accessible. In practice, the mixture of electronic and paper records stored in different places and the disorganisation of the nurse's office made it difficult to follow the history of care and treatment of a patient and to audit the quality of information held. Information we requested during the inspection was not provided in a timely manner.
- Staff made notifications to external bodies as needed. This included 17 notifications sent to the Care Quality Commission between May 2018 and April 2019. The service also raised concerns with the local authority and NHS England about safeguarding matters.

Engagement

- Staff, patients and carers had access to up-to-date information about the work of the provider and the services they used or worked in. The provider issued regular bulletins to staff. The service emailed news about important changes directly to staff members, as well as learning from serious incidents. Team meeting minutes and clinical governance meeting minutes were available to read. The service website provided information on the services offered by the hospital.
- Patients and carers had opportunities to give feedback on the service they received, however there was little evidence this feedback was used to improve the service. Some issues were repeatedly raised, such as the lack of weekend activities, but not addressed.
- The service engaged well with carers and families. They did not hold a carers' group as many were not local, but they produced a handbook and invited carers to relevant meetings when appropriate.
- Leaders engaged with external stakeholders such as commissioners, local authorities, NHS trusts and the advocacy service.

Learning, continuous improvement and innovation

- We found little evidence of consistent learning or continuous improvement on the ward. That which did take place tended to be undertaken by specific professions, rather than the service as a whole. Newer members of staff told us their attempts at innovation were frequently rejected by long standing colleagues.

Requires improvement

Personality disorder services

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

Are personality disorder services safe?

Requires improvement

Safe and clean environment

Safety of the ward layout

- Staff were meant to complete daily environmental risk assessments according to the provider's policy. However, when we reviewed these records, staff did not complete them regularly. Staff only recently completed them on 4 and 11 June, 18 May and 23 and 26 April. Some of these assessments identified hazards but contained no corresponding actions. Furthermore, the assessment on 11 June did not identify unresolved risks from the 4 June assessment; they were overlooked. For example, there was a leak in the quiet room and a broken sink in a patient bathroom.
- The ward layout did not allow staff to observe all parts of the ward. There were blind spots along the corridors. Staff mitigated this through the use of observations, convex mirrors and closed-circuit television.
- There were ligature anchor points on the ward and staff mitigated most of these risks adequately. The provider had completed a ligature risk assessment in November 2018. However, risks remained because outstanding actions did not have specific completion dates. It also did not allocate responsibility for managing the risk of the ligature anchor points. Some risks were to be "managed locally", however it did not specify how this would be done or who was responsible for this. Two types of ligature cutters were available in the office; however, some staff were not clear on which ones to use.
- The provider completed an annual fire inspection in November 2018 and a fire risk assessment in September 2018. The provider had completed all actions required. Staff completed bi-weekly fire alarm tests. The provider had held a fire evacuation drill on December 2018.
- Staff wore personal alarms. There were alarms in patients' bedrooms, however these had not been working for some time. The provider said that if a patient required increased support at night, they would increase their level of observation. However, one patient told us of occasions where they required support from staff at night and could not raise the alarm from their bedroom so had to wait until staff carried out routine observation checks.

Maintenance, cleanliness and infection control

- Patients were provided with care in a clean and hygienic environment. All areas we inspected were visibly clean. The ward had full time domestic staff. Cleaning records were up to date and demonstrated that the ward areas were cleaned regularly.
- Furnishings in the communal lounge were not well-maintained. We found sofas in were worn and torn, exposing the material underneath, but it had not been identified as a potential infection control issue. There were no clear timescales for these to be replaced.
- Patients did not receive care and treatment in a well-maintained ward. Maintenance issues identified by patients and staff were not addressed in a timely

manner. For example, the windows near the passenger lift had been broken for two years and not repaired. This had been identified as a concern in our most recent Mental Health Act visit report for New Dawn Ward. We also found rain water leaking into the ceiling of the quiet room. No timescales had been set for the work to be completed. The service did not have an on-site maintenance team, there were vacancies which the provider was recruiting into. A maintenance person from another Cygnet hospital visited weekly to carry out any urgent repairs. The provider reported that for some works to the building they required the permission of the landlord which was not always forthcoming.

- Staff adhered to infection control principles, including handwashing. Disposable gloves, aprons and liquid gel were available on the ward. Staff carried out infection control audits to monitor and assess the risk from infection.

Clinic Room and Equipment

- The clinic room was fully equipped with accessible resuscitation equipment.
- Patients were placed at risk of unsafe treatment because emergency drugs were not stored in one place and were dispersed throughout the room. They were not in a 'grab bag'. This meant there could be a delay in patients receiving emergency medicines because they were not easily accessible to staff.
- The arrangements for checking emergency medicines were not safe. We found one of two epi pens (medicines used to treat anaphylaxis) had expired in February 2019 and one of the two oxygen cylinders available on the ward was empty. Staff checked the emergency drugs daily; however, we found that the record did not tally with the contents in the bag. For example, if medicine had expired this was not recorded. We raised this with the ward manager during our inspection, who devised a new recording template for staff to use.
- The clinic room did not have adequate space to prepare medicines or for clinical procedures to take place as the room was extremely small. There was no examination couch. Staff told us clinical activities, for example cleaning wounds and carrying out examinations, were undertaken in patient bedrooms.
- The clinic room appeared clean and tidy, however, staff did not keep cleaning records for the clinic room. There were no cleaning stickers visible on the equipment or other indicators of cleanliness at the time of inspection. We raised this with the ward manager who implemented a daily cleaning audit during the inspection.
- All equipment required for physical health monitoring, except the blood glucose machine, had been calibrated within the last year. This meant that staff could not be sure the blood glucose machine was working correctly.

Safe staffing

Nursing staff

- The ward operated with two registered nurses and two healthcare assistants during the day and two and one at night.
- There were three vacancies for registered nurses. The ward manager told us these posts had been recruited into and were being processed by the human resources team. Staff reported that recent staff vacancies had meant that on some shifts there was only one permanent registered nurse working with an agency nurse. They reported that this presented challenges when trying to provide consistency in care as agency staff did not know the patients on the ward.
- Between 1 March 2018 and 28 February 2019, New Dawn Ward had a sickness rate of 3.8% of permanent staff overall.
- There was a high turnover of staff. The hospital reported that four staff had left New Dawn Ward since March 2018. The total staff turnover rate for the hospital between the period of March 2018 to February 2019 was 22%. Staff on the ward told us some long-standing staff had left which had a negative impact on the ward dynamics. The high turnover of staff was identified as a risk on the service risk register.
- A staffing matrix was used to identify the amount of staff required to provide safe care on the ward. The ward manager could adjust staffing levels daily to take account of the case mix by using an online system to book bank staff. Agency workers were used when the clinical need increased.

- When agency and bank nursing staff were used, staff received an induction to familiarise themselves with the ward. The induction included ward orientation, introduction to colleagues, safety rules, first aid, security and keys.
- All patients were allocated to a named nurse or healthcare assistant each day. This meant patients always had someone available for a one-to-one discussion during the day.
- Staff shortages rarely resulted in staff cancelling escorted leave. Leave was only cancelled if there was a change in the patient's presentation.
- There were enough staff to carry out physical interventions such as restraint. During our inspection we observed staff responding to emergency alarm calls on Sunrise Ward.

Medical staff

- There was adequate medical cover day and night and a doctor could attend the ward quickly in an emergency. There was a full time consultant psychiatrist and a full-time specialty doctor. Cygnet operated an out of hours on-call duty rota. A duty doctor could attend quickly in the event of a medical emergency. These doctors were associate specialists in mental health. Consultants were available on-call out-of-hours.

Mandatory training

- Staff had received and were up to date with mandatory training. This included prevention and management of violence and aggression (PMVA) training, monitoring physical health, infection control, information governance, safeguarding, the Mental Health Act, health and safety and responding to emergencies. The compliance with mandatory training was above 88% for all courses.

Assessing and managing risk to patients and staff

Assessment of patient risk

- Staff completed a risk assessment for each patient upon admission and updated this regularly. Individual patient risks were discussed at daily handover, hospital meetings and multidisciplinary meetings. Staff used a recognised risk assessment tool; the 'short term assessment of risk and treatability'.

Management of patient risk

- Staff were aware of and dealt with specific risk issues such as self-harming.
- Staff identified and responded to changing risks to, or posed by, patients. For example, where required patients were placed on enhanced observations when there was increased risk to ensure their safety.
- Staff met daily and discussed individual patient risk and management plans during handovers and the morning hospital meeting. The multidisciplinary team reviewed risk assessments using a traffic light system (red, amber, green).
- The ward had used the safewards model since September 2017 and used a variety of interventions which were part of this package. For example, the patients ran a mutual help meeting every evening as part of the safewards initiative.
- Staff followed the provider's policy when carrying out patient observations. Most patients on the ward were put on 15-minute observations. Random room searches were carried out subject to risk. All patients were searched using a metal detector when returning from leave.
- Staff adhered to best practice in implementing a smoke-free policy.
- The service displayed a notice to tell informal patients that they could leave the ward freely.

Use of restrictive interventions

- From 1 September 2018 to 28 February 2019, New Dawn Ward reported seven incidents of restraint. Restraint was used on two different patients. During these restraints, there were three incidents of rapid tranquilisation and three incidents of prone restraint.
- During our inspection we reviewed seven incidents of restraint that had taken place between 8 February 2019 and 11 June 2019. The records showed that staff only used restraint when verbal de-escalation had failed. The incident records showed a variety of restraint methods were used, for example, arm holds. Where prone restraint was used this was for the least amount of time possible to administer rapid tranquilisation. The records showed patients and staff were debriefed following each incident.

Requires improvement

Personality disorder services

- At our inspection in 2017, we recommended that all incidents of rapid tranquilisation were followed up with appropriate physical health checks which are documented. At this inspection we found improvements. Staff followed National Institute for Health and Care Excellence (NICE) guidance following the administration of rapid tranquilisation. They checked patients' vital signs in case of deterioration.
- The provider had a corporate strategy on reducing restrictive practices led by the Director of Nursing. There was a reducing restrictive practice lead for the hospital who monitored restraints and incidents and supported the hospital with prevention management of violence and aggression (PMVA) training. Audits were carried out by the lead and all restraints were reviewed by the medical team and discussed at the morning hospital meeting which was attended by all senior staff, the ward manager and team leaders.
- All staff were required to complete training in restrictive interventions and were up-to-date at the time of inspection.

Safeguarding

- Between 30 April 2018 and 30 April 2019 there were 17 safeguarding notifications received by CQC for the hospital.
- Staff were trained in safeguarding, knew how to make a safeguarding alert and did so when appropriate. They were able to seek advice from the hospital social worker who was also the safeguarding lead for the service.
- Staff could give examples of how to protect patients from harassment and discrimination, for example, staff reported that they had supported a patient who had been harassed through their social media account.
- Staff knew how to identify adults and children at risk of, or suffering, significant harm. Staff told us they would raise concerns with the nurse in charge or the ward manager. A flow chart was located in the nursing office which described the process to raise a safeguarding concern, as well as details of the local authority safeguarding team.
- Children were not allowed to visit the ward but could visit family in a visitors' room located on the ground floor.

Staff access to essential information

- The provider did not ensure that staff had easy access to essential information needed to deliver safe care and treatment. There were a mixture of electronic and paper records which were stored in various places. Staff took a long time to locate records. The service had recently migrated to an electronic patient record system. Plans were in place to move information from the paper records to the electronic system, however, there was no completion date for this. All relevant staff, including bank and agency staff, had access to patient records.

Medicines Management

- Medicines were not always being managed safely. We found shortfalls with the checking of emergency medicines. Medicines were not being managed in line with the provider's medicine policy. Controlled drug stock checks were not being carried out on each shift.
- Medicines were provided through an external pharmacy. They provided the ward with a weekly audit of medicines management, e-learning programmes, classroom sessions and competency assessments for staff. The pharmacist provided advice on issues via a weekly live view report which alerted staff to any errors identified and action required. Audits on rapid tranquilisation were completed monthly and were monitored through governance meetings across the service. However, the medicine audits had not identified shortfalls in the arrangements for checking emergency medicines and stock checks of controlled drugs.
- Staff reviewed the effects of medicine on patients' physical health regularly in line with National Institute for Health and Care Excellence (NICE) guidance.

Track record on safety

- Between 12 March 2018 to 5 February 2019, the service reported nine serious incidents for New Dawn Ward. Six of these incidents related to self-harm. Following the inspection site visit, but prior to the publication of this report, we were notified of a very serious incident which had taken place on the ward and was being fully investigated.

Reporting incidents and learning from when things go wrong

Requires improvement

Personality disorder services

- All staff were expected to report incidents, near misses and accidents. The incident form monitored the category of incident, patient and staff debrief, the type of restraint used, the duration of restraint, physical observations and medical check following restraint. When rapid tranquilisation was used, the dosage, outcome of the incident and any actions taken, including safeguarding and duty of candour, were recorded. Staff recorded incidents in an incident book, which the ward manager transcribed on to an online incident reporting system. This enabled the manager to 'sign off' the incident form.
- Staff had a good understanding of the duty of candour. They were aware of the principles of being open and transparent following an incident or mistake. We reviewed two incident reports which showed that staff had met with the patient following a medicine error and offered an apology.
- Staff received feedback from investigations of incidents including where incidents had taken place on the other ward within the service, through team meetings, daily hospital meetings, emails and newsletters. Improvements were made to practice following incidents; for example, following a medicine error two nurses were required to administer medicines.

Are personality disorder services effective?

(for example, treatment is effective)

Good

Assessment of needs and planning of care

- We reviewed four care and treatment records. All admissions to the ward were planned. Staff completed a comprehensive mental and physical health assessment of the patient in a timely manner soon after admission. Initial assessments were comprehensive, outlined the presenting problem, risks, physical health condition and plan of care.
- Staff assessed and supported patients with their physical health needs and worked collaboratively with specialists when needed. Comprehensive physical assessments were completed and plans for on-going monitoring of health conditions and healthcare investigations were developed. This included close and regular monitoring of blood samples, heart rate, pulse, urine tests, temperature, weight monitoring and electrocardiogram (ECG). An ECG checks the hearts rhythm and electric activity and is important to ensure patients receive the right medication.
- Care plans were personalised, holistic and recovery orientated. They reflected the assessed needs of the patient. Staff updated care plans regularly including after multidisciplinary meetings and care programme approach meetings.

Best practice in treatment and care

- Staff provided a range of care and treatment interventions suitable for the patient group. Patients had access to medication, psychological therapies, activities, training and work opportunities.
- The hospital had a head of occupational therapy who started in February and was shared with another Cygnet service. The ward had a full-time occupational therapist (OT) and shared one part-time OT assistant across both wards. The occupational therapy department gathered patient feedback to review the therapy timetable quarterly. Examples of groups offered included self-nurture, leisure activities and cooking. Staff promoted these in the daily morning planning meetings and attendance at groups was voluntary. Staff also offered the same activities individually to patients on enhanced observation who could not attend a group. The occupational therapy team used the model of human occupation screening tool (MOHOST) at the beginning and end of each intervention. They used the recorded outcomes to inform care programme approach (CPA) reports and to develop care plans.
- The ward had a part-time assistant psychologist and part-time clinical psychologist who both worked three days a week. There was also a drama therapist who worked across both wards three days a week. The ward provided dialectical behaviour therapy (DBT), a specific type of cognitive-behavioural psychotherapy. The psychologists used a variety of outcome measures, including clinical outcomes in routine evaluation

(CORE), million clinical multiaxial inventory (MCMI) and difficulties in emotion regulation scale (DERS). Patients could access group and weekly individual therapy for the duration of their stay.

- Staff ensured that patients had good access to physical healthcare, including access to specialists when needed. We saw evidence of patients being referred to specialists related to their physical health diagnosis and attending physical healthcare appointments with the support of staff.
- Staff supported patients to live healthier lives. The hospital was smoke free and had access to resources for dealing with issues relating to substance misuse. Staff told us patients were encouraged to eat healthy meals and were able to choose their food menu on a daily basis.
- Staff participated in clinical audit. Staff carried out regular audits on care plan documentation, risk assessments and the care programme approach (CPA). When shortfalls were identified, action plans were in place to ensure that improvements were made.

Skilled staff to deliver care

- The team included the full range of specialists required to meet the needs of patients on the ward. This included doctors, nurses, occupational therapists, clinical psychologists and a social worker.
- Staff were experienced and qualified and had the right skills and knowledge to meet the needs of the patient group. The ward manager reported that they could seek additional specialist advice from other Cygnet hospitals, for example, the ward had sought advice on how to manage the needs of a patient with autism.
- Managers provided all staff including bank and agency staff with appropriate induction.
- Between 1 March 2018 and 28 February 2019, the clinical supervision rate was reported to be100%, which was above the provider's target of 90%.
- The percentage of staff that had an appraisal in the last 12 months was 92%.
- We reviewed supervision records for four staff. The records were brief and did not detail any discussions regarding incidents, learning from practice or professional development. Staff reported that they did not find supervision to be supportive or helpful. They told us they did not discuss personal matters as they felt the issues would not be kept confidential.
- Staff members had access to regular team meetings. These took place monthly.
- Some staff had received specialist training for their role. They were trained in dialectical behaviour therapy (DBT) which enabled them to work with patients in a way that was consistent with the therapeutic programme. Other staff reported that they had not had specific training to work with patients with a diagnosis of personality disorder.
- The ward manager had not formally dealt with any poor staff performance but told us supervision would be used as a first point of addressing any issues or concerns relating to performance.

Multidisciplinary and inter-agency team work

- Staff held regular and effective multidisciplinary meetings to discuss referrals, review patient risk, care and treatment and discharge planning. Patients were invited to attend the meeting and were involved in reviewing and planning their care.
- The hospital held daily heads of professions meetings. Senior managers reviewed physical health records, incidents, safeguarding, admissions and staffing.
- Staff shared relevant information about patients and care at shift handover meetings. Nursing staff held handover meetings twice per day. Relevant information on each patient was shared, including any changes in risk presentation.
- Staff worked together and with other health and social care professionals to deliver effective care and treatment. Care co-ordinators regularly attended care programme approach meetings. Staff reported that they had good relationships with the GP, commissioners and local authority social services.

Adherence to the MHA and the MHA Code of Practice

- All staff had training in the Mental Health Act (MHA). Staff were trained in and had a good understanding of the MHA, the Code of Practice and the guiding principles. This was part of mandatory training.

Requires improvement

Personality disorder services

- Staff had access to administrative and legal advice on the implantation of the MHA and its Code of Practice. Staff knew who their MHA administrators were. The service had a full-time corporate MHA lead who provided support for the MHA administrators.
- Staff had easy access to the MHA policies and procedures and to the Code of Practice. Policies were available on a shared drive where staff could access them. There was a folder in the nursing office which contained policies, including the MHA, to ensure all staff had access.
- Patients had easy access to information about independent mental health advocacy. Patients told us advocates visited the ward regularly.
- Staff explained to patients their rights under the MHA in a way that they could understand, repeated it as required and recorded that they had done it. We saw that patients signed to confirm they had had their rights read to them and understood them.
- Staff ensured that patients were able to take Section 17 leave (permission for patients to leave hospital) when this had been granted. We observed a morning planning meeting where patients could request to take their Section 17 leave.
- Staff stored copies of patients' detention papers correctly and they were available to all staff that needed to access them. Patients' detention papers were stored in the patients' files.
- Staff completed quarterly MHA audits by selecting random files of detained and informal patients on both wards to ensure all paperwork and procedures complied with the MHA and Code of Practice.
- Care plans for patients getting ready for discharge referred to Section 117 aftercare services to be provided for those who had been subject to the MHA. We saw evidence of staff on the ward liaising with home treatment teams in relation to aftercare.
- Staff completed quarterly MHA audits by selecting random files of detained and informal patients on both wards to ensure all paperwork and procedures complied with the MHA and its code of practice.

Good practice in applying the MCA

- One hundred percent of staff had training in the Mental Capacity Act (MCA). This was part of staff's mandatory training.
- Staff had a good understanding of the MCA and were able to explain how they worked with patients in a way that promoted their understanding and participation in decision making.
- The ward had made no deprivation of liberty safeguards (DoLS) applications in the last 12 months.
- The provider had a policy on the MCA, including DoLS. Staff were aware of the policy and had access to it.
- Decision-specific assessments were completed where patients lacked capacity to consent to a specific decision.
- Patients had access to an independent mental capacity advocate if required.

Are personality disorder services caring?

Requires improvement

Kindness, privacy, dignity, respect, compassion and support

- We observed patients being treated with kindness and respect. However, two patients raised concerns about staff not being discreet and not maintaining confidentiality of information about patients. For example, one patient reported that they could hear staff discussing other patients in the nursing office. Another patient said that staff discussed other patients in front of them.
- Staff supported patients to understand and manage their care, treatment and condition. Patients were able to discuss their care and treatment during ward rounds and could meet with the pharmacist to discuss their medicines.
- Staff directed patients to other services when appropriate and, if required, supported them to access those services. We saw evidence of patients being supported to attend hospital and GP appointments.
- Most patients said staff treated them well and were caring.

Requires improvement

Personality disorder services

Involvement in care

Involvement of patients

- Staff used the admission process to inform and orient patients to the ward and to the service. Patients received a 'service user handbook' on admission. This provided information about the ward, the roles and responsibilities of each member of staff, therapies available, safeguarding and how to complain.
- Staff involved patients in care planning and risk assessment. All patients we spoke with confirmed they were involved in developing and reviewing their care plans and risk assessments and worked in partnership with the team. Patients were enabled to make amendments to their care plan and could voice their opinions.
- Staff ensured that patients could access advocacy. Patients told us independent advocates attended the ward twice a week.
- Staff enabled patients to give feedback on the service they received through annual feedback surveys and weekly community meetings. We reviewed survey results for 2018, patients had given staff care and attitude a high score, but we saw that concerns raised by patients were not addressed promptly by the provider and some issues were still on-going.
- We reviewed community meetings minutes and they confirmed that concerns raised by patients were not addressed in a timely manner. For example, minutes for the 16 June 2018 showed that patients had requested liquid soap and paper towels. This was repeated at subsequent community meetings and it was not until the meeting of the 8 October 2018 that a maintenance request was put in for this. In the minutes of 18 March 2019, patients had raised a request for a new remote control for the air conditioning. This was brought up in subsequent meetings, including an entry on 29 April 2019 saying the clinical service manager was buying a new remote control. However, this was not actioned until 3 June 2019. Patient feedback was invited, but not reliably responded to. However, we did see changes to the frequency of the 'breakfast club' on the 'you said, we did' board which was displayed on the ward.

Involvement of families and carers

- Staff informed and involved families and carers appropriately. The ward had a family and friends' group which met regularly. Staff provided information to family members to help them understand personality disorder and treatments available. The consultant psychiatrist also provided family therapy.
- Patients told us with their consent, family and carers were invited to attend ward rounds. One patient told us their family members were in regular contact with the consultant.

Are personality disorder services responsive to people's needs?

(for example, to feedback?)

Requires improvement

Access and discharge

Bed Management

- The provider reported an average bed occupancy of 99.6% for New Dawn Ward from March 2018 to February 2019.
- The average length of stay for current patients on the ward was 382 days. Two patients had been on the ward for over three years.
- There was always a bed available for patients returning from overnight leave. Patients were only moved if this was required on clinical grounds. For example, if they required admission to the general hospital.
- When patients were moved or discharged from the ward, this happened during the day so that the necessary professionals and family members could be involved.

Discharge and transfers of care

- In the last six months, there was one delayed discharge on the ward. This had been delayed by four months. The ward manager reported that a suitable placement had now been found for the patient and a transition care plan was in place to support them with their discharge.
- Staff planned for patients' discharge, including good liaison with care co-ordinators. Staff told us the care co-ordinator was invited on the day of the patient's

admission and to every ward round to keep them updated with the patient's progress. Care co-ordinators were also invited to care programme approach (CPA) meetings prior to discharge.

- Staff supported patients during referrals and transfers between services. For example, we saw evidence of staff supporting patients to attend general hospitals. When patients were admitted to an acute ward a member of staff was allocated to support them on every shift for the duration of their stay

Facilities that promote comfort, dignity and privacy

- Patients had their own bedrooms and were not expected to sleep in bed bays or dormitories. Two of the bedrooms shared a toilet, all the other bedrooms were en suite with a toilet and sink.
- The ward only had one shower room and one room with a bath. The ward had refitted a shower into the room with a bath, however, this had not been working for over a year. Patients said that the water temperature in the shower was cold and did not have good pressure. They reported that these issues were repeatedly raised but not addressed by the provider.
- Patients could personalise their bedrooms and most chose to do so with photographs, pictures and personal items.
- Patients could securely store their possessions.
- The ward had a full range of rooms, including a clinic room, treatment room, dining room, lounge, activity rooms and meeting rooms. Patients could use the visitors' room to meet family and friends.
- All patients were able to make phone calls in private and had access to mobile telephones.
- Patients could access an outside courtyard area on the ground floor with support from staff.
- Patients reported that the food was of a good quality. Patients could make hot drinks and snacks 24/7.
- There was a range of activities available during the week including DBT skills, massage, coffee trips and monthly pets as therapy.
- At our inspection in 2017, we recommended that patients have access to a variety of activities at the weekend. At this inspection we found little improvement. Some informal sessions were available on weekends such as coffee trips and a faith group, but most patients we spoke with said there were no formal weekend activities.

Patients' engagement with the wider community

- Staff ensured that patients had access to education and work opportunities. Staff told us they were supporting a patient to complete their mathematics GCSE qualification. Patients had access to voluntary work in the community.
- There were leisure activities available to patients within the community for example, gym and swimming. The head of occupational therapy reported that patients could request activities they wanted to undertake and they would be supported to do so. Staff told us patients were assisted with travel training, to enable them to gain confidence in using public transport.

Meeting the needs of all people who use the service

- The service was located on the second floor with lift access. However, staff and patients told us that the lift was often broken. The service had four patients with mobility needs, although they did not require wheelchairs. When the lift was broken these patients had to use the stairs.
- Staff ensured that patients could obtain information on treatments, local services, patients' rights and how to complain.
- Information leaflets could be made available in different languages at the patient's request. There was access to interpreters for key meetings and discussions.
- Patients could access appropriate spiritual support upon request. Staff told us they supported some patients to attend church every Sunday. Patients also had access to a multi-faith room.

Listening to and learning from concerns and complaints

- The hospital's compliance assistant managed complaints for both wards. In 2018, the provider

received 28 complaints. Learning from complaints was included in the staff monthly newsletter. However, the provider did not have an overall analysis of the total complaints broken down by ward and themes.

- At our last inspection, we found that staff did not routinely record informal complaints to help identify emerging themes. We found this was still the case during this inspection.

Are personality disorder services well-led?

Requires improvement

Leadership

- Most of the staff were positive about the ward manager and felt they could raise any concerns and they would be listened to. However, due to recent changes in hospital management, staff said that morale had declined and things felt unstable due to a lack of communication and transparency from the provider. Staff felt unsupported by senior managers and said they were unresponsive to feedback. Staff talked about a split between the senior leadership team and multidisciplinary team.
- Staff told us there were development opportunities for a preceptorship scheme, but this scheme was only available in Birmingham. Staff had raised this as an issue and expressed that Birmingham would be too far to travel alongside full-time work, but no further action had been taken to improve the offer. Staff at ward level did not feel there were any other development opportunities.
- Many staff were unfamiliar with Cygnet managers beyond the hospital which indicated they rarely visited the ward.

Vision and strategy

- The provider's senior leadership team had successfully communicated the provider's visions and values to the frontline staff on the ward.
- Staff knew and understood the provider's visions and values and how they applied to the work of their team. Staff told us they would not allow how they felt about the service to impact on delivering the vision and values in their work.

Culture

- Staff felt positive and proud about working for their ward team. They felt supported by the team and felt the team worked very well together.
- Some of the staff had worked at the hospital for several years and the provider had supported them with their professional development.
- Four staff reported that they did not feel valued by the provider and did not receive any appreciation or validation from senior managers. Long-standing staff were disgruntled that long service and positive appraisals were not reflected in their pay. They said the provider had not communicated about this.
- Staff completed annual surveys, however, two staff said they did not receive any feedback nor had they seen any improvements based on issues they repeatedly raised.
- Three members of staff told us about experiences of being bullied by colleagues. We raised this with the provider during the inspection. Staff on New Dawn Ward were concerned that confidentiality was not always maintained around their personal issues.
- Four staff raised concerns about the performance and professionalism of a colleague. They said they had raised their concerns to senior managers but had not received any feedback or seen any improvement.
- Some staff on New Dawn Ward expressed concerns about the culture, staffing and management of the other ward within the hospital, Sunrise Ward. Staff reported it had not impacted on them. They told us bank staff did not want to work on Sunrise Ward.

Governance

- The provider's systems were not always being operated effectively to monitor and improve the quality of the service, or people's experience of receiving care. While the provider sought feedback from patients and staff this had not been acted on in a timely way to make improvements. Outstanding maintenance issues were slow to be addressed. At our previous inspection of

Sunrise Ward in November 2018, we identified governance as an area of concern. There was no evidence that consideration had been given to whether the action taken should also apply to New Dawn Ward (as most policies and procedures were the same for both wards, as was the senior leadership team).

- 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. Monthly integrated governance meetings were held and attended by ward managers and senior staff within the service. A standardised agenda was in place which covered key areas of performance such as the use of restrictive interventions, use of rapid tranquilisation, complaints, feedback from community meetings and an update on the current risk register.

Management of risk, issues and performance

- Staff maintained and had access to the hospital risk register. Items from the risk register fed into the corporate risk register for the provider. Staff at ward level could escalate concerns when required. Items on the risk register included staffing and issues raised in the last CQC inspection. Although the risk register included fire risk management, it did not specifically include the management of four patients on New Dawn Ward with reduced mobility, especially with only three staff working at night. The risk register did not include the delays and high number of outstanding maintenance issues on the ward. The risk register was dated March 2019 and showed completion dates for all actions as March 2019, although some actions were still ongoing and not completed.
- The hospital used monthly integrated governance meetings and quality assurance meetings to assess information from sources such as investigations, incidents, complaints and the staff representative group. This information formed the basis for developing recommendations and identifying learning to be shared with staff. Local governance structures linked to the organisation's governance framework. Items from the risk register fed into the corporate risk register for the provider.
- The service had plans for emergencies. A business continuity plan included all the telephone numbers for use in an emergency. There were also contingency plans covering foreseeable incidents such as bad weather, severe staff shortage, infectious diseases and serious disruption to information technology and telephones.

Information management

- The service collated information about patient care. The data was used to improve the quality of patient care and the understanding of service needs.
- Managers had access to information to support them with their management role. This included information on the performance of the service, staffing and patient care. Managers were able to compare their service with other services run by the provider.
- Staff had access to the equipment and information technology needed to do their work. The information technology infrastructure, including the telephone system, worked well and helped to improve the quality of care.
- Information governance systems included confidentiality of patient records. Patient records were kept in the nurses' office. Electronic information was protected by passwords.
- The information required to deliver patient care was available and accessible. However, the mixture of electronic and paper records held in different places made it difficult to follow the history of care and treatment of a patient and to audit the quality of information held. Information we requested during the inspection was not provided in a timely manner.
- Staff made notifications to external bodies as needed. This included 17 notifications sent to the Care Quality Commission between May 2018 and April 2019. The service also raised concerns with the local authority and NHS England about safeguarding matters.

Engagement

- Staff, patients and carers had access to up-to-date information about the work of the provider and the services they used. The provider issued regular bulletins to staff. The service emailed news about important changes, as well as learning from serious incidents,

directly to staff members. Team meeting minutes and clinical governance meeting minutes were available to read. The service website provided information on the services offered by the hospital.

- Patients and carers had opportunities to give feedback on the service they received, however we saw that this feedback was not always used to improve the service.
- Staff told us they made suggestions for improvements through surveys but did not receive feedback.

Learning, continuous improvement and innovation

- The ward had implemented the 'safewards' clinical model.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

The provider must ensure all equipment used to monitor patients' physical health is calibrated and properly maintained in line with the manufacturer's guidance. Regulation 15 (1) (e)

The provider must ensure that maintenance issues on New Dawn Ward are resolved in a timely way. Regulation 15 (1) (e)

The provider must review the arrangements for maintaining and storing disposable medical equipment and nasogastric feeds so that they are easily accessible and fit for purpose. Regulation 12 (1) (2) (g)

The provider must ensure that alarms in patient bedrooms are working, so that staff assistance can be summoned. Regulation 12 (1) (2) (e)

The provider must ensure that there are sufficient qualified and experienced nurses on duty on Sunrise Ward to provide effective leadership and management on each shift and to ensure safe and effective care and treatment to patients. Regulation 12 (1) (2) (c)

The provider must assure itself that the staff have the right qualifications and competencies to carry out their roles, including assurance that individual staff members are competent to carry out safe care and treatment for patients with eating disorders. Regulation 12 (1) (2) (c)

The provider must ensure that staff follow procedures for the safe observation of patients. Regulation 12 (1) (2) (c)

The provider must ensure that emergency drugs are checked regularly, are accessibly located and fit for use. Controlled drugs must be managed safely in line with relevant legislation and auditing processes must be further developed to ensure shortfalls are identified. Regulation 12 (1) (2) (a) (b) (c)

The provider must ensure their patient care and treatments records are easily accessible, so staff can easily find information to deliver care and treatment. Regulation 12 (1) (2) (b)

The provider must ensure they are always open and transparent with people who use services and provide an apology when things go wrong. Regulation 20 (1) (4) (d)

The provider must ensure they provide evidence-based psychological treatments on Sunrise Ward in line with best practice. Regulation 12 (1) (2) (a) (b) (c)

The provider must ensure staff receive regular good quality supervision. Regulation 18 (1) (2) (a)

The provider must ensure staff treat patients with dignity and respect and that patient confidentiality and privacy is maintained. Regulation 10 (1) (2) (a)

The provider must ensure effective governance systems are in place to monitor, assess, manage and mitigate risks and act in a timely manner to address issues that could impact on patient safety. Regulation 17 (1) (2) (a) (b)

The provider must ensure that systems for learning from incidents are effective and lead to service improvements. Regulation 12 (1) (2) (b)

The provider must continue to ensure that culture and morale within the staff teams is addressed, multidisciplinary working relationships are improved and professionalism is promoted. Regulation 17 (1) (2) (a)

The provider must ensure the hospital's leadership team has the skills, knowledge and capacity to reduce patient safety risks at this location. Regulation 17 (1) (2) (a) (b)

The provider must ensure that patient feedback is listened to and responded to in a timely manner so that improvements can be made to the service. 17 (1) (2) (a) (e)

Action the provider SHOULD take to improve

The provider should ensure that the ligature risk assessment for both wards is clear, accurate and details who is responsible for managing each risk. All staff should know how to use both types of ligature cutters.

The provider should ensure that daily environmental risk assessments on New Dawn Ward are completed.

The provider should ensure that the sluice room on Sunrise Ward is accessible and fit for purpose.

Outstanding practice and areas for improvement

The provider should ensure that all new staff to Sunrise Ward undertake an induction to the service.

The provider should ensure that all staff on New Dawn Ward undertake training in personality disorders.

The provider should ensure that all relevant staff receive a debrief after a serious incident.

The provider should ensure that care plans are regularly updated to reflect the needs of the patients.

The provider should ensure that regular team meetings continue to take place.

The provider should ensure that themes and trends from complaints are analysed.

The provider should review how they handle and respond to patient complaints on Sunrise Ward.

The provider should record informal complaints and identify any emerging patterns and themes.

The provider should ensure that meaningful activities are provided at the weekend.

The provider should continue with its plans to eliminate shared bedrooms as soon as possible.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 20 HSCA (RA) Regulations 2014 Duty of candour

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

Regulated activity	Regulation
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

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