Cygnet Hospital Clifton

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?	Requires improvement
Are services responsive?	Good
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. This is because ward based staff did not always manage patient risks well and staff actions did not always protect patients from avoidable harm. Staff were not always sufficiently trained or experienced to meet the needs of patients and leadership was not embedded at all levels of the service.

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 Edward Baker
Chief Inspector of Hospitals

Overall summary

Cygnet Hospital Clifton provides specialist low secure mental health and rehabilitation service for men with a personality disorder.

We rated Cygnet Hospital Clifton as inadequate because:

- The service did not always provide safe care. Ward based staff did not always manage patient risks well and staff actions did not always protect patients from avoidable harm. This included incidents of harm to patients when staff failed to follow plans or procedures to keep patients safe and incidents when staff behaved poorly towards patients. For example, when harm occurred to patients during high level observations provided by staff. The provider used temporary staff to maintain ward staffing levels, but patients expressed greater concern about the attitude and behaviours of temporary staff towards them. The provider investigated incidents, but it was not always clear what ward based staff had learnt from incidents and how practice had changed to prevent reoccurrence. This meant risks were not always reduced and incidents happened again.
- Staff were not always sufficiently trained or experienced to meet the needs of patients. The provider identified that the limited experience and competencies of some staff contributed to safety incidents and inconsistent standards of relational security practice. The standard of, and staff's completion of specific training to meet the needs of patients was not always good. Staff did not always work together effectively to ensure care and treatment remained safe and effective for patients using the service.
- Some staff did not always treat patients with kindness and compassion, and some did not always provide patients with support when they needed it. Patients sometimes believed staff failed to keep them safe and purposefully provoked them. Staff and patients reported concerns about the confidentiality of information in the service. It was not clear how staff managed and applied advance statements in the service.
- The service was not always well led. Some concerns raised at the previous CQC inspection remained including the way staff treated patients and the way staff managed risks to keep patients safe. Positive and effective leadership was not embedded at all levels of the service. Governance processes did not always demonstrate that risks and staff deployment were managed well. Some staff at the service continued not to feel respected, supported and valued.

Summary of findings

However:

- The provider had introduced actions to address concerns at the hospital, but it was too early to measure the impact of these when we inspected. This included the introduction of ward managers to improve ward based leadership, improvements to the personality disorder training available to staff and changes to supervision practices that made discussions about security duties, relational security, learning from incidents and staff conduct mandatory between staff.
- Staff developed holistic, recovery-oriented care plans informed by a comprehensive assessment and ensured that patients had good access to physical healthcare. Therapy staff provided a range of treatments suitable to the needs of the patients, and in line with national guidance about best practice.
- Staff understood and discharged their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005.
- Staff planned and managed discharge and liaised with services that would provide aftercare. As a result, discharge was rarely delayed for other than a clinical reason.

Summary of findings

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Inadequate

Cygnet Hospital Clifton

Services we looked at:

Forensic inpatient or secure wards.

Summary of this inspection

Background to Cygnet Hospital Clifton

The Cygnet Hospital Clifton is a specialist low secure mental health and rehabilitation service for men with a personality disorder. Patients may also present with complex mental health needs, and challenging behaviours.

The hospital has two wards, both can accommodate up to 12 patients. Ancaria ward is the assessment and initial treatment ward; it offers a defined pathway through to Acorn ward which has a focus on rehabilitation. All patients are detained under the Mental Health Act 1983. When we inspected the hospital had 21 patients, nine on Ancaria ward and 12 on Acorn ward.

Cygnet Hospital Clifton is registered with the CQC to provide the following regulated activities:

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

• Diagnostic and screening procedures

• Treatment of disease, disorder or injury.

The CQC had previously inspected this service in October 2012, March 2013, October 2013, July 2015, April 2016, November 2016 and August 2018. Following the inspection in August 2018, we told the provider they must make improvements to:

- ensure staff treat patients with dignity and respect.
- ensure staff observation practices are undertaken in line with good practice and keep risks to patients as low as possible
- ensure handovers of verbal and written information between staff is effective and minimises the risk of untoward incidents occurring to patients
- ensure all eligible staff receive training in the Mental Health Act and Mental Capacity Act the is sufficient to their roles
- ensure staff monitor and record patient observations following the administration of rapid tranquilisation
- ensure staff keep an accurate and complete record of the care and treatment provided to patients
- ensure staff maintain the confidentiality of information of all people using or employed by the service
- ensure staff make regular checks of emergency equipment.

During this inspection we found the provider had made improvements. However, we found concerns remained in some of these areas. For example, staff checks of emergency equipment, staff treatment of patients and staff observation practices to ensure risks to patients were as low as possible.

Between May 2014 and January 2020, there have been five Mental Health Act reviews of the hospital. The last review was in March 2019 on Ancaria ward. Concerns included the presence of blanket restrictions, an absence of advance statements for patients, managers did not monitor the use of emergency treatment under the Mental Health Act and poor record keeping. The provider submitted an action statement to CQC detailing how they planned to address the concerns raised.

Our inspection team

The team that inspected the service comprised three CQC inspectors, one CQC Mental Health Act reviewer, one specialist nurse advisor with experience of low secure and rehabilitation services and one expert by experience. An expert by experience is someone who has experience of using mental health services or through contact with those using them.

Summary of this inspection

Why we carried out this inspection

We inspected this service as part of our ongoing comprehensive mental health inspection programme. However, following concerns raised to CQC, we inspected this service ahead of the scheduled date. This inspection was unannounced.

How we carried out this inspection

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

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

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

During the inspection visit, the inspection team:

- visited both wards at the hospital, looked at the quality of the ward environment and observed how staff were caring for patients
- spoke with seven patients who were using the service
- spoke with three family members or carers
- spoke with the hospital manager
- spoke with 11 other staff members; including doctor, nurses, occupational therapist, psychologist and nursing assistants
- attended and observed one multi-disciplinary hand-over meeting
- looked at six care and treatment records of patients
- carried out a specific check of the medication management on both wards and reviewed the medicines charts of 11 patients
- obtained feedback from one commissioning case manager
- looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the service say

Five patients we spoke with believed staff shortages resulted in cancellations and delays to access leave, activities, restricted items and access to outside spaces. They believed staff turnover and the use of agency staff was high at the hospital. This prevented them from building relationships and trust with staff. Of the seven patients we spoke with, five raised concerns about the way staff sometimes spoke or behaved to them. This included that staff failed to keep them safe, belittled them, purposefully provoked them or ignored them. Patients detailed two incidents when staff had not spoken appropriately or behaved well towards them. .

Carers found the hospital clean, tidy and well maintained. They found staff friendly, polite and caring. All commented on staffing at the hospital including the high turnover of staff, not always enough staff to facilitate escorted leave and not always enough staff to facilitate visits. Two carers did not feel as involved in their relative's care as they would like to be and told us they were not always invited to meetings to plan or discuss care. However, overall, the carers we spoke with believed their relatives to be safe at the hospital and believed staff managed risks well.

We obtained feedback from one commissioning case manager. They reported positively about staff's communication and engagement with local commissioners, the introduction of a structured programme for patients and the quality of physical healthcare provided. Staff skill mix and high agency use were identified as a concern, as were incidents related to

Summary of this inspection

staff practices to keep patients safe. It was not always clear what staff learnt from incidents, how staff practice changed to prevent incidents reoccurring and how the provider supported and developed staff to safely meet the needs of patients.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Inadequate

We rated safe as inadequate because:

We rated safe as inadequate because:

- Staff did not always manage patient risks well and incidents occurred from staff omissions in care. This included incidents of harm to patients when staff failed to safely follow plans or procedures to keep patients safe. For example, when harm occurred to patients during high level observations provided by staff. It was not always clear what staff had learnt from incidents and how practice had changed to prevent reoccurrence. This meant risks were not always reduced and incidents happened again.
- Staff did not always complete daily security checks to ensure the hospital environment remained safe. This was demonstrated in staff omissions to record the completion of security checks and staff meeting records. We also saw that staff practices to meet relational security standards were not always good. Incidents occurred that identified staff failed to maintain professional boundaries with patients and failed to maintain information confidentially.
- Staff actions or omissions in care did not always protect patients from avoidable harm. This included when staff behaved poorly towards patients or when staff failed to follow plans or procedures to keep patients safe. The local authority had undertaken an investigation of safeguarding and quality concerns at the hospital. They had concluded the investigation procedure assured by oversight of NHS England and the CQC.
- Staff did not always keep complete records of care and treatment delivered to patients. This included records of patient observations and medicine self-administration records.
- Staff did not always check emergency equipment to the frequency prompted by the provider's guidance, although overall practice had improved since our previous inspection.

However:

- The provider had made some additional investment to improve the hospital environment and staffing levels. Electronic 'fob' access now reduced staffs' need for keys when moving around the hospital and increased the number of qualified nurses working on wards during the day.

Summary of this inspection

- The provider had reviewed staff supervision practices to make discussions about relational security, lessons learnt from incidents and security duties mandatory between staff.
- Clinic rooms were clean, well ordered and well equipped. Staff completed checks to ensure medicines remained safe for use with patients.
- Staff regularly reviewed the effects of medications on each patient's physical health. Staff did not use rapid tranquilisation to manage patient presentations.

Are services effective?

Requires improvement

We rated effective as requires improvement because:

- Not all staff ward based staff were experienced or had the right skills and knowledge to deliver effective care to patients. Staff completion of training specific to meeting the needs of patients with a personality disorder and ensuring patient safety through observation and engagement was low. The existing personality disorder training available to staff was described as basic and improvement was recommended by the Quality Network for Forensic Mental Health Services.
- Concerns were raised that not all staff worked well together to ensure care and treatment remained effective for patients using the service.

However:

- Staff assessed the mental health and physical health needs of all patients on admission. They developed individual care plans, which they reviewed regularly and updated as needed. Care plans reflected the assessed needs, were personalised, holistic and recovery-oriented. They included positive behavioural support and as required medicine plans. Staff ensured patients had good access to physical healthcare and supported patients to live healthier lives.
- The provider had reviewed and made changes to its personality disorder training available to staff. This was planned to commence in February 2020.
- Therapy staff provided a range of care and treatment interventions suitable for the patient group and consistent with national guidance on best practice. They used recognised rating scales to assess and record severity and outcomes.

Summary of this inspection

- Staff participated in clinical audit and benchmarking initiatives. We saw examples of audits that demonstrated where good practice was taking place and where improvements were being made in relation to care and treatment concerns.
- Staff supported patients to make decisions on their care for themselves. They understood the provider's policy on the Mental Capacity Act 2005 and assessed and recorded capacity clearly for patients who might have impaired mental capacity.

Are services caring?

Requires improvement

We rated caring as requires improvement because:

- Some staff did not always treat patients with kindness and compassion. Patients raised concerns in their conversations with us and two incident records detailed occurrences when staff had not spoken appropriately or behaved well towards patients. Records from staff meetings demonstrated staff did not always provide patients with help and support when they needed it.
- Patients and carers expressed concerns about staffing at the hospital, including high staff turnover rates. Patients described staffing as a barrier to building relationships and trust with staff. Two carers told us there was not always enough staff to facilitate escorted leave and not always enough staff to facilitate visits.
- Staff and patients reported concerns about the confidentiality of information. This concern was raised at our previous inspection
- Staff did not always ensure the privacy of patients. This included failing to wait of permission before entering bedrooms and failing to ensure treatment interventions were delivered privately.
- Staff practice to manage and apply advance statements was not embedded. An advance statement is written preferences, beliefs and wishes about your future care.

However:

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

Summary of this inspection

Are services responsive?

Good

We rated responsive as good because:

- Staff planned and managed discharge well. They liaised well with services that would provide aftercare and discharge was rarely delayed for other than clinical reasons.
- Each patient had their own bedroom with an en-suite bathroom and could keep their personal belongings safe. There were quiet areas for privacy. The food was of a good quality and patients could make hot drinks and snacks at any time.
- The service met the needs of all patients who used the service, including those with a protected characteristic. Staff helped patients with communication, advocacy and cultural and spiritual support.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team and the wider service.

However:

- When we inspected the provider had a voluntary suspension of admissions in place. The provider took this decision to focus attention on the induction and training of new ward staff and keep the use of temporary staffing to a minimum. The decision followed incidents about staff actions or omissions to protect patients from avoidable harm. The provider wanted to ensure nursing staff were suitably skilled to safely meet the needs of patients using the service.

Are services well-led?

Inadequate

We rated well-led as inadequate because:

- Positive, effective leadership was not embedded at all levels of the service. Plans to increase leadership at ward level through the introduction of clinical leads had not been successful.
- Our findings from the other key questions did not always show that governance processes did not always demonstrate that risks and staff deployment were managed well. Changes did not always become embedded to practice and incidents of a similar theme continued to happen.
- Some staff did not feel respected, supported and valued. Records of staff meetings and the results of the providers local 2019 survey demonstrated this. Staff did not always feel able to raise concerns without fear of retribution and staff raised whistleblowing concerns directly to CQC.

However:

Summary of this inspection

- The provider had introduced ward manager positions to improve ward based leadership but, when we inspected, the impact of these roles was yet to be seen. The provider was supporting the hospital manager to improve the service and implement secure services policies and governance structures.
- The provider communicated its visions and values to frontline staff and staff knew them. Staff had the opportunity to contribute to discussions about the strategy for their service.
- Staff, patients and carers had access to up-to-date information about the work of the provider and the service. The provider had processes to allow staff, patients and carers to give feedback about the service and developed action plans based on this feedback.

Detailed findings from this inspection

Mental Health Act responsibilities

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

The provider made Mental Health Act and Code of practice training available to staff as part of mandatory training requirements. The provider reported that 92% of eligible staff had received training. This was an improvement from the 45% reported at our previous inspection.

The service had a dedicated member of staff to provide administrative support for the implementation of the Mental Health Act and its Code of Practice. The staff member was new to post and did not yet demonstrate good understanding of the Mental Health Act, the Code of Practice and the guiding principles. The psychiatrist and an experienced Mental Health Act administrator from one of the provider's nearby locations regularly supported the new member of staff. However, in November 2019 staff missed the renewal of one patient's detention and detained the patient illegally.

The provider had clear, accessible, relevant and up-to-date policies and procedures that reflected all relevant legislation and the Mental Health Act Code of Practice. Staff stored copies of patients' detention papers and associated records correctly and so that they were available to all staff that needed access to them.

Staff explained to patients their rights under the Mental Health Act in a way that they could understand, repeated it as required and recorded that they had done it. This included information about independent mental health advocacy. Care plans included information about after-care services available for those patients who qualified for it under section 117 of the Mental Health Act.

Staff ensured that patients were able to take Section 17 leave (permission for patients to leave hospital) when this has been agreed with the responsible clinician or, where required, the Ministry of Justice. However, on return to the hospital, staff did not routinely review and record the outcome of Section 17 leave with patients.

Staff adhered to consent to treatment and capacity requirements. We reviewed 11 medicine charts and those needing legal authorisation had correctly completed forms attached. This meant that nurses administered medicines to patients under the right legal requirements. Staff requested an opinion from a second opinion appointed doctor when necessary.

Staff did regular audits to ensure that the Mental Health Act was being applied correctly and there was evidence of learning from those audits.

Mental Capacity Act and Deprivation of Liberty Safeguards

The provider made Mental Capacity Act training available to staff as part of mandatory training requirements. The provider reported that 90% of eligible staff had received training. This was an improvement from the 45% reported at our previous inspection. Staff we spoke with demonstrated understanding of the Mental Capacity Act and the five statutory principles.

The provider had a policy on the Mental Capacity Act that included Deprivation of Liberty Safeguards. Staff were aware of the policy and knew how to access it. Between November 2018 and October 2019, staff made no Deprivation of Liberty Safeguard applications. Staff understood when to make Deprivation of Liberty Safeguard applications and knew to monitor the progress of applications to supervisory bodies.

Staff knew where to get advice regarding the Mental Capacity Act and Deprivation of Liberty Safeguards. This included accessing the policy and speaking to senior clinical staff.

Staff took all practical steps to enable patients to make their own decisions. Records showed that, for patients

Detailed findings from this inspection

who might have impaired mental capacity, staff assessed and recorded capacity to consent appropriately. This was done on a decision-specific basis regarding significant decisions, including the capacity to consent to treatment.

When patients lacked capacity, staff knew how to make decisions in a patient's best interests, recognising the importance of the person's wishes, feelings, culture and history.

The provider had arrangements in place to monitor and audit adherence to the Mental Capacity Act. Staff included discussions about the Mental Capacity Act at integrated governance meetings.

Overview of ratings

Our ratings for this location are:

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

Inadequate

Forensic inpatient or secure wards

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

Are forensic inpatient or secure wards safe?

Inadequate

Safe and clean environment

Safety of the ward layout

Access from the reception to the hospital environment was through air-lock doors. Air-lock doors consist of a small chamber between two locked doors, both sets of doors cannot be opened at the same time. Both wards were locked and doors throughout the hospital were locked. Since our previous inspection the provider had introduced electronic 'fob' access to many of the doors in the hospital. This reduced staffs' need for keys when moving around the hospital.

Staff obtained and signed for hospital keys from the reception at the start and finish of shifts. We saw staff kept keys firmly attached to them using belts and pouches.

The provider had security policies and procedures in place to guide staff and included environmental security as part of staff induction. There was an identified security lead for the hospital. The provider required staff to monitor and complete security checks daily.

Two staff told us there was not always enough staff to properly monitor and complete security checks. For example; they believed the handover period between shifts did not allow enough time for staff allocated security responsibilities to attend the handover and complete security checks that required completion by two people. However, the time the provider allocated to handovers was in line with other NHS and independent health care providers. We reviewed two weeks of Acorn ward security records. The records, chosen at random from October and December 2019, both had omissions where staff should have signed to indicate that security checks had been completed. The hospital manager monitored and reported to staff when security checks were not completed. For example, staff meeting records for December 2019 and January 2020 recorded concerns about staff attitudes to security procedures and staff's non-completion of security checks. The January 2020 staff meeting gave ward managers responsibility for ensuring security roles were carried out correctly.

Staff practices to meet relational security standards was not always good. Relational security is staff's knowledge and understanding of a patient and of the environment; and how they use that information to provide safe care and treatment. It includes professional boundaries between staff and patients and procedures to reduce risks. We reviewed the records of four staff meeting that took place between October 2019 and January 2020. Three of the four meetings recorded concerns about staff failing to maintain professional boundaries with patients. This included staff and patients sharing personal information and inconsistent staff practices to maintain information confidentially. The provider made relational security training mandatory for staff and the completion rate for this was 92%. We also saw the hospital manager had made relational security conversations mandatory to staff supervision practices.

The provider used closed circuit television cameras throughout the hospital. The hospital manager reported plans to increase the provision of closed circuit television cameras to ward lounges, ward clinic rooms and all communal areas in the hospital. This was an action

following the investigation of incidents. Camera monitors were located at reception and in the hospital manager's office. Staff used closed circuit television camera recordings as evidence to review incidents and to audit staff practice. The provider displayed posters advising patients, staff and visitors that closed circuit television cameras operated at the hospital.

The provider regularly risk assessed the hospital environment. The provider had arrangements in place for a range of environmental risk assessments including fire, infection control and health and safety. In November 2019, the provider completed a comprehensive ligature risk assessment using a recognised tool. Ligature points are fixtures to which people intent on self-harm might tie something to strangle themselves. We saw the provider had actions in place to reduce ligature risks identified by the assessment.

Ancaria ward was located on the ground floor and Acorn ward on the first floor. Both wards had the same layout, although since our previous inspection the provider had made improvements to the extra care area on Ancaria ward. The placement of staff and routine observation practices ensured staff observed all parts of the wards. Staff supervised shared patient areas when in use and kept them locked when not in use. This included therapy rooms, an information technology room and a gym. The hospital had two visiting rooms, one of which had access to a secure outside area.

The hospital accommodated male patients only. This complied with national guidance about, and expectations governing the provision of single sex accommodation.

All bedrooms were en suite so each patient had their own shower, wash basin and toilet. Each ward also had communal toilets and bathrooms.

Patient bedrooms and bathrooms had anti-barricade doors to prevent holding, barring and blocking. The provider trained staff about anti-barricade mechanisms at induction. Bedrooms doors had observation panels that could be operated externally by staff when making observations and internally by patients when they wanted privacy.

Staff had access to personal alarms. Staff checked personal alarms daily to ensure they worked safely. Since our previous inspection the provider had updated the hospital's personal alarm system to one that located and informed staff of exactly where assistance was required. During the inspection we saw staff routinely carrying personal alarms and responding promptly to alarm calls.

Patients had access to nurse call points in bedrooms and corridors. Staff carrying personal alarms accompanied patients in other areas of the hospital where assistance might need to be called for. This included in emergencies. Staff accompanied visitors around the hospital or issued visitors with personal alarms on arrival. The provider had plans in place to remove old nurse call points and install additional call points where needed.

Maintenance, cleanliness and infection control

Communal areas of the hospital were visibly clean. The provider displayed artwork and ward decorations chosen by patients. Where patients had damaged or removed these, the provider had plans to redecorate with alternatives that could not be damaged or removed. During the inspection we raised a concern about an area of Ancaria's quiet room that required attention to prevent potential harm. The hospital manager communicated this to maintenance staff and it was fixed the same day. The service employed two whole time equivalent maintenance staff who contributed to an on-call rota.

Cleaning records for the hospital were present and demonstrated regular cleaning. The service employed four whole time equivalent housekeeping staff. Housekeepers worked seven days a week.

Staff adhered to infection control principles including handwashing. We saw posters demonstrating correct handwashing techniques and hand gel dispensers throughout the hospital.

Seclusion room

The provider had recently re-developed the extra care area of Ancaria ward, this included a seclusion facility. The facility had a toilet, shower, clocks visible to the patient from within the seclusion room, and an intercom providing two-way communication. The facility provided clear observation and was equipped with anti-rip blankets. The facility had access to a small outside secure area that was overlooked by neighbouring residential homes. The hospital manager was aware of the risk this presented to

the privacy and dignity of patients requiring seclusion. The provider had a plan in place to resolve this concern and expected completion by April 2020. The provider applied screening to temporarily address the immediate concern.

Clinic room and equipment

Both wards had clinic rooms, and these were visibly clean, tidy and well ordered. Clinic checklist and cleaning records were present and demonstrated staff cleaned daily. Records demonstrated staff cleaned portable examination equipment. The completeness of clinic room and portable equipment cleaning records had improved since our previous inspection.

Staff had access to equipment necessary for carrying out physical health checks. This included an electrocardiogram machine. Staff recorded when equipment had last been checked to ensure it was working properly.

Staff made daily checks of clinic rooms and medicine fridge temperatures. Staff recorded the actions they took to safeguard medicines when room or fridge temperatures went above recommended safe ranges. The quality and effectiveness of medicines can be affected by changes in storage temperatures.

The provider had emergency grab bags including oxygen, ligature cutters and an automated external defibrillator stored securely at the hospital reception and in ward offices. This ensured all staff had access to the equipment in an emergency.

Staff did not always check emergency equipment to the weekly standard prompted by the provider's guidance. Between October 2019 and the date of inspection we saw four omissions. For example; records on Ancaria ward demonstrated one staff check between January 1st and January 13th, 2020. However, overall staff practice to check emergency equipment had improved since our previous inspection.

We saw first aid and burns kits securely stored throughout the hospital. Records showed staff regularly checked kits to ensure the contents remained in date.

Safe staffing

The service had a planned staffing establishment of 12 substantive whole time equivalent qualified nurse positions. When we inspected, four whole time equivalent qualified nurse positions were vacant.

In addition to qualified nurses, the service had a planned staffing establishment of 36 nursing assistant positions. When we inspected, one whole time equivalent nursing assistant position was vacant.

Staff worked two shifts to cover the 24-hour period. Staffing numbers during the day were two qualified nurses and four nursing assistants for Ancaria ward, and one qualified nurse and four nursing assistants for Acorn ward. At night staffing numbers reduced to one qualified nurse and four nursing assistants on each ward. Since our previous inspection, the provider had increased its overall staffing establishment and increased the number of staff allocated to each shift. Staffing numbers had been calculated to account for one patient being nursed on one to one observation.

Qualified nurses were present on the hospital site at all times. However, there were times when a ward might only be staffed by nursing assistants for short periods of time. For example; at night to dispense medicines that required two qualified nurses to be present. Staff carried radios to maintain communication when a qualified nurse was not present on the ward.

Senior management staff and members of the multidisciplinary team worked during the day Monday to Friday and were supernumerary to ward staffing numbers. This included ward managers, security leads and additional support leads. For example; the physical health lead and art lead.

We reviewed actual ward staffing levels against planned ward staffing levels for two weeks in January 2020. This demonstrated 14% of shifts had been staffed below planned staffing levels. Staff sickness or bank and agency staff cancellations notified at short notice accounted for actual staffing not meeting planned numbers. Patients and staff commented on the impact of staffing levels to escorted leave and ward activities. Five patients we spoke with believed staffing levels contributed to cancellations and delays to access leave, activities, restricted items and access to outside spaces. Four staff told us that although staffing did not often result in leave cancellations it sometimes negatively impact on activities. One patient also told us staffing levels rarely allowed regular one-to-one time with their named nurse and overall, care and treatment records supported this. This meant patients were given less opportunity to form a meaningful therapeutic relationship with a named nurse or keyworker. However, provider information about staffing levels and engagement

in meaningful activities did not always support the views of staff and patients. The hospital manager reported shifts were rarely short staffed and provided evidence to demonstrate that activities were rarely cancelled. They identified that staff organisation and co-ordination of shifts remained an issue. For example; more than one patient having leave booked to occur at the same time. Other staff we spoke with shared this view. In addition to existing actions, the hospital manager believed the introduction of ward managers would ensure better organisation of shifts.

The provider used temporary staff to meet safe staffing levels. Between August and October 2019, the provider reported 235 shifts filled by bank staff and 436 shifts filled by agency staff to cover sickness, absence, vacancies or enhanced observations of patients. During this period, of all available qualified and unqualified shifts, agency staff filled 22.5% and bank staff filled 12%. This had increased since our previous inspection. Records showed temporary staff contributed to safety incidents at the hospital including patient observation and relational security incidents. Patients expressed greater concern about the attitude and behaviours of temporary staff towards them. The hospital manager reported they used agency staff familiar with the hospital where possible. All agency staff received an induction prior to working on wards. Bank and agency staff were required to attend handovers at the start of a shift.

Staff called for assistance from other areas of the hospital when additional staff were needed to assist in physical interventions. The provider made observation and engagement and the management of actual or potential aggression training available to staff. However, when we inspected staff completion of observation and engagement training was below the providers 85% target and concerns remained about how staff sometimes completed and recorded patient observations.

Between November 2018 and October 2019, the hospital's staff sickness rate was 5.5%. This was the same as at our previous inspection and higher than the provider's average sickness rate of 4%.

Staff turnover at the service remained high. Between November 2018 and October 2019, the provider reported 29 staff leavers from a total of 75 substantive staff. A staff turnover rate of 39%. In our conversations with patients, three spoke specifically about high staff turnover and how this prevented them from building relationships and trust with staff. The provider offered face to face exit interviews and on-line exit surveys to staff leavers. However, between October 2018 and August 2019 only one local staff leaver completed an online exit survey. The provider identified the service needed to improve local uptake of face to face exit interviews and uptake of online exit surveys.

Between July and December 2019, the provider recruited 21 staff to work at the hospital. Of those recruited, five voluntarily left or did not pass their probation period.

As of January 2020, the hospital employed 36 female staff and 10 male staff in registered nurse or nursing assistant roles. The hospital manager reported no complaints about staff gender mix and facilitated requests from patients to have care and treatment provided by male staff.

Medical staff

The hospital employed one whole time equivalent consultant psychiatrist and one whole time equivalent speciality grade doctor, both contributed to an overnight on-call rota cover Monday to Thursday. The providers regional on-call rota provided medical cover at weekends.

Mandatory training

The provider ensured mandatory training was available to all staff. The provider monitored completion rates and reported on them as part of governance indicators. As of January 2020, there was a staff training and education compliance rate of 93%. The provider identified 22 mandatory courses for staff at Clifton Hospital, this was more than the nine courses identified at our previous inspection. Mandatory courses included suicide and risk, relational security, safeguarding and health and safety. In the providers 2019 staff survey of Clifton Hospital, 78% of the 46 respondents reported they had enough training to do their job well.

Assessing and managing risk to patients and staff

We reviewed six care and treatment records. All demonstrated that staff completed a risk assessment of every patient on admission. Records also showed that staff updated risk assessments regularly. We also saw occupational therapy risk assessments present for a range of activities.

Staff used recognised risk assessment tools, including the Short-Term Risk Assessment and Treatability tool and the Historical, Clinical Risk assessment. This tool included a

number of risk categories including violence, self-harm, substance misuse, self-neglect and vulnerability. The Historical, Clinical Risk assessment assesses a patient's probability of violence. In addition to these tools, staff assessed patients' daily risk levels. The provider used a daily risk assessment where patients' behaviours were rated as red, amber or green in relation to their current presentation and behaviours displayed. Staff reviewed and formulated management plans when patients reached an agreed threshold specific to personality disorder presentations. Staff recorded daily risk ratings in care and treatment records and met to discuss patients' daily risks at handovers.

Management of patient risk

Staff were aware of and dealt with any specific risk issues. For example; we saw staff completed choking assessments with patients.

Staff did not always follow the provider's policies and procedures when completing and recording prescribed observations with patients. This remained a concern from our previous inspection when we told the provider they must ensure staff observation practices were undertaken in line with good practice and keep risks to patients as low as possible.

Between November 2018 and October 2019, the provider notified CQC of incidents where actual harm had occurred to patients prescribed high levels of observations, including one to one observation. Incident records and learning communications about the investigation of incidents identified that problems with staff observation practices persisted, although fewer recent incidents had resulted in actual harm to patients. During the inspection, we saw examples of staff failing to record observations upon completion and changes to high-level observations not supported by care plans. We acknowledge that the provider had introduced revised observation and engagement training for staff, allocated observation and engagement champions to staff teams and displayed information about good observation practices in staff only areas, but this had not yet embedded into staff practices.

During the inspection we did see some good staff observation practices including staff knowledge of individual patient's observation levels and observations completed in an unpredictable way. This meant patients who were at risk of self-harm would find it harder to predict when staff were going to check on them.

The provider had policies in place and trained staff in how to carry out searches of patients. Staff learnt lessons from search related incidents local to the hospital and at other Cygnet services. The hospital manager had changed search practices to address patient concerns about long waits for staff to search them. As a result of these changes patients reported staff search practice had improved.

Staff applied blanket restrictions. Blanket restrictions are restrictions on the freedoms of patients receiving mental healthcare that apply to everyone rather than being based on individual patient's risk assessments. Some patients we spoke with thought the service was overly restrictive. We saw staff applied blanket restrictions following safety concerns regarding specific patients. For example; patients' access to ward kitchens and razors. We did not always find staff had carried out individual risk assessments to support these restrictions. During the inspection staff had applied the restriction to razors following a security incident that resulted in serious harm to a patient. This meant all patients' whose risk had not increased were no longer able to shave themselves without supervision from a nurse. The hospital manager explained the restriction as a short term measure while they reviewed staff experience and competency to undertake security tasks. Senior and multidisciplinary staff met later and agreed individualised risk assessments and care plans for patients to access sharps. Records showed that prior to this incident, staff had not applied blanket restrictions on patients access to razors

Staff met monthly to discuss existing blanket restrictions and consider ways of reducing or eliminating restrictions. For example; to provide patients with unsupervised access to the internet. Staff maintained a blanket rules audit to identify blanket rules or restrictions in the hospital. The audit included reasons for the restriction and actions to review or reduce the restriction.

The provider had implemented a smoke-free policy and staff ensured nicotine replacement therapy was available to patients on prescription when needed. Where possible, staff encouraged patients to access community smoking cessation support.

Use of restrictive interventions

Staff told us that restraint was rarely used with patients. The provider included training in de-escalation and restraint techniques as part of the management of actual or potential aggression training for staff. The provider had a prevention and management of violence and aggression policy in place to guide staff practice. This included guidance on de-escalation techniques.

Between May and October 2019, the provider reported five incidents of the use of seclusion. Of the incidents, four had occurred from Ancaria and one from Acorn. This was a reduction from the 12 reported at our last inspection. In the same period, the provider reported no incidents of long-term segregation at the hospital. The provider had a policy and procedure for seclusion and long-term segregation.

When we inspected, no patients were being cared for in seclusion or long-term segregation. We reviewed one record of a seclusion incident from Ancaria ward. This demonstrated that staff had completed the necessary reviews of the patient in seclusion and terminated the episode of seclusion at the earliest opportunity.

Between May and October 2019, the provider reported 44 incidents of restraint involving five patients. Only one of these had occurred on Acorn ward. The number of reported restraint incidents had increased since our last inspection. However, the provider identified that 40 restraint incidents occurred with one patient to maintain safety during a period of enhanced observations.

Between May and October 2019, the provider reported there were no incidents of restraint which resulted in the patient being facedown or administered with rapid tranquilisation. Staff audited the use of rapid tranquilisation at the hospital, this demonstrated there had been no use of rapid tranquilisation in 2019. This improvement meant we were unable to follow-up on a concern from our previous inspection where we identified staff failed to monitor and record patient observations following the administration of rapid tranquilisation by injection. The provider had a rapid tranquilisation policy and procedure available to guide staff. The policy referenced guidance on practice from the National Institute for Health and Care Excellence and Maudsley Guidelines.

Staff we spoke with demonstrated an awareness of the definition of restraint, as outlined in the Mental Capacity Act.

Safeguarding

The provider made safeguarding training available to staff and reported a completion rate of 78%. The training was delivered online and included the safeguarding of adults and children. However, safeguarding training compliance was lower than that reported at the previous inspection. The provider had a policy and procedure which informed staff practice. Staff we spoke with knew how to raise a safeguarding concern and did so when required.

Staff described how they would protect patients from harassment and discrimination. This included monitoring patient interactions for evidence of bullying. Staff received training in equality and diversity, and there was policy to guide staff practice.

Staff knew how to identify adults and children at risk of or suffering significant harm. Staff accessed the safeguarding lead and the provider's policy for guidance. The hospital's social worker was the identified safeguarding lead who escalated concerns, liaised with external agencies, and ensured feedback to the local authority.

The provider notified the local authority and the CQC of safeguarding concerns when staff actions or omissions resulted in harm to patients. This included when staff used unacceptable language to patients and failed to correctly undertake prescribed observations.

In July 2019, the local authority initiated a local early intervention meeting. This was prompted by a whistle-blower concern and subsequent site visit. The concerns included staff shortages, poor communication between staff, poor awareness and poor management of risk. The local authority was concerned with the provider's assurances and escalated the service to a local provider investigation procedure. The purpose of the provider investigation procedure was to oversee safeguarding and quality concerns. In November 2019, the local authority discontinued the investigation procedure assured of oversight of NHS England and the CQC.

In January 2020 the local authority advised the CQC of recent safeguarding concerns raised by staff from Clifton hospital. The local authority was satisfied with the provider's investigation and actions taken to protect the patient.

The provider had safe procedures for children that visited the hospital. The hospital social worker assessed the suitability of visits with children prior to them taking place. All visits to the hospital involving children occurred in the visiting room.

Staff access to essential information

Information needed to deliver patient care was available to all relevant staff when they needed it and was in an accessible form. This included when patients moved between teams. The provider made access to its electronic care records and intranet available to agency staff.

The provider used a combination of electronic and paper records that acted as the patient's care and treatment record. Staff reported that this caused no difficulty in entering or accessing information.

Medicines management

The provider had established medicines management practices in relation to medicines reconciliation, ordering, delivery and checking medicines. Staff kept complete records of controlled drugs and drugs liable for misuse. There was a contract in place for the disposal of clinical waste. Staff had access to a current British National Formulary for reference.

An identified pharmacist visited wards weekly to audit medicine administration charts and medicines management practices. Reviews included administration omissions, medicine self-administration practices, and storage of drugs liable for misuse. Following a visit, the pharmacist submitted a report of outstanding actions to the hospital manager.

During the inspection, we reviewed 11 medicine charts. All were in good order, contained a complete record of medicine administration, and recorded patient allergies or drug sensitivities.

Staff did not always ensure that records to support patient's self-administration of medicines was complete and up to date. It was not clear that staff reviewed, and recorded patients practices to self-administer medicines safely or in line with the providers policy guidance. On Ancaria ward, staff had not clearly documented changes to a patient's medicine self-administration status and registered ward staff could not clearly communicate the patient's current administration status. Pharmacy audits identified and recorded that staff must complete self-administration paper work in line with the providers policy.

Staff reviewed the effects of medication on patients' physical health regularly and in line with National Institute for Health and Care Excellence guidance. This included blood tests and electrocardiograms. Staff completed an audit in November 2019 that demonstrated no use of high dose antipsychotics with patients in 2019.

Track record on safety

Between November 2018 and October 2019, the provider identified 32 serious incidents occurring at the service.

The provider reported the three most frequently occurring serious incidents at Clifton hospital during this period were self-harm, alleged abuse by a third party and disruptive/ aggressive behaviour. Some serious incidents concerned staffs practice to protect patients from harm during prescribed observations or access and supervision to restricted items. For example, between September and October 2019 the provider notified CQC of four incidents of actual or alleged self-harm during prescribed observations.

Reporting incidents and learning from when things go wrong

Staff described occurrences they would report as an incident. Staff had access to a range of policies to guide their practice in the reporting and management of incidents.

Between November 2018 and December 2019, staff reported 443 incidents. Categories of the incidents staff reported included abuse, accident to a person, medication, security, self-harm and violence. The three most occurring incidents reported were security, self-harm and verbal threat to staff members.

Senior staff met to discuss all newly reported incidents at the daily morning meeting. They also discussed all incidents and reported on all serious untoward incident investigations at monthly governance meeting.

Staff received feedback from the investigation of incidents. This included meeting to discuss that feedback at staff meetings and reflective practice sessions. Staff had access to a lessons learnt log as part of ward communication folders. We reviewed the records of four staff meetings held

at the service between October 2019 and January 2020. Three of the records included concerns about staff practice to complete and record prescribed observations. For example, the October 2019 recorded that high level observations were not being completed and the January 2020 meeting recorded a concern about incorrect recording and the frequency of completed observation checks.

It was not always clear what staff had learnt from incidents and how practices had changed to prevent reoccurrence of incidents. Actions and additional learning the provider introduced following the investigation of incidents had not always resulted in embedded changes to staff practices and repeated incidents occurred. For example; staff's completion of prescribed observations. However, there was evidence the provider reviewed the progress of actions and made changes when outcomes were not met.

Staff were open and transparent and explained to patients when something went wrong. The hospital's policy for incident reporting and management detailed when staff should ensure they apply Duty of Candour.

The provider ensured staff were debriefed and received support after a serious incident. Our conversations with staff and review of records demonstrated this. Staff we spoke with provided examples of how they debriefed and supported patients after incidents.

Are forensic inpatient or secure wards effective?

(for example, treatment is effective)

Requires improvement

Assessment of needs and planning of care

We reviewed six care and treatment records. All contained a comprehensive assessment that staff had completed during the initial patient assessment period. Areas of assessment included mental health history, medical history, offending history and substance misuse.

All of the six records seen demonstrated staff completed a full physical health examination on admission and provided ongoing monitoring of physical health needs.

Care plans were present in all the care and treatment records reviewed. Care plans were detailed, addressed the individual needs of patients, linked to assessments and covered a full range of needs. We found care plans had some recovery focus and considered opportunities for discharge. Additional care plans provided staff with guidance on the use of as required medicines and positive behavioural support interventions.

Records showed staff reviewed and updated care plans with patients.

Best practice in treatment and care

Staff provided a range of care and treatment interventions suitable for the patient group, which included psychological therapies. Policy and procedure guidance to staff followed National Institute for Health and Care Excellence recommendations. The provider had introduced a structured programme for patients focussing on occupational therapy and psychological interventions. A commissioning case manager told us this had been previously been lacking from the service. Psychology staff offered a range of interventions appropriate to patients with personality disorders. There were no waiting lists to access psychological therapies. Patients commented positively about the accessibility and quality of psychology interventions. The provider had supported the provision of occupational therapy with staffing assistance from one of its nearby locations. The provider monitored patient engagement in meaningful activities. Records from week commencing 19 January 2020 demonstrated that all patients had exceeded the agreed 25 hour target for weekly meaningful activity.

Staff ensured that patients had good access to physical healthcare, including access to specialists when needed. Staff developed care plans for patients with specific physical health needs. The hospital had an identified physical health lead.

All patients were registered with a local general practitioner surgery and dentist. A doctor from the surgery visited the hospital to see patients weekly. Patients able to attend for physical healthcare appointments in the community were encouraged to do so. The provider had introduced onsite provision of optician and chiropody services to the hospital.

Staff supported patients to live healthier lives. This included access to a gym and a health group. Carers we spoke with commented positively about the ways staff helped their relatives to be healthy.

Staff used recognised rating scales to assess and record severity and outcomes. Staff used Health of the Nation Outcome Scales to record and review a patient's progress. Multidisciplinary staff used assessment and outcome tools specific to their professional discipline with patients.

Staff used technology to support patients effectively.

Staff participated in clinical audit and benchmarking initiatives. The provider had an annual clinical audit programme that staff participated in. The hospital benchmarked its performance against similar Cygnet services locally. However, we saw one example where staff had not embedded recommended changes to practice following an audit. Staff had not ensured medicines self-administration paper work was completed in line with the providers policy.

Skilled staff to deliver care

We were not assured that all ward based staff were experienced or had the right skills and knowledge to meet the needs of the patient group. Actions the provider took following incidents supported this. For example; the provider had made changes to staff allocated security tasks after an incident demonstrated that inexperienced staff did not always have sufficient skills or competency to complete them safely. The provider identified it had not always been possible to recruit nurses with forensic experience and it contributed to inconsistent standards of relational security practice. Staff we spoke with were not always happy with the abilities of newly recruited staff and the level of support new staff required to complete ward based tasks. A commissioning case manager commented on a need for the provider to review its recruitment programme and ensure that recruitment was accompanied by specialist personality disorder training.

Staffs completion of specialist training for their roles did not always meet the provider's 85% target completion rate. This included training specific to personality disorder and observation and engagement. However, when we inspected only 35% of nursing assistants and 62% of nurses had completed face to face personality disorder training and only 71% of staff had completed observation and engagement training. The standard of specialist training necessary to staff roles was not always sufficient. In May 2019, the Quality Network for Forensic Mental Health Services visited the hospital and described the existing one day personality disorder training provided to staff as being only of a basic level. It recommended the level of personality disorder training should be increased. Staff we spoke with shared this opinion. The hospital manager described changes in personality disorder training, commencing February 2020. The provider described the training as detailed and robust and was to be delivered inhouse by the psychology department.

In addition to qualified nurses and nursing assistants, the hospital had a multidisciplinary team to meet the needs of patients. This included a consultant psychiatrist, a speciality doctor, an occupational therapist, a social worker, a psychologist, an assistant psychologist, and two therapy coordinators.

Additional visiting professionals contributed to the multidisciplinary team. This included a general practitioner, speech and language therapist, dietician, podiatrist, pharmacist, and music teacher.

Managers provided new staff with an induction to the service. The hospital manager reported that a change to the local induction process had had positive outcomes for staff. There was a five-day induction, this included contributions from multidisciplinary staff. Areas covered during induction included observation and engagement, relational security and provider values. The provider supported nursing assistants to complete care certificate training and had a target for all nursing assistants to be compliant by June 2020. When we inspected, 10 support staff had completed care certificate training.

All new staff were subject to a six-month probationary period. Supervising staff reviewed progress monthly and, after six months, formally assessed the staff members conduct against agreed performance criteria. Records showed probation reviews did not always happen on time. However, the provider used staff supervisory practices to oversee staff competence and performance during this time.

Managers ensured that staff had access to regular team meetings. We viewed records from September 2019 to January 2020. Meetings followed a set agenda that included what was working well, what was not working so well, and lessons learnt.

The provider made annual appraisals available to staff. At the end of December 2019, the provider reported an appraisal rate for non-medical staff of 94%. This was in line with appraisal rate reported at our previous inspection and

above the provider's 90% target rate. The provider had a package of paperwork to support staff appraisals, this included a knowledge and skills matrix from which staff competency was assessed.

The provider made supervision available to staff. Supervision is a meeting to discuss case management, to reflect and learn from practice, personal support and professional development. Staff engaged in monthly supervision meetings. At the end of December 2019, the provider reported a supervision rate of 95%. This had increased from the rate reported at our previous inspection. The hospital manager had recently changed the agenda of supervision meetings to include mandatory discussions about serious incidents, lessons learned, security duties, restricted items access, boundary challenges, diary management and staff conduct and professionalism. The agenda prompted staff to read a 'policy of the month'.

Managers identified the learning needs of staff during appraisals and supervision. However, staff told us that some opportunities to develop could be difficult to access because of ward staffing demands. For example; reflective practice.

Managers dealt with poor staff performance, initially through probation reviews and supervisory practices. The providers human resources department supported managers to escalate and manage concerns. We saw examples of staff employment being terminated for using unacceptable language to patients and agency staff barred from working at the hospital after being found asleep during their shift. Managers communicated poor staff performance to external agencies and registered staff professional bodies. We saw the provider continued to introduce actions to improve local staff performance.

Multi-disciplinary and inter-agency team work

Senior staff, multidisciplinary team staff and ward nursing staff attended daily morning meetings each morning. Staff discussed staffing levels, incidents, patient risk levels, patient observation levels, and patient community leave. We observed one morning meeting where staff discussed and reviewed patient risk, physical health, prescribed observation levels, complaints and restrictive practice. We observed positive and practical discussions between staff in attendance.

Staff held a weekly multidisciplinary team meeting. During the meeting, staff discussed and reviewed the care and treatment of six patients. This meant that patients had a formal review of their care and treatment once every four weeks. However, two staff told us that differences of opinion between members of the multidisciplinary team staff sometimes made reaching care and treatment decisions difficult.

At our previous inspection we told the provider they must ensure the handover of verbal and written information between staff is effective and minimises the risk of untoward incidents occurring to patients. Ward staff held handover meetings at changes of shift during the day. The hospital manager reported changes in practice that had brought some improvements. For example; the newly introduced ward manager role attended daily handovers between ward staff. Staff used handover books, ward diaries and staff allocation sheets to support verbal handovers. We reviewed handover notes, they demonstrated staff shared basic information to maintain patient safety including risk and observation level.

Staff reported effective working relationships with teams outside the hospital. For example; with regional commissioning case managers. CQC had observed senior staffs' positive participation with the local authority in relation to safeguarding concerns.

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

The provider made Mental Health Act and Code of Practice training available to staff as part of mandatory training requirements. The provider reported that 92% of eligible staff had received training. This was an improvement from the 45% reported at our previous inspection.

The service had a dedicated member of staff to provide administrative support for the implementation of the Mental Health Act and its Code of Practice. The staff member was new to post and did not yet demonstrate good understanding of the Mental Health Act, the Code of Practice and the guiding principles. The psychiatrist and an experienced Mental Health Act administrator from one of the provider's nearby locations regularly supported the new member of staff. However, in November 2019 staff missed the renewal of one patient's detention and detained the patient illegally.

Inadequate

Forensic inpatient or secure wards

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

Staff explained to patients their rights under the Mental Health Act in a way that they could understand, repeated it as required and recorded that they had done it. This included information about independent mental health advocacy

Staff ensured that patients were able to take Section 17 leave (permission for patients to leave hospital) when this has been agreed with the responsible clinician or, where required, the Ministry of Justice. However, on return to the hospital, staff did not routinely review and record the outcome of Section 17 leave with patients.

Staff adhered to consent to treatment and capacity requirements. We reviewed 11 medicine charts and those needing legal authorisation had correctly completed forms attached. This meant that nurses administered medicines to patients under the right legal requirements. Staff requested a second opinion appointed doctor in a timely way in accordance with the Mental Health Act Code of Practice.

Staff stored copies of patients' detention papers and associated records correctly and so that they were available to all staff that needed access to them.

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

Staff did regular audits to ensure that the Mental Health Act was being applied correctly and there was evidence of learning from those audits.

Good practice in applying the Mental Capacity Act

The provider made Mental Capacity Act training available to staff as part of mandatory training requirements. The provider reported that 90% of eligible staff had received training. This was an improvement from the 45% reported at our previous inspection.

Staff we spoke with demonstrated understanding of the Mental Capacity Act and the five statutory principles.

Between November 2018 and October 2019, staff made no Deprivation of Liberty Safeguard applications. Staff understood when to make Deprivation of Liberty Safeguard applications and knew to monitor the progress of applications to supervisory bodies.

The provider had a policy on the Mental Capacity Act that included Deprivation of Liberty Safeguards. Staff were aware of the policy and knew how to access it.

Staff knew where to get advice regarding the Mental Capacity Act and Deprivation of Liberty Safeguards. This included accessing the policy and speaking to senior clinical staff.

Staff took all practical steps to enable patients to make their own decisions.

Records showed that, for patients who might have impaired mental capacity, staff assessed and recorded capacity to consent appropriately. This was done on a decision-specific basis regarding significant decisions, including the capacity to consent to treatment.

When patients lacked capacity, staff knew how to make decisions in a patient's best interests, recognising the importance of the person's wishes, feelings, culture and history.

The provider had arrangements in place to monitor and audit adherence to the Mental Capacity Act. Staff included discussions about the Mental Capacity Act at integrated governance meetings.

Are forensic inpatient or secure wards caring?

Requires improvement

Kindness, privacy, dignity, respect, compassion and support

At our previous inspection, patients raised concerns about the way staff sometimes treated them and we told the provider they must improve this. However, this continued to be a concern. Of the seven patients we spoke with, five raised concerns about the way staff sometimes spoke or behaved to them. This included that staff failed to keep them safe, belittled them, purposefully provoked them or ignored them. Patients detailed two incidents when staff

had not spoken appropriately or behaved well towards them. Both incidents were supported by incident report records and demonstrated senior staff acted to address staff performance in these incidents. Patients expressed greater concern about the attitude and behaviours of temporary staff, rather than those of staff employed directly by the provider.

During the inspection we were informed of alleged concerns about recent staff practice including staff attitude following an incident of restraint and staff behaviour to prevent the escalation of an incident involving a patient. Senior staff were investigating these concerns.

We reviewed staff meeting records from October 2019 to January 2020. Three of the four records demonstrated that staff did not always provide patients with help, emotional support or advice when they needed it. For example, the staff meeting record from January 2020 detailed that staff spent a lot of time in ward offices and had not engaged with patients. Our observations of staff practice during the inspection supported this. Records also identified staff had not supported patients to clean and tidy bedroom areas when this had been raised as a concern.

Staff did not always protect the privacy of patients. Three told us staff did not always knock and wait for permission before entering individual bedrooms. During the inspection we saw a visiting health professional treating patients. Staff had not provided privacy screens for the intervention being delivered.

Our interview response from patients differed from the outcomes reported in the provider's Clifton hospital 2019 patient survey. The survey received 12 responses 75% of which reported staff were approachable, polite and treated patients with respect.

Staff supported patients to understand and manage their care, treatment or condition. Our conversations with patients and the results of the provider's 2019 patient survey confirmed this.

Staff directed patients to other services when appropriate and, if required, supported them to access those services.

We saw examples of good practice that demonstrated staff understood the individual needs of patients, including their personal, cultural, social and religious needs.

The provider prompted staff to raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards patients. For example; the agenda for supervision meetings discuss included staff conduct and professionalism. The hospital manager reported staff escalated concerns about unsafe practices of others. For example; if a staff member slept when on duty.

At our previous inspection, concerns were raised about the way staff maintained the confidentiality of information of all people using or employed by the service. We told the provider they must improve this. The provider had completed actions towards this. However, concerns remained about how effectively privacy films applied to ward office windows worked. The provider had referred this to maintenance, but the concern remained when we inspected. We did see other staff actions to maintain confidentiality including screens to cover patient sensitive information recorded on boards. During our interviews with staff and patients concerns about confidentiality remained. In the providers local 2019 patient survey, 50% of respondents felt confidentiality was respected by staff.

Involvement in care

Involvement of patients

At our previous inspection, we raised concerns that staff did not always keep patients informed of changes to the service. The hospital manager described improvements to staff practices that included introducing changes to patients during community meetings and providing printed copies of changes in procedures. However, two patients we spoke with still felt staff did not always keep them informed of changes to the service.

Records demonstrated staff involved patients in care planning, assessments and multidisciplinary review meetings, but it was not always clear if staff had shared copies of care plans with patients. For example; only two of the six records we reviewed, clearly demonstrated staff had provided a copy of the care plan. However, of the seven patients we spoke with, four told us they'd felt involved in developing their care and treatment plans and three told us staff had shared copies of plans with them. Patients from Acorn ward responded more positively about involvement in their care and treatment than those from Ancaria ward.

Inadequate

Forensic inpatient or secure wards

When appropriate, staff involved patients in decisions about the service. This included staff recruitment, participation in the People's Council, and a patient representative from the People's Council attending monthly governance meetings.

Staff enabled patients to give feedback on the service they received. This included an annual patient survey, feedback cards and community meetings.

Care and treatment records demonstrated staff asked patients about advance statements, but practice did not appear routinely embedded. An advance statement is written preferences, beliefs and wishes about your future care. Care records did not demonstrate how staff managed and applied advance statements. One patient told us staff had asked them to sign an advance statement without first asking them what they wished to have included in it. Staff should give patients at risk of presenting with behavioural disturbance the opportunity to have their wishes and feelings recorded in an advance statement.

Staff ensured that patients could access advocacy. An advocate visited the hospital twice a week. Patients we spoke with were positive about the advocacy service they received.

Involvement of families and carers

Staff provided examples of how they informed and involved families and carers. This included invitations to meetings and family events at the hospital. One carer told us staff did not always invite them to meetings and another wanted better communication from staff.

The provider enabled families and carers to give feedback on the service they received. An action plan resulting from the services 2019 carer survey included actions to increase engagement with carers. It also included concerns raised by carers in relation to staff assisting patients with self-care and staff attitude when responding to carers.

Staff and carers had worked together to create a carers handbook. This handbook was available in reception. It included information about the hospital, visiting policies, staff profiles, information about the Mental Health Act 1983 and the Triangle of Care. The Triangle of Care model promotes collaborative working between patients, carers and staff.

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

(for example, to feedback?)

Good

Access and discharge

Bed management

The provider's website had clear information on bed availability and how to make a referral. NHS England's specialist commissioners funded the hospital's beds. The provider had a central online referral team who processed referrals.

Between May and October 2019, the provider reported average bed occupancy of 89% on Ancaria ward and 97% on Acorn ward.

In November 2019 the provider introduced a voluntary suspension of admissions to the hospital. This remained in place when we inspected. The provider took this decision to focus attention on the induction and training of new staff including ward managers. They wanted to ensure that they kept the use of temporary staff to a minimum. The provider also wanted to finish an independent external investigation of whistleblowing concerns to CQC. Cygnet's regional operations manager reviewed the suspension of admissions regularly with NHS England and CQC.

Staff ensured patients were not moved between wards during an admission episode unless it was justified on clinical grounds and was in the interests of the patient.

When staff discharged patients or moved patients between wards they ensured this happened at an appropriate time of day.

Between February 2019 and February 2020, the average length of stay of patients on Ancaria ward was 19 months. In the same period for patients of Acorn ward, it was 41 months. Both had increased since our previous inspection. The provider calculated an average length of stay for patients of low secure services as 18 months but expected length of stay to be longer for patients of specialist services. This included personality disorder presentations.

Between February 2019 and February 2020, the service discharged three patients from Ancaria ward. In the same

period there were no discharges from Acorn ward. However, the hospital manager identified three Acorn patients with expected discharge dates of between three and six months.

Discharge and transfers of care

There was a pathway of progression, allowing patients to move from Ancaria to Acorn ward as their mental health improved. The hospital admitted most patients to Ancaria ward for assessment. When patients were ready to progress, patients then moved to Acorn ward for rehabilitation and discharge preparation. Sometimes staff moved patients between wards if there were issues with relationship dynamics or safeguarding.

Between November 2018 and October 2019, the provider reported no delayed discharges from the hospital. However, the hospital manager identified the need for robust multiagency discharge planning might sometimes impact negatively on the length of stay of some patients.

Staff planned for patients' discharge, including liaison with case managers.

Staff supported patients during referrals and transfers between services. For example; staff supported patients requiring treatment in acute hospitals.

The facilities promote recovery, comfort, dignity and confidentiality

Patients had their own bedrooms and did not have to sleep in bed bays or dormitories. Bedrooms had an en suite shower and toilet. Bedroom doors had viewing panels which opened and closed. This meant staff could observe patients in their bedrooms while also allowing privacy. Patients had access to their bedrooms during the day.

Patients could personalise their bedrooms, including personal belongings and items of furniture.

Patients had somewhere secure to store possessions. The provider made ward safes and lockers available to patients. Our conversations with patients and the results of the provider's 2019 patient survey confirmed this. However, missing property was a main theme of complaints made by patients.

Staff and patients had access to a range of rooms and equipment to support treatment and care. Both wards had a clinic and activity and therapy rooms. There was a lounge, quiet room and dining room. Additional areas of the hospital provided a gym, woodwork, computer and art rooms. Patients accessed these areas under the supervision of staff. The hospital manager had purchased new gym equipment.

The hospital had a secure garden that patients could access under staff supervision. However, patients told us access could be delayed waiting for staff to become available.

The hospital had facilities for a recovery college. The hospital manager reported it was not very active but had plans to increase this from February 2020.

The provider had visitor's policy and staff made visitors to the hospital aware of security procedures. There were two visitors' rooms near reception where patients could meet visitors in private. The provider had improved visitor rooms following feedback from patients and carers.

Patients without a mobile phone could make calls in private using ward based phones.

The hospital had secure outdoor areas. Patients accessed them under staff supervision. However, patients told us there could be delays in accessing fresh air due to staff availability.

Patients we spoke with provided positive feedback about the choice and quality of the food at the hospital.

Patients on both wards had could make hot drinks 24 hours a day. Staff on Ancaria ward could make snacks for patients 24 hours a day. Patients on Acorn ward could make their own snacks 24 hours a day.

Since our previous inspection, the provider introduced a visiting hairdresser and tuck-shop to the hospital.

Patients' engagement with the wider community

The service offered patients a structured therapy timetable delivered on site and in the community. This included skills and creative groups. For patients with access to community leave, staff ensured access to education and work opportunities. One patient we spoke with believed not enough educational opportunities were offered onsite.

Staff supported patients to maintain contact with their families and carers. Patients reported positively on this.

Meeting the needs of all people who use the service

Inadequate

Forensic inpatient or secure wards

We saw a range of information available to patients. This included advocacy services, how to complain, staff information, safeguarding and information about mental and physical health and contraband items and patient activities. All information was in English, but staff told us how this could be translated into other languages. The provider ensured staff and patients had easy access to interpreters and signers. Staff described how they met the communication preferences of patients at the hospital.

The hospital was accessible to all who needed it and took account of patients' individual needs. Staff made adaptations for patients with restricted mobility. For example; by supporting them to use the lift and access mobility equipment. All en suite facilities had step-free wet room showers.

The provider ensured patients had a choice of food to meet individual dietary, religious or ethnic needs.

Staff ensured patients had access to spiritual support. Some patients attended local church services to meet their spiritual needs. The hospital had a dedicated area and resources to support multi-faith worship.

Listening to and learning from concerns and complaints

Between November 2018 and October 2019, the provider received 30 complaints. The provider upheld eight complaints and no complaints were referred to the Ombudsman. The provider reported the top three themes of complaints as staff sleeping on duty, missing property and poor staff communication and conduct.

Patients and carers knew how to raise a concern or make a complaint. This was demonstrated in conversations we had and the outcome of the providers 2019 local patient survey.

Staff knew how to handle complaints appropriately. The provider had a policy and procedure in place to guide staff practice. This included ensuring when patients complained or raised concerns, they received feedback.

The provider has processes in place to ensure patients who raised concerns or complaints were protected from discrimination and harassment.

Staff received feedback on the outcomes from investigations into complaints and acted on the findings. Staff shared feedback at governance and staff meetings. The hospital manager described changes made following the investigation of a complaint.

Between December 2018 and December 2019, the provider recorded 22 compliments for Clifton Hospital. We saw staff discussing compliments and recognising staff contribution during a local governance meeting..

Are forensic inpatient or secure wards well-led?

Inadequate

Leadership

The hospital manager had been in post since June 2018 and had been new to low secure services. The provider supported the hospital manager to perform their role. Following our previous inspection, the hospital manager was supported to improve the service and introduce the provider's secure services policies and governance structures. This was ongoing and included regular onsite attendance by senior staff from a nearby Cygnet location.

Leadership to deliver high quality care was not embedded at the service. The hospital manager reported the service had established systems in place to support the delivery of care and treatment. However, identified that not all staff followed these systems because of inexperience or lapses in otherwise good practice. The providers previous plan to introduce greater leadership at ward level had not succeeded. Ward manager roles now replaced clinical leads. However, when we inspected it was too soon for the provider to demonstrate the impact of ward manager roles to the care staff delivered.

During the inspection, we saw the hospital manager and senior staff were visible in the service. The regional operations director visited the hospital regularly. Patient and staff experience of senior staff was generally positive, identifying them as approachable and hands on. The provider had plans to increase the visibility of ward managers with the introduction of ward based managers offices.

The provider made leadership development opportunities available, including opportunities for staff below team manager level.

Vision and strategy

Staff knew and understood the provider's vision and values. In the providers local 2019 staff survey, 96% of the 46 respondents indicated they understood the provider's values.

The provider communicated its vision and values to the frontline staff. These were accessible to staff on the provider's intranet and internet. The hospital manager reported how Cygnet's vision and values informs recruitment and supervisory practices.

Staff had the opportunity to contribute to discussions about the strategy for their service.

Senior staff could explain how they were working to deliver care within the budgets available. The provider reported on budgets as part of key performance indicators and during quarterly senior manager meetings.

Culture

Some staff did not feel respected, supported or valued. This had not improved since our previous inspection when we told the provider they should ensure planned changes to the service improve staff experience, and this is demonstrated in staff feedback. The results of the providers local 2019 staff survey demonstrated only 39% of the 46 respondents identified a feeling of respect for each other. This had reduced from 75% reported in the providers 2018 staff survey. Staff meeting minutes identified incidents of staff being impolite to each other and not working positively with agency staff. Staff we spoke with reported negative attitudes towards new starters from existing staff. The hospital manager was aware of concerns about examples of poor relations between staff and advised they would be addressed during supervision or in meetings between himself and staff. An action plan was in place as a result of the staff survey and proposed to improve staff experience through team work, supervisory practices and leadership from ward managers.

Not all staff felt positive and proud about working for the provider and their team. Only 48% of respondents in the providers local 2019 staff survey recommended Cygnet as a great place to work. This had reduced from 70% in the 2018 survey. The respondent in the staff exit interview reviewed did not recommend Cygnet as a place to work.

The provider had a whistleblowing process in place. The hospital manager had also organised drop-in human resources sessions that allowed staff to raise concerns confidentially. However, some staff did not always feel able to raise concerns without fear of retribution. During the inspection, staff expressed concern about speaking to CQC and the potential negative impact this might have. Between July 2019 and January 2020, CQC received seven whistle-blower concerns about Clifton hospital. Whistle-blowers' concerns included staffing, staff turnover, staff support and risk management. The provider investigated whistle-blower concerns CQC raised with them and had initiated an independent review of concerns.

Managers dealt with poor staff performance when needed. The provider had a clear process of escalation and we saw how the hospital manager implemented this. Staff meeting records showed that managers raised concerns with staff directly.

Teams did not always work well together. Conversations with staff and records of staff meetings demonstrated this. A commissioner of the service identified improvement in the way the multidisciplinary team and ward staff worked together but believed this still needed further work. Where the hospital manager was aware of difficulties, they acted to address them.

Staff appraisals included conversations about career development and how it could be supported.

The provider promoted equality and diversity in its day to day work. Staff completed equality and diversity training as part of mandatory training requirements. The provider carried out an equality and diversity assessment of all policies and procedures.

The service's staff sickness and absence rates were higher than the provider's target.

Staff had access to support for their own physical and emotional health needs through an occupational health service.

The provider had an awards programme that recognised the success of teams and individual staff members. Locally, the service ran an 'employee of the month' scheme and we saw good practice in governance meetings to recognise staff contributions.

Governance

The provider had established governance systems in place. For example, senior staff investigated incidents and used systems to deal with poor staff performance. Senior staff met to discuss performance indicators and actions at local and regional governance meetings. We reviewed three local governance meeting records between September 2019 and January 2020. Records were detailed and included the outcome of local audits. However, records did demonstrate that some concerns persisted in the service and the impact of actions to address the concerns was not always clear. For example; all three records recorded concerns about staff lapses in relational security and two recorded that observations were not always done well by all staff.

Following the previous CQC inspection, the provider implemented an action plan to address the concerns raised. However, we found concerns remained in some of these areas. For example, staff checks of emergency equipment, staff treatment of patients and staff observation practices to ensure risks to patients were as low as possible. Training completion rates for some courses to ensure care and treatment remained safe for this patient group did not meet the providers target completion rate. For example; personality disorder training and observation and engagement training. Actions implemented from the investigation of incidents did not always become embedded to practice and incidents of a similar theme continued to happen.

The provider had improved frameworks of what must be discussed at ward handovers and team meetings to ensure essential information, including learning from incidents and complaints, was shared and discussed. However, it was not clear staff always understood and used essential information to protect patients from avoidable harm.

The provider had a clear framework of what must be discussed at local governance and regional operational governance meetings. This included key performance indicators to gauge the performance of services, and benchmarking performance against similar services within the region. The provider had introduced combined local governance meetings between Clifton Hospital and a nearby Cygnet location also providing low secure care.

Staff undertook or participated in local audits. Senior staff met to discuss the outcome of audits at local governance groups. Audits demonstrated where good practice was taking place, for example; meeting the needs of and monitoring of physical health. The provider used audit to monitor care and treatment concerns. Some demonstrated improvements, for example; a reduction in the concern of staff sleeping on duty. However, we also when staff had not embedded recommended changes to practice. For example, following a medicines audit.

Concerns were raised that staff did not always work well together to meet the needs of patients. For example, about how staff organised and co-ordinated care effectively. However, staff did understand arrangements for working with teams external to the provider.

Management of risk, issues and performance

The provider had a local risk register in place for the period 2018/2019. Processes were in place to allow staff to escalate concerns. Senior staff met to discuss and review risk registers at integrated governance meetings.

We saw the 2018/2019 risk register included concerns about staff skill mix, lack of boundaries in staff practice and high numbers of staff in probation period. However, senior staff had recorded this concern as completed in August 2019. We saw the risk register did not reflect concerns that had arisen during 2019. For example; escalation by the local safeguarding authority to a provider investigation procedure. Also, it did not reflect current concerns, including staff turnover and relational security, or concerns raised by staff to CQC during this inspection. However, the provider did have a local improvement plan that covered many of these concerns and an action plan specific to one serious safeguarding concern. The provider included these as part of the local overarching action plan.

The hospital had a business continuity plan to prepare for and manage emergencies. For example; adverse weather or infection outbreaks.

Inadequate

Forensic inpatient or secure wards

.The provider had invested in improvements to the hospital environment, equipment for patients and leadership roles for staff. We saw no evidence the provider was making cost improvements that might compromise patient care in the service.

Information management

The provider used systems to collect data from wards and directorates that were not over-burdensome for frontline staff. Hospital administration staff contributed to the collection of data from wards.

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. Staff completed information governance training as part of mandatory training requirements. When we inspected, 98% of staff had completed this training. Staff accessed electronic care records with the use of individual logon identifications and passwords.

The hospital manager had access to information to support them with their management role. The hospital used key performance indicators to gauge the performance. These included incidents, safeguarding, staffing, complaints, and training. The hospital manager reported ward managers would have access to performance indicators. The provider presented key performance indicators in an accessible monthly report, they tracked performance against other Cygnet hospitals, and senior staff met to discuss them.

Staff made notifications to external bodies as needed. This included to the local authority and CQC. However, we were told that staff did not always report serious incident to commissioners within the required time frame.

Engagement

Staff, patients and carers had access to up-to-date information about the work of the provider and the service. This included intranet access for staff, a well-resourced reception area, and the provider's website.

Patients and carers had opportunities to give feedback on the service they received in a manner that reflected their individual needs.

Managers and staff had access to the feedback from patients, carers and staff and used it to make improvements. The provider had action plans in place to address concerns raised from patient, carer and staff surveys.

Patients and carers could be involved in decision-making about changes to the service. For example, patient participation in staff recruitment. However, two patients we spoke with still felt staff did not always keep them informed of changes to the service.

Senior staff engaged with external stakeholders, including commissioners and the local authority. Commissioners completed regular quality visits.

Learning, continuous improvement and innovation

Staff met to discuss learning from incidents and actions for improvement at team and governance meetings.

The provider had a research policy in place to guide staff practice. Multidisciplinary staff discussed research initiatives as part of monthly continuing professional development.

In November 2019, staff participated with the service's GP to audit the physical health needs and monitoring of patients at the hospital. The audit results demonstrated staff had monitored the six parameters relevant to physical health reported by NHS England.

Staff did not report they were involved in innovations and we did not see any examples of innovations at Clifton hospital. However, we did see evidence of quality improvement initiatives taking place in the service. For example, investment in a new extra care facility.

The hospital manager provided an example of a quality improvement tool being implemented by ward managers. This was the Situation, Background, Assessment and Recommendation communication tool.

The hospital was part of the Quality Network for Forensic Mental Health Services. This is a quality improvement network for low and medium secure inpatient forensic mental health services across England. As part of this, in May 2019 the hospital had participated in a peer review. Peer review is a process of professional assessment by people working in the same field. The review included

Inadequate

Forensic inpatient or secure wards

positive feedback about patient involvement, links with the community GP service and weekly reflective practice. Included as areas for improvement were relational security, personality disorder training and blanket restrictions.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

The provider must ensure all staff complete training that is sufficient to meet the needs of patients, demonstrate staff competence and ensure patients safety (Regulation 18, Staffing)

The provider must ensure staff follow plans, pathways and procedures when delivering care and treatment. (Regulation 12, Safe care and treatment)

The provider must ensure staff maintain the confidentiality of information of all people using or employed by the service. (Regulation 17, Good Governance)

The provider must ensure staff maintain accurate records of patient care and treatment, including patient observations, and patients' self-administration of medication. (Regulation 17, Good Governance)

Action the provider SHOULD take to improve

The provider should ensure all staff ensure the privacy of patients at all times.

The provider should ensure all staff treat patients with dignity and respect at all times.

The provider should ensure staff understand, develop and apply advance statements with patients.

The provider should ensure staff complete security checks of the hospital environment.

The provider should ensure they deploy sufficient numbers of suitably competent, skilled and experienced ward based staff to safely meet the needs of patients using the service.

The provider should ensure staff conduct and the provision of care and treatment protects patients from avoidable harm or abuse.

The provider should ensure staff check emergency equipment to the frequency directed by local guidance.

The provider should ensure staff work effectively together to meet the needs of patients using the service.

The provider should ensure changes to the service improve staff experience and this is demonstrated in staff feedback.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Incidents occurred from staff omissions in care. This was a breach of Regulation 12 (2) (b)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance The provider did not always maintain complete records of patient care and treatment, including patient observations and medicines self-administration Staff did not always maintain the confidentiality of information. This was a breach of regulation 17(2)(a)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing Incident reports and records did not always support that staff were sufficiently trained or experienced. Staff completion of training to meet the needs of patients with personality disorders and ensure patient safety was low. This was a breach of regulation 18 (1) (2)(a)