Cygnet Hospital Harrogate

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	Requires improvement
Are services safe?	Inadequate
Are services effective?	Requires improvement
Are services caring?	Requires improvement
Are services responsive?	Good
Are services well-led?	Requires improvement

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

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

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

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

Summary of findings

Overall summary

We rated Cygnet Hospital Harrogate as requires improvement because:

- The hospital did not deliver safe care. Staffing levels on the wards were unsuitable for the acuity and number of patients and staff turnover was high. The hospital used a high number of agency staff and this had an adverse impact on the safety of patient care. Staff did not use an individual risk assessment as the basis for the decision about which observation level each patient should be on. They did not consistently carry out observations in a safe manner nor did they record these accurately. Staff did not carry out physical health monitoring appropriately after they had given rapid tranquilisation. Use of restraint was high and some members of staff expressed the view that restraint was used more often than necessary when there was low staffing levels on the wards. Insufficient action was taken following serious incidents to mitigate the risk posed. The on-call system was flawed and there were delays in patients receiving medical support from doctors. Patients' bedrooms were not always placed according to gender. Blanket restrictions were in place. Staff did not always promptly ascertain what medicines patients were taking for physical health conditions, or whether they had allergies, when they were admitted.
- Care was not consistently effective. The hospital did not have a multi-disciplinary team and care was not reflective of their statement of purpose. Patients could not access activities or therapies seven days a week. Documents such as section 17 leave forms were not correctly completed. Consent to care and treatment was not recorded in all patient files. Informal patients' rights under the Mental Health Act were not upheld on admission as they could not leave the hospital unaccompanied.
- Staff were not always caring. They could be "abrupt" to patients when the wards were busy. Staff were heard discussing patient confidential information at the nurses' stations. Patients did not feel informed of or involved in risk assessment and medicines decisions. Carers were not involved in care decisions or routinely contacted. Because of the absence of appropriate rooms or an examination couch, staff had to hold one to one meetings with patients and undertake physical examinations in patients' bedrooms.
- The governance structures were not robust. The auditing processes were not always effective. Not all ligature risks had been recognised and paperwork errors were not identified. Staff morale was low and not all staff felt they could raise concerns with their line manager. Staff did not feel supported within clinical supervision. Mandatory training was not consistently enforced. The service was placed under financial restrictions that limited their ability to respond to concerns that they had identified.

However:

- There was good team working and respect between teams. Staff had access to opportunities not expected of their role; such as a health care support worker leading the Safe Wards implementation. The managers had created a staff representative group where staff could raise concerns anonymously without managerial presence and evidenced actions following this. Staff were complimentary of the clinical and hospital manager. Staff had regular appraisals and managerial supervision; engaged in de-briefs following incidents and encouraged reflective practice regarding improvements. Poor performance was investigated and appropriate support put in place.
- Shortly before the inspection, Sanctuary had implemented Safe Wards as an ongoing initiative to reduce restrictive practice. Patients were more complimentary of the staff approach on Sanctuary.
- Care plans were personalised and reflected the patient's voice and that the service was discharge and recovery focused. Patients had a comprehensive assessment on admission.
- Duty of candour was embedded and patients were told when things had gone wrong. Patients felt safe to raise concerns; staff acted on patients' concerns raised in complaints and community meetings.

Summary of findings

Patients had regular access to an independent mental health advocate who also assisted with social needs such as housing. The hospital was linked to an interpreter service for patients who required it and had good disabled access.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Acute wards for adults of working age and psychiatric intensive care units	Requires improvement 	

Summary of findings

Contents

Requires improvement

Services we looked at

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

Summary of this inspection

Background to Cygnet Hospital Harrogate

Cygnet Hospital Harrogate is a 36-bed independent hospital, which provides in-patient care for people over the age of 18 years who are experiencing mental health problems. Patients are admitted from across the United Kingdom and the hospital provides care and treatment for informal patients and patients who are detained under the Mental Health Act 1983. Patients pay privately for their care or are admitted because their local NHS hospitals have no available beds.

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

The hospital had two wards:

Haven Ward, an acute admission ward for male and female patients with a mental health problem with 19 beds.

Sanctuary Ward, an acute admission ward for females with a mental health problem with 17 beds.

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

• treatment of disease, disorder or injury

• assessment or medical treatment, for persons detained under the Mental Health Act (1983).

The hospital has been inspected on four previous occasions. The last inspection took place in December 2016 and the hospital did not meet regulation 10 of the Health and Social Care Act (Regulated Activities) regulations 2014 Privacy and dignity. This was because the hospital did not provide a dedicated lounge that was always available solely for the use of female patients. This meant the hospital did not meet national guidelines for mixed-sex accommodation.

Our inspection team

The team that inspected the service comprised two CQC inspectors and two specialist advisors including one registered mental health nurse and one advanced nurse practitioner.

Why we carried out this inspection

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

How we carried out this inspection

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

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

Summary of this inspection

- 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. We also sought feedback from six patients at two focus groups, as well as 13 staff members at three focus groups, including ancillary and nursing staff.

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 eight patients who were using the service
- spoke with two carers or relatives of patients
- spoke with the registered manager, clinical manager and managers for each of the wards
- spoke with 16 other staff members; including doctors, nurses, health care support workers, group and activity coordinators, human resources and domestic staff
- spoke with the visiting pharmacist
- spoke with the independent mental health advocate
- attended and observed one ward round
- collected feedback from three patients using comment cards
- looked at 10 care and treatment records of patients
- carried out a specific check of the medicines management on both wards
- looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the service say

Cygnet Hospital Harrogate received over 90% in patient satisfaction rates regarding their care and treatment, the environment, and information on their rights in the 2017-2018 patient survey.

Patients spoke mainly in positive terms regarding the staff, stating that they are “caring” and “lovely”. However, they also stated that staff could be “abrupt” and “snappy” when the wards were busier. Patients also reported that staffing levels impacted on the amount of time spent with staff and meant that section 17 leave could be cancelled. Patients also commented on some of the blanket restrictions in place on the wards, such as set smoking times, and said there could be a lack of flexibility from staff.

Patients felt that they could report complaints or concerns without fear of repercussions. Patients found the environment to be comfortable and clean and said that they enjoyed the therapy and activity groups. However, patients also reported that the ward could be boring, particularly at weekends when there were no activities or therapies, or if they were on 15-minute observations as patients on this level of observations stated they were not able to access the therapy groups.

Patients we spoke with said that they had found the treatment to be positive and effective; this was also echoed by carers. They reported that when they had been involved in or witnessed incidents of restraint, they felt it had been proportionate and used when lesser interventions had not proved effective.

Patients said they wanted more information about their medicines options and wanted to be involved in their risk assessments. Some reported delays or errors in receiving their medicines.

Carers were largely positive about the service but did state that the service did not contact them. Some patients also said that they wanted to have more carer involvement in their treatment plans.

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:

• Both wards were understaffed for the acuity and number of patients.

• The distribution of bank and agency staff did not ensure that patient safety, an appropriate skill mix, or continuity of care were consistently achieved.

• The on-call system was flawed, leading to delays in receiving medical support and some nurses staying as nurse in charge of consecutive shifts.

• Timeframes for accessing medical support from the doctors was not acceptable during some incidents.

• There was a high number of incidents involving restraint within the hospital, 191 within a six-month period. Staff reported restraint was not always used proportionately.

• High agency use was negatively impacting on patient care. Five agency staff had been asked to leave for not acting in line with Cygnet policies.

• Most patients were placed on 15-minute observations on admission and were not individually risk assessed to determine their appropriate level of observation.

• Observations, both intermittent and within line of sight, were not safely carried out or documented consistently.

• There were omissions and errors in the physical monitoring of patients following rapid tranquilisation and it was not carried out in line with Cygnet policy.

• There was inconsistency in the enforcement of mandatory training.

• Staff did not always locate patients' bedrooms on Haven ward according to their gender and bedrooms could alternate between male and female. This was not consistent with national guidance on the elimination of mixed sex accommodation.

• High-risk items on the ligature audit did not all have action plans and some ligature risks had not been identified.

• Blanket restrictions were in place such as searching patients on return to the ward, having specific times for patients to access the smoking shelter, and patients on Sanctuary ward used plastic crockery.

Summary of this inspection

• Challenges were presented with continuity of care, patients reported delays in receiving physical health medicines and allergy information was missing on five medicines charts.

However:

• Patients were evidenced to receive timely apologies when something went wrong and were told about any actions taken to improve processes to prevent the same happening again.

• The hospital had mitigated blind spots on the wards using mirrors and closed-circuit television cameras.

• Staff demonstrated robust safeguarding reporting and investigation of incidents and had clear lines for distributing lessons learnt.

• The hospital had low incidents of seclusion and evidenced carrying it out in line with Cygnet's seclusion policy.

• There was evidence that de-briefs were occurring with staff and patients following incidents.

• All patients had risk assessments in place that were updated regularly.

• Staff had access to emergency medicines, grab bags and equipment such as defibrillators.

Are services effective?

Requires improvement

We rated effective as requires improvement because:

• The range of treatments provided did not reflect the service's statement of purpose. The ward team comprised only of doctors and nurses. Patients had no access to a social worker, an occupational therapist or a clinical psychologist. This limited the range of therapies available which is not in keeping with National Institute for Health and Care Excellence guidelines.

• Meaningful activities and therapy groups were not available to patients seven days a week.

• Three care plans did not have record of consent to care and treatment.

• There were errors and omissions in the section 17 leave documentation.

• Informal patients' rights were not upheld as they were not able to leave the hospital unaccompanied when they entered the service.

• Staff did not feel supported by the current clinical supervision structure.

Summary of this inspection

However:

• Staff completed assessments, including physical health examination on admission and conducted ongoing physical health monitoring.

• All information to deliver care was stored securely and was accessible.

• Patients had personal behaviour support plans in place that provided individualised primary, secondary and tertiary responses to manage behaviours.

• Staff received an annual appraisal of their work performance and regular managerial supervision. Poor performance was seen to be addressed in a timely manner.

• Staff had access to specialist training for their roles and were supported to pursue further education.

• De-briefs and team meetings were documented to be happening regularly, the minutes from Haven ward's team meetings were good.

• All patients had received information about their rights.

Are services caring?

Requires improvement

We rated caring as requires improvement because:

• Staff did not always treat patients with kindness or respect during interactions when the ward environment was busy and complaints had been raised regarding staff attitude.

• Carers were not routinely contacted or involved in decisions about patient's treatment and care.

• Patient confidentiality was not upheld at the nurses' stations as staff could be heard discussing patient information.

• Patients were not involved in risk assessments and did not feel informed or included in decisions about medicines treatment options.

However:

• Care plans were individualised and reflected the patient's voice.

• The independent mental health advocate made weekly visits to the wards and assisted with a wide variety of patient needs.

• Staff held bi-weekly community meetings with patients and there was evidence of patient requests being actioned.

• Patients and expert by experiences were used to inform service improvements such as reducing restrictive practice audits.

Summary of this inspection

Are services responsive?

Good

We rated responsive as good because:

• Discharges happened in a timely manner and the service ensured that patients were discharged to an appropriate setting.

• Patients had access to food and drink throughout the day and night and were complimentary about the quality and choice of food. Kitchen staff catered to individual dietary requirements and religious needs.

• Patients felt able to complain without fear of repercussions and were given information about how to complain and raise concerns in their welcome pack.

• The service had access to an interpreter service that could assist patients who had English as a foreign language or were hard of hearing.

• The hospital had lifts and disabled access bathrooms to assist people with mobility issues.

• The meeting room and lounge in reception were comfortable and one carer said the welcome from staff and environment made it feels like a house, not a hospital.

However:

• Physical examinations and one to ones took place in patients' bedrooms due to limited clinical space.

Are services well-led?

Requires improvement

We rated well led as requires improvement because:

• The audit systems in place did not ensure safe and quality care, or identify and manage risks. They had not identified the issues we found during the inspection for example in relation to patient observation and rapid tranquilisation monitoring.

• Records were not always accurate or correctly completed, for example section 17 paperwork.

• The morale amongst the staff team, particularly on Haven ward was very low and the hospital had a 51% staff turnover between 01 April 2017 and 31 March 2018.

• Not all staff felt they would be able to raise concerns without fear of repercussions.

• The sustainable delivery of quality of care was put at risk by the financial challenges imposed on the service.

However:

Summary of this inspection

• Staff were very complimentary of the hospital and clinical managers and stated that they were visible and approachable.

• There was evidence of strong team working and mutual support between ward staff.

• The staff representative group provided a safe space for staff to raise suggestions and concerns with anonymity.

• The hospital had multiple groups dedicated to service improvement and development, incorporating the views of the service users and the staff.

• Lessons learnt and communication was effectively distributed up to board level and down to the staff teams.

• The hospital had introduced Safe Wards to Sanctuary and were implementing it on Haven as an ongoing effort to reduce restrictive practice.

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.

In March 2018 the training figures for the Mental Health Act code of practice was 82% for Haven and 69% for Sanctuary. At the time of inspection this had increased to 91% of all staff having completed it. Staff we spoke with demonstrated good understanding of the guiding principles.

All the care plans reviewed documented that the patients' detention had been reviewed by a doctor and that both informal patients and those who had been detained had been read their rights under the Mental Health Act on admission and routinely thereafter. All care plans we reviewed of patients detained under the Mental Health Act had up to date, securely stored and correctly completed detention paperwork.

However, all the patients whose care plans we reviewed and were eligible for section 17 leave had errors with the paperwork. The section 17 file also had a document to sign patients in and out of the ward when using this leave, but there were multiple instances where patients were not signed back in following their return to the unit.

Informal patients spoken with informed us that they were not able to leave at will when they first entered the service and would have to wait for up to a week before they were assessed by the consultant to be allowed access to the hospital grounds and beyond without being accompanied by a member of staff. This is contrary to paragraph 4.51 of the Mental Health Act Code of Practice.

An external company audited prescription charts to ensure that the provider was compliant with the Mental Health Act on a weekly basis and reported any issues to the ward manager and clinical manager via the live view system. Each ward manager also performed a monthly clinical records audit which included Mental Health Act compliance.

We reviewed 32 medicines charts; of those three did not have evidence of consent to treatment.

The hospital employed a Mental Health Act administrator who offered support in making sure The Act was followed in relation to, for example, renewals, consent to treatment and appeals against detention. Staff on the wards had access to the Mental Health Act policy.

Patients from both wards had weekly access to an independent mental health advocate.

Mental Capacity Act and Deprivation of Liberty Safeguards

All staff had completed the Deprivation of Liberty Safeguards and Mental Capacity Act training in March 2018. Staff were trained in and had a good understanding of the Mental Capacity Act 2005, five statutory principles and the definition of restraint.

Staff had access to a copy of the policy on Mental Capacity Act including Deprivation of Liberty Safeguards on both wards.

There had not been any Deprivation of Liberty Safeguards applications made between 01 April 2017 and 31 March 2018.

The ward managers stated that they monitored compliance with the Mental Capacity Act alongside their Mental Health Act audits.

Overview of ratings

Our ratings for this location are:

Detailed findings from this inspection

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

Notes

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

Requires improvement

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

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

Inadequate

Safe and clean environment

There were poor lines of sight throughout the building and wards. The service mitigated this risk using observation mirrors and closed-circuit television cameras that monitored communal areas throughout the hospital and both wards.

Environmental risk assessments had been completed as required within the last 12 months. The communal areas of the hospital were rated as low risk on the ligature audit due to reception staff being present and the communal areas being used by patients and staff. The bannisters and balustrades up the staircase in communal areas had been audited as a low risk for this reason also. However, staff did not sit at reception in the evenings or leave the ward to go in the communal areas during the night shift. As the ward doors were rarely locked, this meant patients could access the rest of the hospital when it had minimal monitoring. We raised this on inspection and the hospital manager informed us that they have since commissioned for these bannisters and balustrades to be boxed in to mitigate the risk.

The ward floor print showing the location of ligature risk was displayed in the staff offices so that staff were aware of the areas of concern. However, the ligature audit did not include the hospital grounds. It also did not have an action plan for all areas that had been identified as "high risk", with some listing staff observation as the mitigating factor.

Sanctuary is a female only ward and was therefore compliant with the Mental Health Act Code of Practice and Department of Health guidance on eliminating mixed sex accommodation. Haven is a mixed sex ward. Both wards provided patients with single rooms with en-suite facilities.

Managers and staff were aware of the requirements for same sex accommodation. The ward had a comfortable designated female only lounge. Staff informed us that where male and female patients' bedrooms were on the same corridor, they tried to locate them at different ends according to gender. However, on occasion, due to the swift patient turnover and patients being settled in their rooms, this was not always possible. Staff said that they mitigated any associated risk through observations and that patients could lock their bedrooms when needed from the inside. There was one incident recorded of a male entering a female's bedroom when they were asleep; staff responded immediately, notified the patient who had been sleeping and placed her on close observations to safeguard her until a male only placement was found. Another male was also moved to a male only unit during a separate incident that had caused concern for the female patients' welfare.

All staff carried personal alarms and all bedrooms had nurse call systems in their rooms which could be moved to suit the requirements of the patient. Bedrooms also had anti-barricade doors with viewing panels that staff and patients could operate.

The hospital was clean, well-furnished and well maintained. There was hand sanitiser in the entrance to the

wards with infection control information. Domestic staff were observed cleaning hospital and ward areas during our visit and the cleaning schedule included daily log sheets, checklists and temperature records. On 26 September 2017 the local council awarded a food hygiene rating of five (very good). Staff were observed to adhere to infection control principles such as hand washing and 87% of staff had completed their infection control mandatory training. The infection control audits had actions shown to be carried out in a timely way.

Both clinic rooms had appropriate emergency drugs stored in the fridges and the fridge temperatures and grab bags were checked daily. Haven had a defibrillator in the clinic. Both the fridges and medicines cupboards were in order. However, there was no allocated individual who cleaned the equipment in the clinics; it was the responsibility of the individual who had used it to clean it and there were no visible stickers showing the date it had last been used.

Safe staffing

Between 01 April 2017 and 31 March 2018, the number of substantive staff was 24 on Haven and 19 on Sanctuary; within the same period the hospital had a 51% staff turnover rate as 11 members of staff from each ward had left. The ward managers gave explanations for each of the staff who had left, including pursuing further education and not feeling comfortable with a faster paced ward with a higher level of acuity. At the time of inspection, the total number of staff on Haven was 18, with one health care support worker on maternity leave. The number on Sanctuary remained at 19, though two nurses were on maternity leave. The hospital had four qualified nurse vacancies which the hospital had filled with three qualified nurses and four preceptorship nurses with an expected start date in September 2018.

Staff worked from 07:30 until 20:00 for a day shift and 19:30 until 08:00 for a night shift. Managers used a Cygnet specific staffing matrix to estimate the numbers and grades of staff needed. Sanctuary's base staffing level was two nurses and three health care support workers during the day and two nurses and two health care support workers at night; Haven's was two nurses and three health care support workers during the day and one nurse and three health care support workers at night. Sanctuary ward had a higher nurse provision as it typically managed a higher number of incidents. Staffing levels were formally reviewed every six months by the hospital manager, clinical manager, operations director and the board. The hospital managers informed us that following the inspection the staffing levels on both wards were increased for the day and night shifts.

Managers told us that they prioritised ward safety and would staff beyond the matrix figures should the ward acuity demonstrate the need. The managers held a meeting each morning to discuss level of acuity on the wards and the level of staffing required. During the inspection, incidents occurred on Haven that required two patients to be escorted to hospital by three members of staff, leaving the ward short staffed. Sanctuary was staffed to base level and Haven had one more health care support worker than their base level. The ward manager did not call for bank and agency support for the remainder of the shift as outlined in the policy. Instead, we observed the ward and hospital managers attending for periods and assistance was requested from Sanctuary ward and agency support was gained for the night shift. We observed staff members moving from one ward to another for short periods to support both wards as Sanctuary had been left short staffed by assisting.

The staff survey for 2018 showed that 28% of staff that responded felt that "there are enough staff on the unit to enable me to do my job properly", 22% responded neutrally, and 50% responded negatively to the statement. Staff told us that the ward can feel "dangerous", "chaotic", "unsafe" and like "constant firefighting" and that they often did not have the opportunity to take their full allocated break as they did not feel the ward would be safe if they did so.

Some staff nurses said that the on-call system was ineffective as not all staff would be willing to come in to assist on a night shift. Four nurses across the focus groups and inspection told us that (though very occasional) they had worked 24-hour shifts. They said that if there was a last-minute requirement for nurse cover and it could not be filled, the nurse in charge from the day shift would remain as nurse in charge of the unit. Managers said that there was no specific policy for managing this situation as it was not the expectation and should be a rare occurrence. However, the provision of three nurses within the hospital during a night shift meant that a nurse from one ward could cover an extended break and they would ensure the nurse had their shifts rearranged to compensate for staying.

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

Requires improvement

The ward rota from 07 May 2018 until 08 July 2018 showed that Sanctuary was staffed below its base staffing levels for nine shifts, two of these shifts were short of one nurse, staff worked overtime to cover 17 shifts and had one regular member of staff (the rest as bank or agency) on the ward for 13 shifts. Of the shifts below staffing levels, three were to facilitate staff accessing training. For the same period Haven was staffed below its base staffing levels for three shifts, staff worked overtime to cover two shifts and had one regular member of staff on the ward for 11 shifts, one shift was staffed solely with agency staff as the only regular staff member assigned to the shift was sick. Most shifts with one regular member of staff were night shifts, and the regular staff member was often a health care support worker. As on the day of inspection, the rotas demonstrated that the wards often relied on sharing staff resources to assist with unexpected absences and incidents on the unit.

In the three-month period between 01 January 2018 and 31 March 2018 the hospital filled 409 shifts with bank or agency staff and six shifts remained unfilled. The ward managers informed us that they mitigated the impact of this by regularly employing agency nurses with knowledge of the wards on a full-time basis to provide familiarity and continuity of care for the patients. This was supported by the rotas which showed the same agency nurses being booked for most night shifts; there was less regularity amongst the agency health care support workers.

There was some evidence of the use of agency staff impacting on patient care, over a six-month period five agency staff had been asked not to return to the service for either inappropriate application of restraint or incorrectly carrying out patient observations. However, the hospital evidenced that they had appropriately investigated these incidents, the agency employing the individual had been notified, safeguarding alerts raised and the Nursing and Midwifery Council contacted where suitable.

Agency staff received a short induction into the unit, which entailed a ward tour and completing an induction sheet to sign that they had read the specified policies, such as the observations policy. Bank staff received a more comprehensive two-day induction prior to starting.

The hospital managers were aware that they had a high use of agency and it is something that they had been actively trying to rectify by recruiting staff into their vacancies. They stated that once the preceptorship nurses were registered with the Nursing and Midwifery Council and able to start their induction (which was anticipated to be in September 2018) there should be limited use of agency nurses.

Patients told us that there was always a member of staff that they could approach in communal areas, usually the person carrying out observations, this was observed during our time on the wards. Patients knew where they could find a qualified nurse but said that they were often in the office. Both staff and patients informed us that they did not get as much time for one to one interactions as they would like, with both citing paperwork and incidents as reasons. Four of the 14 patients that we spoke with during the focus groups and inspection said they had not had any one to one time with their named nurse.

Staff told us that due to insufficient staffing, patients' escorted leave was often rearranged for another day, the timeframe would be reduced, or in some cases leave was cancelled. Seven of the patients with spoke with during the inspection and focus groups said that they had had escorted leave cancelled due to staffing. We were unable to corroborate this on inspection as the hospital did not record planned section 17 leave, only ones that had taken place. We were advised following the inspection that the service had introduced a new system for recording cancelled and postponed leave.

On Haven we observed that when staff activated their personal alarm staff from both wards that were trained in the prevention and management of violence and aggression ran to assist. Whilst this meant that there was enough staff responding to carry out the physical interventions, it also meant that either one of the wards may be left with just one member of staff present (as the health care support worker allocated to observations was required to remain). We raised this with the hospital manager and clinical manager during the inspection and they informed us that the emergency response system to support physical interventions had since been amended; staff would be allocated the role of responding to an alarm at the start of each shift to ensure a safe number of staff remained behind.

Doctors spoken with said that they could attend the ward quickly in an emergency and within around 45 minutes in the night if they were the doctor on call. The Accreditation for Inpatient Mental Health Services and National Institute of Health and Care Excellence guidelines state that a doctor

should be able to respond within 30 minutes to any incidents of disturbed behaviour. The doctors said that if the patient required a more immediate intervention staff would call the emergency services. The doctors worked in a different building and did not carry bleeps so they could only be contacted by phone, and staff told us it could be very difficult to get medical support if they weren't in their office.

Staff also reported that doctors could be reluctant to respond or come to the hospital when on-call. Between 01 January 2018 and 20 June 2018 staff reported four incidents in which delayed medical intervention had impacted patient care; one resulted in prolonged period of restraint (15 minutes in arm holds), a nurse called three doctors to gain advice while a patient was in restraint, one detention under Section 5(4) of the Mental Health Act lapsed as the doctor would not attend the hospital within the required timeframe, and a high risk patient was not clerked in and formally risk assessed for six hours on admission to the hospital as the doctor "refused" to attend, which is in breach of the provider's two hour admissions policy. The hospital manager was aware that this was an area of concern and had sought to address it.

A lack of doctor accessibility was echoed by some of the patients who told us they could be waiting up to a week to be seen by the consultant. The managers informed us that though the formal ward round occurred once a week, the consultants reviewed all patients three times weekly. The hospital manager said that the hospital was changing the consultant psychiatrist provision with the aim to make the role more responsive and supportive to both patient and nurse needs.

The hospital had a comprehensive list of mandatory training it provided to staff. The human resources team monitored compliance with this and notified staff when modules were coming up for renewal. Staff could complete the e-learning courses at home should they wish and would be paid for the time this took. In May 2018 seven of the 28 mandatory training courses had achieved compliance rates of less than 75%. This included the Mental Health Act code of practice (69.2%) on Sanctuary ward, and cardiopulmonary respiration and automatic external defibrillator awareness (70%) on Haven. However, at the time of inspection these training figures had greatly improved and over 80% of staff had completed all the mandatory training courses; except Legionella awareness which was only applicable to three members of staff but one had not completed it.

Assessing and managing risk to patients and staff

Between 01 January 2018 and 20 June 2018 staff recorded 191 incidents of restraint involving 69 patients; 106 incidents on Sanctuary and 85 on Haven. On Sanctuary ward, staff used prone restraint nine times during this period an administered intramuscular rapid tranquillisation on seven of these occasions. On Haven ward, staff used prone restraint six times and administered intramuscular rapid tranquillisation on five of these occasions.

Patients spoken with who had experienced or witnessed staff using restraint said that it had been done proportionately and when there was no alternative. Additionally, staff had recorded that they had tried to verbally de-escalate the patient prior to the use of restraint on all but eight occasions. One incident was a planned intervention, the others were when patients were running to abscond or were acting in anger towards another patient. However, three members of staff stated that they did not feel that restraint was always proportionate due to insufficient staffing levels not providing staff with the time to attempt effective verbal de-escalation. Staff also raised that there could be inconsistent approaches due to the high level of agency use, as regular staff were all trained in line with Cygnet policy but agency staff received their organisation's physical intervention training. This was supported by some incident records that demonstrated that agency staff had used physical intervention techniques that were not in keeping with the hospital policy. Staff said that pain compliance techniques were taught within the physical intervention training, one staff member said they were aware that it had been used once.

Disproportionate use of restraint was queried with the clinical and hospital managers. We were told that this was an area that they had been trying to improve upon with the introduction of routine de-briefs and encouragement of a more openly reflective approach without attributing blame. They described staff approach developing from trying to control an incident to trying to contain it. The clinical manager was creating a training programme to provide guidance to staff in managing an increasingly acute client group and was reassessing the way that staff documented

incidents to allow for a more reflective approach, ensuring the principles of least restrictive practice are evidenced in incident management and documentation and to better represent the risk posed.

There were two incidents of seclusion recorded between 01 October 2018 and 31 March 2018 in which the patients had been secluded in their bedrooms. We reviewed the care records for one of these patients and found that staff had carried out the seclusion, documented it, and stored the documentation in line with the provider's seclusion policy and it had been used when other interventions had not succeeded.

Care plans reviewed during inspection showed that all patients had been placed on 15-minute observations on admission to the service, both those who had been identified as high risk of suicide and harm, and patients with lower risk indicators. When queried, staff, patients and a doctor confirmed that all patients were placed on 15-minute observations upon entering the service. This was not in line with the provider's observation policy which stated that each patient should be individually assessed to determine their observation level. When asked for evidence of patients being placed on a different observation level on admission, the provider evidenced that one patient was placed on an observation level other than 15-minute observations in the two-month period leading up to inspection.

In one of the incidents of seclusion the patient had been placed on 15-minute observations on entering the service despite there being very acute risks, the admission information from their previous placement stated that they should be nursed with line of sight observations by two members of staff and there was a Police presence. The patient was placed on two to one observations four hours after admission, placed in seclusion an hour later and was discharge to a more secure setting the following day.

Six of the 10 care records reviewed had at least one episode where staff had not evidenced that they had checked the patient in accordance with their observation policy. Within the period of 01 January 2018 to 20 June 2018 there were six reported incidents of observations for patients not being carried out, plus a further three incidents of individual patient's observation sheets not being on the observation board, one of these incidents was unnoticed from midnight until 11:00. There were also four incidents recorded of self-harm occurring due to line of sight observations not being correctly carried out. Responses by the service to these incidents included staff receiving additional supervision and the observation policy being reviewed.

We reviewed nine records of restraint and post restrictive intervention charts for incidents in which a patient had had rapid tranquilisation administered, five from Haven and four from Sanctuary. Cygnet's medicine management policy with guidance for administering and monitoring after rapid tranquilisation was written in accordance with National Institute of Health and Care Excellence guidelines and The Maudsley Prescribing guidelines. It states: "If the service user refuses observations or physical monitoring is inappropriate… then level of consciousness and respiratory rate can still be monitored remotely and must still be recorded on the monitoring chart". However, in seven of the restrictive intervention charts staff had failed to record respiration for the timeframes required, or at all. One of the remaining records had incorrectly recorded respirations. In addition, staff had not recorded the level of consciousness for the required timeframes, or at all, in four of the records. Six of the records had not been signed by a doctor to state that the patient had been assessed, two of the records did not state whether the patient had been given the medicines orally or intramuscularly, and two more stated that the patient had not been offered medicines orally first. All the records had been signed by a manager.

The hospital had a corporate service level agreement with an external company to supply medicines to the wards. There was a named pharmacist attached to the hospital who provided weekly audits of medicines standards and compliance with the Mental Health Act. The pharmacist also produced a weekly report which alerted staff to any errors identified and actions required where applicable. A report was also presented to the integrated governance meeting. An external company also provided monthly audits as well as e-learning programmes, classroom sessions and competency assessments. The Governance Director and Quality Assurance Managers took part in the quarterly review meetings and reviewed the prescription chart audit summary, group benchmarking prescription chart error percentages, service level reports, significant interventions reports, persistent and important issues report, training seminar report and training report for e-learning.

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Requires improvement

Staff followed good practice in medicines management and medicines were seen to be stored, recorded and dispensed in line with the Cygnet policy. There was also good evidence of monitoring of side effects following prescription of antipsychotic medicines. Between 01 October 2017 and 31 March 2018 there were 18 medicines errors recorded through the incident report system. Where an error was identified the service was seen to respond promptly and provided additional training or supervision where applicable. For example, the service had an increase in prescription writing errors in April so the ward managers checked the medicines cards daily in response.

There was some concern regarding the reconciliation of medicines and medical information following admission, this was echoed by some staff spoken with. This was evidenced on medicines charts as six of the 32 reviewed had the allergy information missing; as many patients were unable to provide this information when they arrived, there was no way of staff knowing if some patients could have had an allergic reaction to the change in medicines or diet. Also, two of the eight patients spoken with informed us that there had been a two-day delay in receiving their physical health medicines, one of which was an analgesia. The medicines cards showed that the patient who had waited for their analgesia was provided with alternative pain relief in the interim.

Managers told us that staff could complete falls risk assessments and that there was an air mattress should a patient come in at risk of pressure ulcers. However, neither would be a common need for the patient group using the service. Managers informed us that they would be able to seek advice from the provider's older adult services should they be required to provide care for patients with these additional needs.

Staff used the short-term assessment of risk and treatability risk assessment and had training in completing this and risk management as part of the mandatory training. We reviewed 10 risk assessments, all were completed on admission. There was evidence of these being reviewed in ward round, updated following incidents and changes being made to reflect incidents within patients' care plans.

The hospital had recently started a reducing restrictive practice group, which they had conducted with the assistance of one of the patients. Certain blanket restrictions were shown to have been reviewed and removed and this had been discussed in team meetings; such as not turning off the television at midnight, individually risk assessing informal patients to allow them access to the grounds between midnight and 06:00 should they wish to, and not stripping all items from a patient's room in response to risk but individually assessing the risk of items.

However, there was still several blanket restrictions in place. These included: set time on the hour for escorted patients to access the smoking area; none of the patients had keys to their bedrooms; plastic crockery was in place on Sanctuary ward while the rest of the hospital had porcelain; all patients' ground leave was escorted on admission; all patients were searched on return to the ward; all patients were escorted to access the laundry room. When blanket restrictions were raised to the hospital and clinical manager they sought to rectify some with immediate effect such as commissioning keys to be cut for all the bedrooms and replacing the plastic crockery with porcelain crockery on Sanctuary. The hospital manager advised that further changes were made following inspection to address the blanket restrictions mentioned.

People accessed the hospital through two locked main entrance doors but the doors to the wards were not locked unless a serious incident had occurred, in which case it would be reviewed regularly and a notice would be displayed.

Informal patients spoken with informed us that they were not able to leave at will when they first entered the service, some informal patients on both wards were noted to only have "escorted leave" at the time of inspection. Patients told us they could have to wait for up to a week before they were assessed by the consultant to be allowed access to the hospital grounds and beyond without being accompanied by a member of staff. This is contrary to paragraph 4.51 of the Mental Health Act Code of Practice which states that "informal patients must be allowed to leave if they wish, unless they are to be detained under the Act". There were also no signs up stating that informal patients were free to leave at the time of inspection. However, when raised with the hospital manager we were told that one would be printed that day.

At the time of inspection 95% of staff had completed their mandatory training for safeguarding of children and 96% for safeguarding of adults. Staff were clear about what constituted a safeguarding concern, how to raise an alert and that the clinical manager was the safeguarding lead for

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Requires improvement

the hospital. We reviewed 15 safeguarding referrals during inspection, these covered a range of different types of abuse and concern. All except one were reported in a timely manner; the one exception was submitted after a review of the closed-circuit television recording following an incident and was submitted in a timely fashion once it had been identified. Children were not permitted onto the wards and there were designated rooms on the ground floor where visits could be facilitated. Both allocated rooms had key fob access so they could exit unassisted but anyone wishing to enter would need staff assistance.

Track record on safety

Between 01 April 2017 and 31 March 2018, the hospital recorded three serious untoward incidents, two on Haven and one on Sanctuary.

The two incidents on Haven were suspended ligatures and the incident for Sanctuary was regarding an absconsion. The corporate governance meeting minutes from February 2018 showed that the board had discussed means of reducing ligature points within the hospital, and an action plan was created to replace all the windows with anti-ligature windows. This had been implemented at the time of inspection. However, the two serious incidents of ligaturing involved doors and while amendments had been made to address the risk of some doors, there was not a consistent action plan in place to address this risk posed. There were also no changes made to the security of the grounds or the assessment of patients accessing the grounds following the absconsion.

Reporting incidents and learning from when things go wrong

All staff we spoke with were aware of the incident reporting process and knew what to report. Nurses used a paper based method of reporting incidents which was then reviewed by a manager and recorded electronically. Incidents were reviewed within governance meetings to establish themes and areas for improvement. This information was disseminated in supervision and team meetings.

Staff and patients were offered a de-brief after incidents. This followed a structure to discuss if any injuries had occurred, what had gone well, what could be improved upon and a plan of action to establish whether an alternative or less restrictive approach could prove effective. Staff said that de-briefs happened after every incident. The patient was offered a de-brief by a member of staff who was not involved in the restraint to allow them to speak freely about their experience. However, people who had witnessed incidents that could be quite distressing, such as patients not directly involved, clinicians and some members of the ancillary staff, reported that they usually did not receive a de-brief or additional support. Members of the domestic staff said that they received more support as they spent more time on the wards.

Staff and managers exhibited good knowledge of the duty of candour and this was evidenced in patients' care records and in incident reports. Staff demonstrated an open and honest approach to responding when mistakes had been made. A patient also told us that their carer had been contacted to notify them of a medication error. One patient said that they had not had a discussion with the ward manager following a medication error as they had been initially advised by staff. We raised this with the manager and a meeting was arranged with the patient that day.

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

(for example, treatment is effective)

Requires improvement

Assessment of needs and planning of care

We reviewed 10 care records, all showed that a comprehensive assessment was conducted by a doctor on the same date as admission. They also showed that physical examinations had been undertaken and that there was ongoing monitoring of patients' physical health. However, one patient had diabetes, which had been included in the assessment information, but was not included within the physical health interventions section of their care plan until the patient annotated the copy five days after admission.

Eight of the care plans we reviewed had been created within two days of admission, two were unclear on their date of writing but had been signed by the patient within four days. All care plans viewed were up to date. They contained positive behavioural support plans created by a nurse and the patient. Care plans included some or all the following categories: "what I can work on to understand my

mental health", "how I will tell I am getting better", "what I will do to help me get better", "what will help me stay safe" and "what will help me stay healthy and look after myself". They contained two responses to the headings, the patients' views and the multidisciplinary team approach. Since Safe Wards being implemented, there had been a notable improvement in the quality of the person-centred information. There was no evidence in any of the 10 care plans we reviewed of carer involvement.

The hospital was undergoing transformation for the records to be created and stored electronically. However, at the time of inspection all records except daily notes were completed and stored in paper files. These were securely stored within locked filing cabinets in staff offices. Daily notes were kept electronically on password secured computers in the office, staff had individual log ins. If patients moved between wards in the hospital the paper records were taken across and staff could access the electronic daily notes. Staff were familiar with using both paper based and electronic systems at the same time so there were no issues related to recording on two different systems.

Best practice in treatment and care

Medical staff were aware of the National Institute for Health and Care Excellence guidelines regarding prescribing medicines. An external company also provided both onsite and online training on a range of medicines related issues for both nursing and medical staff, for example rapid tranquilisation, controlled drug management, and medicines management including Clozapine dose titration. Staff also followed a variety of policies in keeping with national guidelines such as safeguarding and immediate life support.

The hospital did not provide psychological therapies as recommended by National Institute of Health and Care Excellence guidelines. The therapy department consisted of staff previously employed as a nurse and health care support worker. Facilitators had been trained in cognitive behaviour therapy and anger and anxiety management. However, while they incorporated some of this knowledge into the group work, they did not offer any specific psychological interventions.

At the time of inspection groups were available Monday to Friday during working hours; this is not in line with national guidance for good practice which states an activity and therapy programme should be available seven days a week. Staff would discuss the group programme with patients at the start of the week to decide what would be facilitated, including more therapeutic groups like anxiety management and mindfulness, and social and diversionary activities like flower arranging. The therapy department also trained patients in life support and provided them with a certificate at the end. The hospital manager informed us that the member of staff facilitating weekend activities had left and they had been trying to recruit at the time of inspection. Following the inspection an activity schedule for the weekend was implemented, which staff facilitated on an overtime basis, though this did not include any therapies.

We reviewed 10 care records of patients across both wards. All care records showed that patients had had a comprehensive physical health check on admission and ongoing physical health monitoring. All patients on both wards had their physical observations (blood pressure, pulse, respirations and temperature) taken daily; the hospital also had use of an electro-cardiogram machine. There was evidence of the pharmacists' side effect monitoring scale being used in two care records, National Early Warning Signs being assessed in three, and two patients had evidence of the Commissioning for Quality and Innovation payments framework being utilised. There was also a record of staff contacting a patient's diabetes nurse to discuss their treatment. Where there were concerns about a patient's physical health staff were also able to refer patients to a local GP practice or hospital.

Staff used recognised rating scales to assess and record severity and outcomes including the Health of the Nation Outcome Scales and the non-forensic Mental Health Clustering Tool for all patients admitted to the ward. These are recognised rating scales to assess and record patients' progress during their time in hospital.

Team leaders on the wards were invited to attend the monthly integrated governance meeting to discuss the incidents and figures from the previous month and consider service improvements and the medical advisory committee. These meetings had the risk register as a standard agenda item and allowed staff to raise concerns which could then be raised by management to the corporate risk register if necessary. However, only managers and doctors were recorded as having attended either of the meetings during April and May 2018.

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Requires improvement

Skilled staff to deliver care

The multi-disciplinary team consisted mainly of medical, nursing and support staff. The hospital did not have an occupational therapist, psychologist, or social worker as part of the team. In its place the service utilised the skills of the therapy department and independent mental health advocate. The independent mental health advocate visited the wards weekly and supported the patients at ward rounds where needed. The advocacy quarterly report from March 2018 to May 2018 showed that much of her time was occupied with roles typically expected of a social worker; 28% was spent assisting patients with external matters including contacting housing services, local councils/ authorities, social care and education departments; 17% assisting with financial matters such as benefits; and 13% trying to assist in creating a smooth transition of treatment services at discharge. All staff and patients spoken with said that she had a very positive impact on the service user experience.

The multi-disciplinary team structure was not in keeping with the hospital's statement of purpose which states: "These services provide a range of psychological and occupational therapies including recreational activities… A qualified multidisciplinary team is provided to ensure that the full needs of the people who use our services are met". The hospital manager informed us that there was a recruitment strategy in place to add another discipline into the team, such as a social worker.

All staff had access to and had completed specialist training for their roles. Staff said that they had also been supported to access further training, such as phlebotomy and nurse training and personality disorder training that had been agreed for all staff. Staff said that if they wanted to pursue further qualifications and could demonstrate how it would benefit the service, they felt confident that the service would fund it. Staff who were pursuing further education were also supported, for example through flexible rotas and shifts. Ward managers were completing a NVQ level 5 in leadership and management in health and social care.

Staff were given personal induction programmes which managers signed off within a 12-week period. It was aligned to the Care Certificate standards and included the management of violence and aggression, safeguarding and the Mental Health Act. Staff told us that they also had a period of shadowing someone in post and having more regular supervision before they were given full responsibilities. The induction process was under review at the time of inspection and a new model had been created increasing face to face learning and introducing a module on Safe Wards.

When reviewing staff files, we saw evidence of managers investigating any concerns regarding poor performance in a prompt and timely manner and taking steps to address these, including a tailored supervision plan, additional training and suspension.

The appraisal rates for Haven was 93% and 89% for Sanctuary. Staff clinical supervision rates were over Cygnet's target of 90% for both wards. However, while all staff reported to have had regular managerial supervision, which was conducted with their line manager, they reported that they did not receive clinical supervision. The hospital managers explained that this was a case of staff not recognising their actions as clinical supervision rather than not receiving it. The managers classed interactions such as de-briefs following incidents and team meetings as clinical supervision, we were shown evidence of the documentation recording these, and the staff members it related to were listed on each. However, this approach is not reflective of national guidance for clinical supervision.

Team meetings took place monthly, managers told us that they tried to allocate the rotas to ensure that staff could attend if they had not attended the previous month's meeting. We reviewed the last four team meeting minutes from both wards, they followed a logical structure of agenda items and were a forum to disseminate lessons learnt. At the end of the meetings actions were identified and allocated to staff members. The minutes from Haven were of a high standard, detailed, clear and appeared to be staff led. The minutes from Sanctuary were less focused and it was difficult to pull out the outcomes of the meeting and required actions, for example it stated, "annual leave" but had no comments explaining what had been discussed or future expectations.

Multi-disciplinary and inter-agency team work

Ward rounds occurred twice a week for each ward. Doctors, nurses and the independent mental health advocate, patients and their care coordinators (where possible) regularly attended these. The therapy department and health care support workers were not involved in these assessments. However, some health care support workers

felt they and the therapy department should be more involved in decisions surrounding patient care as they were not currently involved in ward rounds or asked to help inform patient care plans.

All interactions were documented in the patients' daily notes, however both the therapy department and nursing team said that handovers between the two teams should be improved.

There were effective handovers between shifts, all nurses and health care support workers from the starting shift would attend and the nurse in charge of the ending shift would provide the handover. This included information about each patients' activities and any incidents or developments. Staff said that this information was stored in a file on the ward and if they had not been on the ward for a few days they were encouraged to look over the previous days' handovers but one member of staff said that there was rarely time to be able to do this. The clinical manager attended the wards every morning and the ward managers told us that they would attend some handovers within the week to keep updated.

The hospital had effective working relationships with teams outside of the organisation including GP practices and the local authority. The clinical manager met with the local authority regularly as the hospital's safeguarding lead, they had been discussing the parameters for safeguarding referrals at a recent meeting.

Staff reported that maintaining effective communication with patients' local care teams could prove a challenge geographically, as well as not having established working relationships; they said that this could impact upon the continuity of a patient's care and the ability to consolidate patient information on admission. The independent mental health advocate played a key role in trying to establish better lines of communication with patients' home teams.

Adherence to the MHA and the MHA Code of Practice

In March 2018 the training figures for the Mental Health Act code of practice was 82% for Haven and 69% for Sanctuary. At the time of inspection this had increased to 91% of all staff having completed it. Staff we spoke with demonstrated good understanding of the guiding principles.

All the care plans reviewed documented that the patients' detention had been reviewed by a doctor and that both informal patients and those who had been detained had been advised of their rights under the Mental Health Act on admission and routinely thereafter. All care plans we reviewed of patients detained under the Mental Health Act had up to date, securely stored and correctly completed detention paperwork.

However, all the patients whose care plans we reviewed and were eligible for section 17 leave had errors with the paperwork. Namely, there was no start date or end date or times, no patient signatures, many conditions were not completed and there was vague description for locations such as "town" and one had an amendment to the leave but the relevant area for a clinician's signature and explanation had not been completed. Also, when we reviewed the Section 17 file, there were multiple instances where patients were not signed back in following their return from section 17 leave. When we queried staff about how they would know that a patient had returned they said that the staff conducting observations would check.

Informal patients' rights to leave the hospital at any time was not being adhered to as they were placed under the same restrictions as detained patients upon entering the service, limiting them to accompanied access to the hospital grounds.

An external company audited prescription charts to ensure that they were compliant with the Mental Health Act on a weekly basis and reported any issues to the ward manager and clinical manager via the live view system. Each ward manager also performed a monthly clinical records audit which included Mental Health Act compliance and identified if there was a record of patient capacity being considered. Any non-compliance was documented on the clinical records audit action plan. The use of rapid tranquillisation was also audited against the Mental Health Act Code of Practice and Cygnet policy. None compliance was documented in the ward manager packs for the governance meeting with an action plan to address compliance issues.

We reviewed 32 medicines charts; of those three did not have evidence of consent to treatment.

The hospital employed a Mental Health Act administrator, who was supported by an assistant, and offered support in making sure the Act is followed in relation to, for example,

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Requires improvement

renewals, consent to treatment and appeals against detention. They also had access to a Mental Health Act central team for Cygnet who provided administrative support and legal advice on implementation of the Mental Health Act and its Code of Practice. Staff had access to the Mental Health Act Code of Practice in hard copies on the ward and electronically on both wards.

Patients from both wards had weekly access to an independent mental health advocate and staff were clear on how to access and support engagement with the advocate to capture the wider issues of referrals, capacity issues, access to wards/records, re-referral if necessary.

Good practice in applying the MCA

All staff had completed the Deprivation of Liberty Safeguards and Mental Capacity Act training in March 2018. Staff were trained in and had a good understanding of the Mental Capacity Act 2005, five statutory principles. Staff we spoke with about capacity decisions assumed patients had capacity unless staff had reason to doubt this in which case an assessment would be undertaken.

Staff showed an understanding of the Mental Capacity Act definition of restraint and described using restraint for the shortest period and for preventing harm.

There was a hard copy of the policy on Mental Capacity Act including Deprivation of Liberty Safeguards on both wards and staff had access to an electronic copy.

There had not been any Deprivation of Liberty Safeguards applications made between 01 April 2017 and 31 March 2018.

Each ward performed a monthly clinical records audit. The ward managers stated that they would monitor compliance with the Mental Capacity Act alongside the Mental Health Act audits. There was a section within Mental Health Act compliance that questioned if the patient's record contained a completed capacity form to show capacity had been considered and kept with the medicines charts.

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

Requires improvement

Kindness, dignity, respect and support

We observed staff interacting in a natural and kind manner with patients. Staff spoke about patients in a caring and dignified manner in the office and during ward round. However, two incidents occurred during our inspection of the Haven ward which left the unit short staffed, during this time staff were observed to not respond to some patients when approached and provide a diminished level of care to what had been displayed previously. This was reflected by some of the patients who stated that staff on Haven could be "abrupt" and "when they get stressed they can be a bit curt". One patient on Sanctuary ward said that staff could be "snappy and a bit rude".

Staff said that they could raise concerns about disrespectful, discriminatory or abusive behaviour towards patients without fear of repercussions. This was evidenced in the staff files we reviewed as a member of staff had been investigated following concerns raised by a colleague about their approach to patients. Additionally, seven of the 28 complaints made between April 2017 and March 2018 were regarding staff attitude, though many of these were not upheld. Management were aware that this could be an area of concern and had been implementing the use of "soft words" as part of the transition to Safe Wards.

However, patients did comment that negative interactions only occurred when the staffing seemed stretched, with one patient saying the ward became more "security minded". Patients also made positive comments about staff from both wards saying they were "lovely", "caring and respectful" and that they felt "listened to".

Staff demonstrated a passion for delivering care and had a good knowledge of each patient. All patients had a named nurse and there was a board telling them staff that were assigned to them daily. Staff had placed a "get to know me" board with a photograph of them, their likes, dislikes and hobbies in communal areas. Patients could request one to one time with a member of the team in the morning meeting. However, staff reflected that the wards could be

so busy that they didn't have the time to approach patients and provide support; two members of staff said that sometimes the quieter patients didn't get the same time and effort when the ward environment was busy.

Both wards had very small offices that were not fit for purpose and could only seat a few members of staff at a time. As a result, staff could be heard on both wards discussing patient information behind the open nurse's station which did not uphold patient confidentiality.

The involvement of people in the care they receive

Staff provided patients with a comprehensive welcome pack with details about the hospital and their stay on the wards. However, many of the patients we spoke with were not familiar with the contents and patients commented that it may be a lot of information to digest on admission. Some information was available on pin boards in communal areas, or held in the staff office should the patient request it.

We received differing opinions from patients regarding their involvement with care planning. Some said that they felt included and listened to, while others said they had were not involved or had just been brought through a completed copy to sign. However, nine of the 10 care plans reviewed were signed by the patients. The wards used positive behaviour support plans and the majority showed evidence of patient's voice, with quotations, penned amendments and individualised content about what they found helpful when distressed and corresponding primary, secondary and tertiary intervention plans.

Staff stated that some patients came into the service with advanced decisions in place and that these would be used to inform care unless it had been deemed medically inappropriate to do so.

Patients were invited to attend ward rounds and meetings regarding their care and treatment. However, none of the patients said they had been involved in updating their risk assessments but would like to be. In the ward round we observed, risk was discussed once the patients had left the meeting. Patients also told us that they were not given information regarding medicines but staff said that this information would be discussed in ward round and they could receive further information should they request it.

Two patients informed us that they were concerned about the medicines they had been prescribed and possible side effects but that the choice of medicines had not been collaborative.

Patients had access to an independent advocacy service and the independent mental health advocate attended the hospital twice a week. Patients were familiar with who the advocate was and spoke highly of her and there were posters giving information about advocacy in communal areas.

The service received two complaints regarding carers not being kept informed. As a result, staff were reminded of the importance of keeping families updated and that a document was created to ensure family and carer involvement as required and agreed by the patient. However, all the patients spoken with stated that their families and carers had not been involved with decisions about their care. The two carers spoken with said that they had not been contacted by staff from the wards. Though, one carer said they had been involved in discussions about care and had raised concerns about a medication and it was then changed accordingly. They also said that they would call the ward regularly and a staff nurse would always make time to discuss their loved one's care.

The Cygnet service user satisfaction survey for 2017/2018 showed that Harrogate had the highest satisfaction rates across Cygnet for care and treatment, information and rights, environment and therapies, with the first three scoring over 90% and therapies over 80%.

Patients were also able to give feedback in community meetings which were held fortnightly; the agenda items included progress since last meeting, what was positive and what could be improved upon, ward based activities and reducing restrictive practice. There were "you said, we did" boards up in communal areas showing actions the hospital had taken in line with patient and staff recommendations.

The hospital also invited experts by experience to appraise the service and advise on the development of the reducing restrictive practice group. Patients were invited to the bi-monthly group and had been involved in developments such as a blanket rules audit.

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Requires improvement

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

Good

Access and discharge

The average bed occupancy for Haven ward was 87% and Sanctuary ward was 95% from 01 April 2017 to 31 March 2018. The Royal College of Psychiatry states that optimum bed occupancy to deliver high standards of care in acute settings should not exceed 85%.

The ward accepted patients from across the country and cared for many patients outside of their catchment area. A ward manager informed us that they would accept patients based on level of need, not locality. The hospital historically admitted both patients admitted from NHS trusts with no beds available within the area and privately funded admissions. Managers told us that they had informed private organisations that they would not be accepting privately funded patients any longer and anticipated that by October 2018 the service would only accept NHS referrals. Managers said that this decision had been made to ensure that they could fully consider and respond to the needs of the NHS.

Managers informed us that should a patient go on overnight leave, the wards did not use these beds for other patients, and that there was always a bed available for patients should they return to the ward.

Staff told us that patients would not be moved between the wards of the hospital unless clinically necessary to do so for the safety of the patient or other patients on the ward. From 01 October 2017 to 31 March 2018 six patients were cared for on both wards during one period of admission. The hospital had good links with Cygnet Hospital Bierley and Cygnet Hospital Wyke should patients require access to a psychiatric intensive care unit or a male only acute ward; both were based in Bradford.

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

The average length of stay for patients on Haven ward was 18 days and Sanctuary ward was 24 days. Managers reported that there were no delayed discharges. There was evidence of an ongoing focus on discharge. Patients would typically be discharged to a service within their local area. Staff reported that they would sometimes retain patients for longer to ensure that patients were being discharged to a suitable environment in their local area; for example, not discharging patients to homeless shelters. Staff said that working with patients' care coordinators in different geographical areas was often challenging and could pose difficulties when planning for discharge.

Care plans that we viewed did not refer to identified section 117 aftercare services to be provided for those who have been subject to section 3 or equivalent. However, staff said that they had not had any patients that this would be applicable to recently and that if appropriate the Mental Health Act administrator would arrange a section 117 meeting and invite the patient, their care coordinator and the independent mental health advocate to attend.

The facilities promote recovery, comfort, dignity and confidentiality

There was a clinical room on both wards used for the storage, preparation and administration of medicines. The area for patients to receive their medicines on Sanctuary ward was very small. Neither had examination couch so physical examinations took place in patients' bedrooms.

Both wards had limited space so patients were taken to their bedrooms or a lower stimulus communal space for interventions. As there was no seclusion or de-escalation room on either ward staff secluded patients in their bedrooms. This is acceptable practice so long as incidents of seclusion are identified, monitored and recorded. Patient bedrooms were also used for one to ones with staff due to the limited space on the wards.

The hospital managers were aware that the ward layout required improvement and had renovation work agreed for Sanctuary ward to increase the living space, create a larger office, relocate the beverage bay and to install a laundry

room as the only laundry room at the time of inspection was located on Haven. Plans had also been agreed to increase the size of the nurses' office on Haven ward. The start date had not been confirmed.

The hospital grounds had a small amount of green space to the front with a smoking shelter and green space to the rear of the hospital with some picnic benches. Patients spoken with said that all access to the hospital grounds was escorted by staff when first admitted to the hospital for both informal patients and those detained under the Mental Health Act, contrary to Cygnet policy. During inspection the patient board in the staff office also displayed that informal patients were listed as having "escorted" leave, both within the hospital grounds and outside of the hospital. When queried with staff, they confirmed that all patients were escorted when first entering the service.

There was limited security of the grounds, as it was not gated and there was no secure area for patients to access fresh air should they be deemed unsafe for section 17 leave or access to the hospital gardens. The service recorded 61 incidents of patients absconding from the hospital grounds between 01 January 2018 and 30 June 2018, and both staff and patients recognised this as an area requiring improvement. The hospital manager and clinical manager were both aware of this risk and plans for an enclosed garden to be built had been agreed; they were unable to provide a start date for the works.

The hospital had recently lost its contract with a local hotel that had allowed patients to utilise their gym facilities. The hospital had invested in gym equipment and an additional member of the activity team who was a qualified personal trainer to be employed as a lifestyle and fitness coach.

Patients could keep their mobile phones on their person, unless care planned otherwise. Patient had access to a pay phone in a glass booth off the ward. However, at the time of inspection this was out of order and patients were observed to make confidential calls from the nurse's station phone in communal areas. We were told that the phone had been out of order for three weeks at the time of inspection. Staff and patients said that the internet connection on the wards was not good and patients said that certain bedrooms did not have any Wi-Fi connection as the signal was too weak. The hospital manager and clinical manager were aware of this issue and a new internet connection had been installed but had not yet been completed at the time of inspection.

There was a clean and comfortable meeting room and lounge downstairs where patients could see visitors, there was a television and drink making facilities outside of the reception. Children did not go on to the ward and there were games and toys in the meeting rooms to make them family friendly. One carer told us that the nursing and reception staff were always kind and welcoming and helped the family to feel as though they were visiting a home rather than a hospital.

All patients we spoke with said that the food was of a very good quality. They also had access to small kitchens on both wards where they could make hot drinks and snacks at any time.

Due to the very short average length of stay, many patients had not personalised their rooms. However, patients were clear that they could put personal effects in their room should they wish to and some patients that had been on the wards for longer had done this. Each of the bedrooms had a safe where patients could store valuable items.

The hospital had group and activity coordinators who facilitated therapeutic groups and activities in the therapy room, Monday to Friday. There were no set activities or groups on weekends. Patients and staff gave us varying timescales for when patients would be able to access groups, stating they would have access if they were on a maximum of 30-minute observations or a maximum of 60-minutes observations, as the groups were held off the ward. The hospital manager said that this should not be the case as the activity workers could facilitate the 15-minute checks while they were upstairs. The activity assistant also said that they would go onto the ward daily to facilitate some activities for people who had been unable to access group.

Staff and patients informed us that when activities were not facilitated on the unit, there were some items such as puzzles and one member of staff said they taught patients to crochet. Patients raised lack of activities on the ward as a concern in a community meeting and board games and a DVD player had been bought in response. However, patients said they found the wards to be "boring" and that there was very little to do other than access the grounds.

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

Requires improvement

This was observed during inspection as many patients were seen to be sat watching television or sat in communal areas quietly when on the wards. Patients said that this was worse at weekends as the groups were not on.

Meeting the needs of all people who use the service

The hospital had disabled access and there was a lift to Haven ward which is situated on the first floor and could be accessed by staff if required. Patients from both wards had en-suite facilities with a shower which were accessible for patients with mobility issues.

There were no leaflets providing information on the wards and we were told that that was because comprehensive information about the hospital, including complaints procedures, would be found in their welcome pack. These were not seen to be available in different languages but the hospital did accept patients who did not have English as their first language. However, the hospital had access to an interpreter service for patients for whom English was a foreign language and patients who were deaf or had a hearing impairment. Staff knew about the interpreter service and said they could access it for ward rounds and for a short period of each day should a patient require it. This was demonstrated during the focus groups as an interpreter was provided to aid two members of ancillary staff.

Patients reported that the food was high quality, of good variety and that their dietary requirements and religious requirements were met.

There was a multi-faith room upstairs which had a prayer mat with compass and a variety of religious texts. The service also had links with local churches. However, patients reported that they were not aware of this room and there was limited evidence of people's religious or cultural needs being discussed within the care plans. Staff said that patients did not use the multi faith room for religious activities and would remove the items like religious texts they wished to use and take them to their bedrooms. A patient had removed a bible to read in their bedroom when we inspected the service.

Listening to and learning from concerns and complaints

Not all patients we spoke with were able to say how to make complaints. Information regarding how to make a complaint was included within their patient handbook given on admission and was an agenda item for community meetings. Patients told us that they would feel safe to raise concerns without fear of repercussion. They also had regular access to an independent mental health advocate should they wish to raise concerns to someone impartial.

Between 01 April 2017 and 31 March 2018 the hospital received 28 complaints, three were upheld, 10 were partially upheld and 15 were not upheld. No complaints have been referred to the ombudsman. The theme of the complaints included staff attitude, lack of communication and medicines errors. The staff discussed the concerns with the person who had raised them, investigated them and reviewed closed circuit television footage where possible. Staff attitude had been addressed using coaching, supervision and in one case resulted in an agency staff member no longer being used by the hospital.

The service received 12 compliments from 01 April 2017 to 31 March 2018. One written letter came from a carer described the hospital in glowing terms and said the staff on Haven ward as "worth their weight in gold".

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

Requires improvement

Vision and values

Cygnet Health Care had an overall vision to provide superior quality healthcare that patients recommend to family and friends; clinicians prefer for those in their care; purchasers select for their clients; and employees are proud of. We were told that these were under review.

The values of the provider were:

- helpful
- responsible
- empathetic
- respectful
- honest

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

Requires improvement

Staff we spoke with had some awareness of the vision and values of the provider and we found that most interactions observed reflected them. The ward managers did not have ward specific vision or values but said they tried to model their care on the Safe Wards principles. The Sanctuary ward manager said that staff were encouraged to treat patients as they would like themselves or a loved one to be treated.

Staff and patients said that the hospital manager and clinical manager were very visible within the hospital and that the clinical manager would visit the wards daily and the hospital manager around twice a week. The regional manager was said to attend the hospital and visit the wards once a month and the board did a quarterly inspection of the wards.

Good governance

Systems and processes were not always effective in ensuring safe and high-quality care.

Mandatory training figures were inconsistent as they had been very low in March 2018 but were well above hospital targets at the time of inspection. Staff were appraised and received regular managerial supervision but did not recognise the clinical supervision that they currently received and did not reflect that its current structure was assisting their development. Six of the nine nurses and health care support workers spoken with during inspection spoke in negative terms regarding the clinical supervision they received. Some of these staff said they did not receive any, while others said it was either “ad hoc” or “irregular” and organised “informally” between staff.

The staff had a good skill mix and were of the right grades and experience but there was insufficient number to manage the risk presented on the ward and maintain a therapeutic environment. There were multiple clinical audits taking place but the efficacy of these was not consistently demonstrated as there were gaps in care and errors with documentation. For example, errors were found in rapid tranquilisation physical health monitoring, patient observations and section 17 paperwork.

Ward managers received administrative support from a ward clerk, who they described as indispensable. The human resources department monitored key performance indicators, reminded staff of their mandatory training dates and ensured that their registrations with professional bodies and Disclosure and Barring Service checks were in date.

Cygnet Hospitals had a combined monthly integrated governance meeting, medical advisory committee and clinical audit meeting of which a pharmacist, medical and nursing staff could be part of.

The hospital used monthly integrated governance meetings and quality assurance meetings to assess information from sources such as investigations, incidents, complaints and the staff representative group; and used this to form the basis of identifying recommendations and shared learning. Local governance structures linked to the organisation's governance framework. The registered and clinical managers sat in on multiple operational groups and fed suggestions, risks, and learning from these to both senior teams and ward staff to maintain effective communication between the different levels.

The hospital used Cygnet Health Care’s over-arching local action plan model to monitor compliance against recommendations, any non-compliance was then raised to local risk registers. There was evidence of the action plan being adhered to, such as the introduction of the yellow passports patients used to leave the hospital.

Leadership, morale and staff engagement

The hospital did not have a specific freedom to speak up guardian but Cygnet Health Care had a whistleblowing hotline for staff to raise concerns. Staff showed good understanding of the whistleblowing policy. All staff said that they would feel safe and comfortable to raise any concerns to the hospital and clinical manager, they spoke very highly of both and said there was an open-door policy and they could approach at any time. This was also reflected in the patient group and environmental observations as patients were seen to have candid and natural conversations with both during the inspection.

Staff from Sanctuary ward said that they would feel comfortable to raise concerns to their ward manager, but some staff on Haven ward felt that they would not feel comfortable to do the same with their ward manager. Not all staff said that they could raise concerns without fear of repercussions, with some saying this was because it was a small and relatively isolated hospital.

The staff on Haven appeared to have very low morale during the inspection. Staff on both wards said that the morale on the wards fluctuated but that morale on Haven ward had been low for a longer period. Staff said they did not always feel supported by the ward managers when the

wards were under strain; this was supported by our observations on inspection as the Haven ward manager did not call for support for the remainder of the shift when the incidents left the ward short staffed. When asked if they worked in happy staff teams most staff said that they did but that they were also very stressed teams.

The sickness rates within the hospital between 01 April 2017 and 31 March 2018 was 6.2% on Haven and 2.4% on Sanctuary, during this time two members of staff were on long-term sick leave on Haven and had returned to work by the date of inspection.

The 2018 staff survey showed mixed results. Staff could give positive, neutral or negative responses to all questions. 47% of staff responded positively that they would recommend Cygnet as a place to work (19% responded negatively) and 56% responded positively that they would be happy with the standard of care provided by Cygnet if a friend or relative needed treatment (16% responded negatively). There were no bullying and harassment cases on file, but the staff survey also showed that 12% of staff felt that they had personally experienced bullying, harassment or abuse from their managers or peers (85% responded negatively). In the same survey 82% of staff reported that they enjoy working for Cygnet (13% responded negatively) and 81% said they were happy with the support they get from work colleagues (7% responded negatively). The managers had created an action plan to address some of the concerns raised in the survey. The actions listed monitoring clinical and managerial supervision, for the hospital and clinical managers to spend more time on the wards, filling vacancies and orchestrating away days to assist with team bonding.

There was evidence of strong team working and mutual support between the nurses and health care support workers on both wards and they were very complimentary of the strengths of their peers. Staff were open and honest with both patients and their colleagues and showed evidence of implementing the duty of candour.

Staff were given opportunities to take on additional specialist training and were encouraged to take on responsibilities not typical of their roles. For example, a health care support worker chaired the staff representative group. Another health care support was the Safe Wards lead and was championing its implementation on Sanctuary ward.

The staff representative group was created to allow staff to have an open forum to raise any concerns or suggestions. It was led by a health care support worker and no managers attended. The minutes were then given anonymously to the hospital manager to review. Improvements that had been made because of the group included the implementation of a larger staff break room with comfortable furnishings, the introduction of a monthly hospital manager newsletter which was distributed to all staff, and the arrangement of further phlebotomy training dates.

Commitment to quality improvement and innovation

The hospital did not have Accreditation for Inpatient Mental Health Services at the time of inspection.

The service had many ideas for improving the environment and delivery of care and had made suggestions to the senior management team. However, there were long delays in receiving funding and the requests were RAG (red, amber, green) rated according to how essential they were. Many of the suggested improvements had been delayed or declined as a result.

Sanctuary ward was a phase two Safe Ward at the time of inspection and had many of the underlying principles and structure in place within the daily running of the ward. This was still in development and they were looking to introduce “getting to know you” books. The Safe Wards scheme was also beginning to be implemented on Haven.

The managers listed the key principles of their five years forward view as challenging stigma, ensuring physical health care needs are considered alongside mental health care needs and supporting service user choice. The managers had a recruitment plan to introduce an additional discipline to the team, such as a social worker.

The senior nurses also took part in the Cygnet wide nurse practice development group, which provided an opportunity to share lessons and good practice.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must facilitate meaningful activities and therapy for patients seven days a week.
- The provider must ensure that the care provided is appropriate to patients' needs and is reflective of the hospital's statement of purpose.
- The hospital must ensure that patients are always treated with dignity and respect and staff are not abrupt in their approach.
- The provider must ensure that staff discuss patient care in a manner that upholds patient confidentiality.
- The provider must ensure that all patients are individually risk assessed on admission and that an observation level appropriate to their care needs in applied.
- The provider must ensure that staff carry out and record observations in line with their observation policy.
- The provider must ensure that staff carry out and record physical health monitoring following rapid tranquilisation in line with Cygnet's medicine management policy.
- The provider must improve consolidation of medical history on admission and ensure patient allergy information is recorded and patients' physical health medicines are reconciled in a timely manner.
- The provider must ensure staff and patients can receive medical support within an appropriate timeframe.
- The hospital must ensure that there are not blanket restrictions in place which reduce patient's opportunities for autonomy and independence.
- The hospital must ensure that patients are individually risk assessed for suitability to leave the hospital and that informal patients are made aware that they are free to leave at any time.
- The provider must ensure that they have action plans in place to mitigate environmental risks and review these following serious incidents.
- The provider must ensure that systems and process including auditing procedures are robust and effective to ensure safe and quality care, and identify areas for improvement.
- The provider must ensure that patient documentation, such as section 17 leave forms, and patient consent to treatment are completed and recorded accurately.
- The provider must ensure that there are sufficient numbers of experienced and appropriately trained staff on all wards to provide safe treatment, meet the needs of the patients and ensure continuity of care.
- The provider must provide clinical supervision within a framework that the staff recognise as supervision.

Action the provider SHOULD take to improve

- The provider should continue with their plans to reduce restrictive interventions to ensure that the use of restraint is always proportionate.
- The provider should ensure that patients' bedrooms are allocated to allow as much gender separation as possible on Haven ward.
- The provider should ensure they invite other disciplines from within the hospital to ward rounds, rather than just doctors and nurses.
- The provider should assess the effectiveness of the manager on-call and doctor on-call provision.
- The provider should ensure they improve communication with, and involvement of, carers and relatives.
- The provider should continue with plans to improve the environment on the wards to allow for patients to have interventions in a setting other than their bedrooms.
- The provider should involve patients in their risk assessments and improve communication with patients regarding medicines options.
- The provider should continue with plans to reduce ligature risks, such as boxing in the balustrades.
- The provider should ensure that they consistently monitor and carry out mandatory training in line with the provider policy.
- The provider should continue to consider ways to improve staff retention, the morale of staff, and ways to ensure they feel safe to raise concerns without fear of repercussion.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care **How the regulation was not being met:** Care and treatment was not appropriate to patients' needs as it did not provide meaningful activities and therapy seven days a week and patients said they could not always access support. The service did not provide an appropriate multidisciplinary team approach as described in their statement of purpose. **This was a breach of regulation 9 (1) (a) (b)**

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect **How the regulation was not being met:** Patients were not always treated with dignity and respect because patients were not always spoken to with kindness when the staff were under stress. Staff did not always ensure the privacy of the patients as patient confidentiality was not upheld at nurses' stations. **This was a breach of regulation 10 (1) (2) (a)**

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **How the regulation was not being met** Care and treatment was not always provided in a safe way for patients because the service was not assessing the individual risk to the health and safety of patients on admission as most patients were placed on 15-minute observations. Staff and patients did not always have timely access to a doctor for medical help. The service was not doing all that is reasonably practicable to mitigate patient risks as observations were not being consistently carried out or recorded. Patients allergy information was not consistently being recorded. The hospital was not ensuring that medicines were supplied in sufficient quantities to ensure the safety of patients and meet their needs on admission and patients reported a delay in receiving physical health medicines. The service was not ensuring the safe management of medicines as they were not carrying out physical monitoring following the use of rapid tranquilisation in line with the provider policy. **This was a breach of regulation 12 (1) (2) (a) (b) (f) (g)**

Regulated activity	Regulation

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment **How the regulation was not being met:** There were blanket restrictions in place on both wards that were not necessary to prevent, or not a proportionate response to, a risk of harm posed to or by the patients. Informal patients were deprived of their liberty upon entering the service as they were not able to leave the hospital building unaccompanied. **This was a breach of regulation 13 (1) (4) (b) (5)**

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **How the regulation was not being met:** The governance systems in place were not entirely effective. The service did not assess, monitor and improve the quality and safety of the safety of the services provided to patients through their auditing processes. The systems in place did not fully assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk following serious incidents.

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing **How the regulation was not being met:** Sufficient numbers of suitably qualified, competent, skilled and experienced persons were not deployed on the wards, section 17 leave was cancelled and patient did not receive regular one to one time with their named nurse. Staff did not receive sufficient support within the clinical supervision structure. **This was a breach of regulation 18 (1) (2) (a)**

The service did not maintain an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the patient as there were errors and omissions in numerous documents and records.

This was a breach of regulation 17 (1) (2) (a) (b) (c)