Cygnet Hospital Ealing

Quality Report

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

Ratings

Overall rating for this location	Requires improvement
Are services safe?	Requires improvement
Are services effective?	Good
Are services caring?	Good
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

Cygnet Hospital Ealing provides specialist eating disorder and personality disorder services for women over 18 years.

During this inspection we saw that the service had made the improvements we required it to make following our previous inspection when we placed it in special measure because we had serious concerns about the quality and safety of services. As a result, we have taken it out of special measures. However, a condition to restrict the number of patients that can be admitted to Sunrise Ward (eating disorders) remains in place. This allows the ward to admit a maximum of 10 patients.

Our rating of the service overall improved from inadequate to requires improvement. Our rating for the safe and well led domains improved from inadequate to requires improvement. Our rating for caring improved from inadequate to good. Our ratings for effective and responsive improved from requires improvement to good.

We rated Cygnet hospital Ealing as requires improvement because:

- Whilst governance systems had improved since our last inspection, further work was needed to ensure these were robust and effective in driving safety and improvement of the service, and to ensure they were fully embedded. For example, further work was needed to ensure that themes from informal complaints were captured and reviewed and that complaints were dealt with in a timely manner. Further work was also needed to ensure that all staff were able to access regular team meetings that appropriately addressed the work of the ward.
- Some managers were continuing to receive support to improve and sustain the quality of individual and group supervision sessions.
- On New Dawn Ward, staff were not involved in initiatives to improve the quality of services. Staff on this ward were also not aware of learning from incidents from other hospitals with the organisation or how they may impact on the service they were providing.
- The patient call alarm system had been deactivated and patients could not call for help if they needed to.
- Further work was needed to ensure that the ligature risk assessment for the ground floor area clearly identified what management and mitigation was needed by staff to keep patients safe.
- Systems for recording patient safety incidents needed to be improved to ensure staff could report incidents easily. More robust systems were needed to ensure learning from incidents was shared with all staff.
- Staff were not always familiar with their responsibilities to closely monitor the physical health of patients who had received medication by rapid tranquilisation and Some incidents of restraint on New Dawn Ward were not recorded in line with the providers policy and procedure.

However:

- The ward environments were clean. The wards had enough nurses and doctors. Staff assessed and managed risk well. They were working to minimise the use of restrictive practices, managed most medicines safely and followed good practice with respect to safeguarding.
- Staff developed holistic, recovery-oriented care plans informed by a comprehensive assessment. They provided a range of treatments suitable to the needs of the patients and in line with national guidance about best practice. Staff engaged in clinical audit to evaluate the quality of care they provided.
- The ward teams included or had access to the full range of specialists required to meet the needs of patients on the wards. Managers ensured that these staff received training, supervision and appraisal. The ward staff worked well together as a multidisciplinary team and with those outside the ward who would have a role in providing aftercare.
- Staff understood and discharged their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005.

Summary of findings

- Staff treated patients with compassion and kindness, respected their privacy and dignity, and understood the individual needs of patients. They actively involved patients and families and carers in care decisions.
- The service managed beds well so that a bed was always available locally to a person who would benefit from admission and patients were discharged promptly once their condition warranted this.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Specialist eating disorders services	Requires improvement 	We rated specialist eating disorder services as requires improvement because: The patient call alarm system had been deactivated and patients could not call for help from staff if they needed to. Further work was needed to ensure that the ligature risk assessment for the ground floor area clearly identified what management and mitigation was needed by staff to keep patients safe Further work was needed to ensure that patient safety incidents could be reported easily and quickly and that robust systems were in place to share learning from incidents with all staff. Whilst governance systems had improved since our last inspection, further work was needed to ensure these were robust and effective in driving safety and improvement of the service and were fully embedded into practise. For example, further work was needed to ensure that themes from informal complaints were captured and reviewed and that complaints were dealt with in a timely manner. Further work was also needed to ensure that all staff were able to access regular team meetings that appropriately addressed the work of the ward.
Personality disorder services	Requires improvement 	We rated personality disorder services as requires improvement because: The patient call alarm system had been deactivated and patients could not call for help from staff if they needed to. Further work was needed to ensure that the ligature risk assessment for the ground floor area clearly identified what management and mitigation was needed by staff to keep patients safe Further work was needed to ensure that patient safety incidents could be reported easily and quickly and that robust systems were in place to share learning from incidents with all staff.

Summary of findings

Whilst governance systems had improved since our last inspection, further work was needed to ensure these were robust and effective in driving safety and improvement of the service and were fully embedded into practise.
For example, further work was needed to ensure that themes from informal complaints were captured and reviewed and that complaints were dealt with in a timely manner. Learning from other hospitals within the organisation was not routinely shared with or learnt from by ward staff.
Quality improvement initiatives were not embedded into the practice of the ward.

Summary of findings

Contents

Requires improvement

Cygnet Hospital Ealing

Services we looked at
Specialist eating disorders services; Personality disorder services

Summary of this inspection

Background to Cygnet Hospital Ealing

Cygnet Hospital Ealing is made of up two wards. Sunrise Ward is a ward for women over 18 requiring treatment for complex eating disorders. The service offers psychological therapies as well as support and care relating to physical and mental health. At the time of our inspection there were seven patients on the ward. Although there were 17 beds on the ward in total, a condition was in place which meant a maximum of seven patients could be treated on the ward at one time.

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

The service is registered to undertake the following regulated activities:

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

We have previously inspected the service in November 2018 when we took enforcement action and issued the provider with warning notices which required the provider to make improvements to the quality of ligature risk assessments, the ability of staff to safely manage the needs of patients living with specific conditions including eating disorders, improvements to local governance systems and to improve the stability of the local leadership.

The Care Quality Commission carried out a comprehensive inspection of the service in June 2019, where we found that the provider had not made the improvements outlines in the previous warning notices. Following this inspection, the service was rated as inadequate overall, with an inadequate rating for the specialist eating disorder service provided on Sunrise ward, and a rating of requires improvement for the personality disorder service provided on New Dawn ward. The service was placed in special measures. A condition was also imposed on the provider following urgent enforcement action using our powers under section 31 of the Health and Social Care Act. This condition meant that new patients could not be admitted to Sunrise ward without the prior agreement with CQC. In September 2019 it was agreed that one new admission to Sunrise ward could take place up to a maximum of seven patients.

Our inspection team

The team that inspected the service comprised four CQC inspectors, one specialist advisor with a background in nursing and experience working in specialist eating disorder services, and one specialist advisor with a background in clinical psychology and experience working in services for people with a personality disorder.

Why we carried out this inspection

We inspected this service as part of our ongoing comprehensive mental health inspection programme and to follow up on the concerns identified during the June 2019 inspection.

Summary of this inspection

How we carried out this inspection

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

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

During the inspection visit, the inspection team:

- looked at the quality of the ward environment and observed how staff were caring for patients
- spoke with the clinical services manager, eating disorders service manager and ward manager on New Dawn ward
- spoke with the registered hospital manager, service development lead and medical director
- carried out a specific check of the medicine management on the wards including a review of ten medicine records
- spoke with eight patients
- spoke with 24 staff members including doctors, nurses, support staff, occupational therapists, a clinical psychologist, social worker, dietician, pharmacist, physiotherapist and drama therapist
- reviewed seven patient care and treatment records
- observed a multidisciplinary ward round on New Dawn ward
- attended a community meeting and observed a post meal group on Sunrise ward
- observed a handover meeting on each ward
- looked at a range of policies, procedures and other documents relating to the running of the service

What people who use the service say

We spoke with eight patients using the service who were positive about their experiences. Patients said they had copies of their care plans; felt involved in their care; found staff were compassionate and caring and felt confident to raise issues or provide feedback about the service.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Requires improvement 

We rated safe as requires improvement because:

- The patient call alarm system had been deactivated. Patients could not call for help from staff if they needed to.
- Further work was needed to ensure that the ligature risk assessment for the ground floor area clearly identified what management and mitigation was needed by staff to keep patients safe
- Systems for recording patient safety incidents needed to be improved to ensure staff could report incidents easily. More robust systems were needed to ensure learning from incidents was shared with all staff.
- Staff were not always familiar with their responsibilities to closely monitor the physical health of patients who had received medication by rapid tranquilisation and some incidents of restraint on New Dawn Ward were not recorded in line with the providers policy and procedure and some incidents of restraint on New Dawn Ward were not recorded in line with the providers policy and procedure.

However:

- All wards were clean, well furnished, well maintained and fit for purpose.
- The service had enough nursing and medical staff, who knew the patients and received basic training to keep people safe from avoidable harm.
- Staff assessed and managed risks to patients and themselves well and followed best practice in anticipating, de-escalating and managing challenging behaviour. Staff used restraint after attempts at de-escalation had failed. The ward staff participated in the provider's restrictive interventions reduction programme.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse, and they knew how to apply it.

Summary of this inspection

- Staff had easy access to clinical information and maintained high quality clinical records.
- The service used systems and processes to safely prescribe, administer, record and store medicines. Staff regularly reviewed the effects of medicines on each patient's mental and physical health.
- Since the last inspection, improvements had been made to ensure that when things went wrong, staff apologised and gave patients honest information and suitable support.

Are services effective?

Good

We rated effective as good because:

- Staff assessed the physical and mental health of all patients on admission. They developed individual care plans, which they reviewed regularly through multidisciplinary discussion and updated as needed. Care plans reflected the assessed needs, were personalised, holistic and recovery-oriented.
- Staff provided a range of care and treatment interventions suitable for the patient group and consistent with national guidance on best practice. They ensured that patients had good access to physical healthcare and supported patients to live healthier lives.
- Staff used recognised rating scales to assess and record severity and outcomes. They also participated in clinical audit, benchmarking and quality improvement initiatives.
- The ward teams included or had access to the full range of specialists required to meet the needs of patients on the wards. Managers made sure they had staff with a range of skills need to provide high quality care. They supported staff with appraisals, supervision and opportunities to update and further develop their skills. Managers provided an induction programme for new staff.
- Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care. The ward team(s) had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation.
- Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice and discharged these well. Managers made sure that staff could explain patients' rights to them.

Summary of this inspection

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

Are services caring?

Good

We rated caring as good because:

- Staff treated patients with compassion and kindness. They respected patients' privacy and dignity. They understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition.
- Staff involved patients in care planning and risk assessment and actively sought their feedback on the quality of care provided. They ensured that patients had easy access to independent advocates.
- Staff informed and involved families and carers appropriately.

Are services responsive?

Good

We rated responsive as good because:

- Staff managed beds well. This meant that a bed was available when needed and that patients were not moved between wards unless this was for their benefit. Discharge was rarely delayed for other than clinical reasons.
- The design, layout, and furnishings of the ward/service supported patients' treatment, privacy and dignity.Each patient had their own bedroom and could keep their personal belongings safe. There were quiet areas for privacy.
- The food was of a good quality and staff carefully considered safe access to drinks and snacks in the least-restrictive way for patients.
- The service met the needs of all patients who used the service – including those with a protected characteristic. Staff helped patients with communication, advocacy and cultural and spiritual support.
- Some improvements had been made to the way in which complaints were managed, although further work was needed to improve the timeliness of complaint responses, and to record and analyse trends from informal complaints.

Are services well-led?

Requires improvement

We rated well led as requires improvement because:

Summary of this inspection

- Whilst governance systems had improved since our last inspection, further work was needed to ensure these were robust and effective in driving safety and improvement of the service and were fully embedded into practise.
- For example, further work was needed to ensure that themes from informal complaints were captured and reviewed and that complaints were dealt with in a timely manner. Further work was also needed to ensure that all staff were able to access regular team meetings that appropriately addressed the work of the ward.
- On New Dawn Ward, staff were not involved in initiatives to improve the quality of services. Staff on this ward were also not aware of learning from incidents from other hospitals with the organisation or how they may impact on the service they were providing.

However:

- Leaders had the skills, knowledge and experience to perform their roles, had a good understanding of the services they managed, and were visible in the service and approachable for patients and staff.
- Staff knew and understood the provider's vision and values and how they were applied in the work of their team.
- Staff felt respected, supported and valued. They felt the service promoted equality and diversity and provided opportunities for career development. They could raise concerns without fear of retribution.
- Ward teams had access to the information they needed to provide safe and effective care and used that information to good effect.
- Some managers continued to receive ongoing support to improve and sustain the quality and content of individual and group supervision sessions.

Detailed findings from this inspection

Mental Health Act responsibilities

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

Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice and discharged these well.

All staff had received training in the Mental Health Act (MHA) and could access support with understanding and administering the MHA as needed. Policies and procedures relating to the use of the MHA were easily available to staff.

An independent mental health advocate visited the service.

Detained patients had their rights communicated with them appropriately on a regular basis.

Staff stored copies of patients' detention papers and associated records including leave forms in paper files. These were securely stored, orderly and readily accessible to staff who needed use to them.

Audits of detention paperwork including Section 17 leave forms and audits of detained patients' rights under Section 132 were completed regularly.

Mental Capacity Act and Deprivation of Liberty Safeguards

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

All staff had received training in the Mental Capacity Act (MCA) and had a good understanding of the MCA and its statutory principles. Staff accessed information on the application of the MCA with ease. The relevant policy was stored on a shared drive.

The hospital social worker was available to support staff with advice on the MCA.

Capacity assessments relating to consent to treatment had been completed and were detailed, clearly illustrating how the decision about whether the patient had capacity had been reached.

Staff supported patients to make decisions and always assumed they had capacity to do so in the first instance. When patients lacked capacity, staff made decisions in their best interests, which recognised the importance of the person's wishes, feelings, culture and history.

Overview of ratings

Our ratings for this location are:

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

Notes

Requires improvement

Specialist eating disorder services

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

Are specialist eating disorder services safe?

Requires improvement

Safe and clean environment

Safety of the ward environment

The patient call alarm system had been deactivated and patients could not call for help from staff if they needed to.

Further work was needed to ensure that the ligature risk assessment for the ground floor area clearly identified what management and mitigation was needed by staff to keep patients safe

All wards were clean, well furnished, well maintained and fit for purpose.

The ward layout was complex and did not allow staff to easily observe all areas. Staff did not have clear lines of sight from the nursing station. There were numerous blind spots and the ward was split across two floors. To mitigate these risks, staff conducted routine hourly environment checks on all areas of the ward. Patients were individually risk assessed against the potential need for more enhanced observations. Closed-circuit television cameras were used to observe some blind spots from the nursing office. The provider had plans to redevelop the building by August 2020. Part of this work aimed to improve ward layouts which would make it easier for staff to observe all parts of the ward.

During the last inspection in June 2019 staff could not describe how they were working to safely manage environmental risks. This included the risks presented by potential ligature points. A ligature point is anything that could be used to attach a cord, rope or other material for hanging or strangulation. During our last inspection we also identified that staff did not always understand how to use the ligature cutters provided and ligature risk assessments were unclear.

During this inspection, the way staff managed ligature risks had improved. Ligature cutters were present in both the nursing office and clinic room, and staff knew how to use them. Ligature risk assessments and 'heat maps', which summarised the key environmental risks on a clear plan of the building, were easily accessible to staff. The staff induction process was now more thorough and included an overview of environmental risks including ligatures and how these should be safely managed by staff.

However, although ligature risk assessments were now more detailed than when we last inspected, there was a lack of detail about how the identified ligature risks should be managed on the ground floor. For example, the ligature risk assessment for the ground floor summarised that identified risks should be 'managed locally', but it did not indicate what management strategies staff should use to do this.

The ward was for females only and so complied with Department of Health and Social Care guidance on mixed-sex accommodation.

Staff wore personal pin-point panic alarms. Staff reported that they tested these at the start of each shift and that they worked and were responded to by colleagues.

During the last inspection in June 2019 call alarms in patient bedrooms were not working and patients could not use these to summon assistance from staff. During this

inspection call alarms remained de-activated and therefore unusable. Staff did not consider whether call alarms would be suitable for specific patients by considering individual patient risks.

Maintenance, cleanliness and infection control

All ward areas were clean and well maintained. Staff reported that the system for escalating local maintenance issues had improved because a full-time handyman now worked on-site.

Staff followed infection control principles including appropriate handwashing techniques, use of equipment including aprons and gloves, and hand sanitiser was readily available. Infection control audits were completed to ensure staff continued to follow these principles.

During the last inspection in June 2019 the sluice room on Sunrise ward was not easily accessible to staff. During this inspection the sluice room had been decommissioned as it was not in regular use. Appropriate dry waste disposal facilities were available in the treatment room. The sluice room on New Dawn ward could be used by staff if required, although staff reported this was a rare occurrence.

Clinic room and equipment

A clinic room was located on the ground floor. This was a small room where medicines were stored and administered. A separate treatment room was situated on the upstairs part of the ward. This room contained clinical equipment and an examination couch.

Clinic rooms were fully equipped including emergency drugs and resuscitation equipment. A crash bag was also located in the nursing office for ease of access.

During the last inspection in June 2019 clinical equipment including blood glucose monitoring equipment was not always calibrated and safe to use. During this inspection all clinical equipment had been calibrated, was clean and ready to use safely. Staff had a system to review when different pieces of equipment next needed to be serviced or calibrated.

During the last inspection in June 2019 medical equipment and nasogastric feeds were not stored in a consistent, orderly manner. Staff could not locate this equipment with ease and patients' feeds were delayed. During this inspection this had improved. A dedicated storage room for nasogastric feeds and associated equipment was in use. This room was tidy, well ordered and each piece of equipment was clearly labelled so staff could easily locate items.

Safe staffing

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

Nursing staff

During the last inspection in June 2019 nursing staff were not effectively deployed or supervised to do their job effectively and they lacked the necessary skills and experience to deliver safe care and treatment. During this inspection this had improved. Staff now had the necessary skills and experience to safely meet the needs of patients. Leaders supervised staff regularly and supported them to access training, so they could develop their skills and experience.

Minimum staffing levels on the ward were two registered nurses and two non-registered nurses (healthcare support workers) on both day and night shifts. We reviewed recent staffing rotas, which showed these staffing levels were often exceeded. The service manager reported they were able to increase staffing levels with ease if they felt this was needed. For example, if any patient required enhanced observations.

The provider was working to recruit to seven registered nurse vacancies on Sunrise ward at the time of the inspection. Five potential candidates were in the pipeline at the time of the inspection. A recruitment strategy was in place whereby the provider worked closely with recruitment agencies and every Thursday was kept free for hospital leaders to conduct recruitment interviews.

Non registered nurse (healthcare assistant) posts were over-recruited to at the time of the inspection. Many of these staff were doing bank shifts on New Dawn ward, which specialised in providing care and treatment to females living with a personality disorder. Staff reported that this cross-working positively added to their experience in managing patients who presented with multiple mental health needs.

Vacant shifts that could not be covered by substantive staff working additional bank shifts, were covered by agency

staff. The vacant registered nurse posts on Sunrise ward were being covered by long-term agency staff who had completed a full induction and accessed the same training and supervision as substantive staff.

Staff turnover on Sunrise ward was high. Twenty-two out of a total of 30 substantive staff had left their posts between November 2018 and October 2019. Many staff working on the ward had only been in post a few months at the time of the inspection. Hospital leaders reported that many staff left shortly after the last inspection when leaders challenged poor practice.

The total percentage of permanent staff sickness on Sunrise ward between November 2018 and October 2019 was 2.3%.

Nursing staff were always visible in communal areas and there were enough staff to allow for patients to have regular one to one time with their named nurse. We did not identify any occasions where shortages of staff had led to activities or escorted leave being cancelled, and there was enough staff available to safely carry out physical interventions if necessary.

Medical staff

One full-time consultant psychiatrist and speciality ward doctor worked on the ward. They could tend to emergencies promptly and meet with patients as necessary. The provider operated an out of hours on-call duty rota. A duty doctor could attend quickly in the event of a medical emergency. These doctors were associate specialists in mental health. Consultants were available on-call out of hours.

Mandatory training

Staff had received and were up to date with appropriate mandatory training. At the time of the inspection 93% of staff across the hospital had completed mandatory training. The training course with the lowest compliance rate was Prevention and Management of Violence and Aggression training, for which 86% of staff were compliant. All staff now received Immediate Life Support training regardless of their role, in place of the basic life support training course which some staff used to complete. Other mandatory training courses included equality and diversity, food safety, infection control, safeguarding individuals at risk and information governance.

Assessing and managing risk to patients and staff

Staff were not always clear about their responsibilities in relation to regular physical health monitoring following the administration of medicines by rapid tranquilisation, although this was detailed in the provider's medication policy.

Staff assessed and managed risks to patients and themselves well and followed best practice in anticipating, de-escalating and managing challenging behaviour. Staff used restraint after attempts at de-escalation had failed. The ward staff participated in the provider's restrictive interventions reduction programme.

Assessment of patient risk

Staff completed an initial risk assessment when patients were admitted to the ward. This included a review of recent and historic risk, particularly those identified during their time with community treatment teams. Risk assessments were updated monthly as a minimum. They were also updated to reflect any changes in risk, such as incidents.

Staff discussed each patient's risks every morning during a handover session and a daily risk screen was recorded for each patient. This helped staff focus on current risk and review how effectively management and mitigation plans were working, adjusting as necessary.

The breadth of the risk assessment process had improved since the last inspection. A physiotherapist was now in post. As well as having ongoing input into patients' care, they also assessed the risks of falls in patients with mobility issues. A Management of Really Sick Patients with Anorexia Nervosa (MARSIPAN) risk assessment was now completed on admission to identify physical health risks. This included factors such as musculoskeletal weakness, fluid retention and electrolyte imbalance. These indicators helped staff identify heightened risks including the onset of refeeding syndrome, where electrolyte imbalance can disrupt metabolic processes and increase the risk of death.

Management of patient risk

Staff discussed changes in risk and the management strategies they would use to manage risks each morning during the nursing handover. Strategies were clearly document in patient care plans and some were also summarised on the patient display board in the nursing office. For example, an overall red, amber or green risk rating was clearly displayed beside each patient's name depending on their overall level of risk. A column denoting

whether patients required enhanced observations by staff and whether individual patients could safely access bathrooms either with or without supervision by staff, depending on their risk of water-loading or purging, were also clearly summarised on the wipe board.

During the last inspection in June 2019 staff did not follow the provider's procedures for the safe observation of patients. Patients reported that staff fell asleep whilst they were supposed to be observing them and the provider had not assured itself that staff were competent to safely observe patients.

At this inspection this had improved, and staff now safely observed patients to help manage their identified risks. Each staff member completed engagement and observation training and had their competency in this area checked. Staff understood their responsibilities when undertaking observations and understood the different levels of enhanced patient observation, such as intermittent and continuous observations, that might be used during times where specific patient's risks were elevated. During this inspection, one patient was subject to intermittent observations four times per hour. This was clearly communicated to staff at the start of the handover and detailed on the staff wipe board in the nursing office. Observation records were completed for each patient, and all patients were observed each hour as a minimum. These records were completed consistently by staff.

Blanket restrictions were applied to patients' freedoms only when justified. For example, bathroom access was restricted immediately following mealtimes to help manage risks of water loading and purging. Searches were performed on patients when they returned from leave or if staff had reasonable suspicions that the patient might have restricted items about their person. Staff completed search forms to clearly document each search.

The hospital was smoke-free and staff were able to store smoking paraphernalia for patients who wished to smoke when they left the premises.

Informal patients were told about their right to leave the ward at any time but were asked to let staff know that they planned to leave. This right was displayed on a notice situated next to the main exit from the ward and was shared with patients on admission to the ward.

Use of restrictive interventions

Between 1 May and 31 October 2019 there were 96 episodes of restraint on Sunrise ward. None of these restraints had been performed in the prone (face-down) position. Seventy-five percent of these episodes of restraint had been performed on one patient. They had since been transferred to a more suitable service that could better meet their individual care needs.

Between 1 May and 31 September 2019 there were no reported incidents of rapid tranquilisation on Sunrise ward. Five incidents of intramuscular rapid tranquilisation took place during October 2019 and these were discussed at the provider's integrated governance meeting.

During the inspection we identified and reviewed one incident relating to the use of rapid tranquilisation that occurred during December 2019. This followed efforts by staff to manage the patient's challenging behaviour using verbal de-escalation and supportive arm holds. Staff reported they would only use restraint and rapid tranquilisation as a last resort if other techniques such as verbal de-escalation had failed.

The provider had a strategy to reduce restrictive interventions and the third phase of this strategy to cover the period 2020-2022 was in being drafted at the time of the inspection. Restrictive interventions including numbers of restraints, prone restraints and rapid tranquilisation were reviewed each month during the hospital integrated governance meeting. A reduction in restrictive interventions had been observed between October and December 2019 which was attributed to changes in the complex needs of patients on the ward during that time.

A nominated staff member was a restrictive practice champion and they had delivered training to staff about what constituted a restrictive intervention. They also attended a three-monthly regional reducing restrictive practices board to discuss new approaches to managing complex situations and reduce the need to use restrictive interventions. Staff also received preventing and management of violence and aggression training, which aimed to reduce the likelihood that staff would need to use restrictive interventions.

Safeguarding

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

Staff were trained in safeguarding and knew when to make a safeguarding alert to the local authority safeguarding team. Ninety-five percent of staff had completed mandatory training in safeguarding individuals at risk.

Information about how to raise safeguarding concerns was clearly displayed on the ward for staff and patients to see.

Updates on safeguarding referrals were given by the social worker who worked at the hospital during the monthly integrated governance meeting. The social worker kept track of open cases and liaised with the local authority about ongoing safeguarding investigations. Three cases were currently open to safeguarding investigations during the time of the inspection.

Staff followed safe procedures for children visiting the wards. Separate rooms were available outside the main ward areas where staff would facilitate visits by families with children.

Staff access to essential information

Staff had easy access to clinical information and maintained high quality clinical records.

During the last inspection in June 2019 care and treatment records were not easily accessible and staff found it difficult to locate all the necessary documentation in relation to patient care. During this inspection, whilst a mixture of electronic and paper records were in use, staff found it much easier to locate information. Information relating to patient care and treatment and care plans had been moved onto the electronic system, where progress notes and risk assessments were also stored. Agency staff had access to the necessary systems and could locate patient care and treatment records with ease.

Other documentation including Mental Health Act detention paperwork, physical health checks and medicine records were kept in paper format. Staff could locate these without difficulty.

Medicines management

The service used systems and processes to safely prescribe, administer, record and store medicines. Staff regularly reviewed the effects of medicines on each patient's mental and physical health.

Staff followed good practice in medicines management and improvements had been made since the last inspection.

During the last inspection in June 2019 emergency drugs were not stored consistently or checked regularly. Staff did not follow the provider's medicine policy in relation to the safe management of controlled drugs. During this inspection emergency drugs were kept in grab-bags. This meant that staff now knew where they were and could access them promptly in an emergency. Grab bags were checked by staff weekly to ensure the contents were in-date and safe to use. Although there were no controlled drugs in use at the time of the inspection, a controlled drug recording book was ready for use in the clinic room. Staff explained the process of how they recorded stock level changes in the controlled drug record and understood the importance of countersigning when these medicines were administered.

A pharmacist, who worked for an external pharmacy, visited the ward once per week. They completed monthly audits of prescription charts, the clinic room and controlled drugs. They also completed a three-monthly stock check. The pharmacist wrote a report and highlighted action that needed to be taken following these audits. Any identified actions had been addressed promptly.

Daily checks of both ambient room and fridge temperatures were completed by staff, who knew what action they would take if temperatures fell outside the normal range. Staff had recently acted to improve the safe storage of medicines by relocating a medicine storage cabinet within the clinic room to an area that was less prone to overheating.

Staff reviewed the effects of medicine on patients' physical health regularly in line with National Institute of Health and Care Excellence (NICE) guidance. Staff received training in managing medicine and competency checks were also completed following training.

Track record on safety

One recent serious incident took place on Sunrise ward in November 2019. Senior staff on-site discussed the incident at the hospital's integrated governance meeting, including a discussion regarding immediate learning to minimise the likelihood of similar incidents re-occurring.

Reporting incidents and learning from when things go wrong

Requires improvement

Specialist eating disorder services

Further work was needed to ensure that patient safety incidents could be reported easily and quickly and that robust systems were in place to share learning from incidents with all staff.

Since the last inspection, improvements had been made to ensure that when things went wrong, staff apologised and gave patients honest information and suitable support.

Staff knew what incidents to report and how to report them. However, the incident reporting system was complex, consisting of an electronic and numerous paper forms to fill in, presenting a risk that some information relating to incidents might not be reported in the appropriate place. The provider was working to simplify the system at the time of the inspection.

During the last inspection in June 2019 staff were not always open and transparent with people when things went wrong. During this inspection staff had been open with patients and apologised when mistakes had been made. For example, the week before the inspection there was an incident where staff misread their shift allocations which meant that an allocated snack time did not go ahead as planned, which caused distress to some patients. Staff told patients how the incident had come about and apologised at a community meeting.

During the last inspection in June 2019 staff did not have the opportunity to discuss recent incidents and reflect on what could be learnt from them. During this inspection this had started to improve, although more work was needed to ensure this learning from incidents was systematic at ward level. Senior staff attended a monthly integrated governance meeting, where they discussed the overview of recent incidents, discussed potential reasons for themes in the type of incidents, and discussed what staff had learnt from incidents to help prevent similar incidents re-occurring in the future. For example, incidents of challenging behaviour including self-harming behaviours had increased on Sunrise ward in October 2019. This was because there were a few newly admitted patients to the ward who were initially unsettled at the start of their stay.

Improvements needed to be made to the way learning from incidents was shared with staff. Although staff discussed examples where recent incidents had been discussed during the morning handover, there was no systematic process by which discussions about recent incidents took place. This was because the quality of team meetings on Sunrise ward needed improvement and leaders explained that learning from recent incidents would be a standing agenda item at these meetings in future.

During the last inspection in June 2019 staff did not always have the opportunity to join a debrief discussion after serious incidents. Staff now attended debriefs after significant incidents which were led by the psychologist.

Are specialist eating disorder services effective?

(for example, treatment is effective)

Good

Assessment of needs and planning of care

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

Staff completed a comprehensive assessment on admission, which included assessments of their mental health, current risk and physical health needs. Other assessments including occupational therapy and psychology assessments were also completed shortly after admission.

Staff assessed and supported patients with their physical health needs and worked collaboratively with specialists when needed. Comprehensive physical assessments were completed and plans for on-going monitoring of health conditions and healthcare investigations were developed. Bone density scans were completed for patients who needed them.

During the last inspection in June 2019 care plans were not always regularly updated. During this inspection, we reviewed four patient care plans on Sunrise ward and saw they had been updated in a timely manner to accurately reflect the current needs of the individual patient. Care plans were holistic and recovery-oriented, containing goals that patients were working towards. For example, healthy weight targets.

Requires improvement

Specialist eating disorder services

Best practice in treatment and care

Staff provided a range of care and treatment interventions suitable for the patient group and consistent with national guidance on best practice. They ensured that patients had good access to physical healthcare and supported patients to live healthier lives.

Staff used recognised rating scales to assess and record severity and outcomes. They also participated in clinical audit.

During the last inspection in June 2019 patients could not always access the full range of treatments and interventions to promote their recovery, including limited access to evidence-based psychological treatments. During this inspection this had improved. A new interim clinical psychologist worked on the ward and supported patients with both one to one and group psychology sessions. Psychology needs were considered on an individual basis when patients were admitted to the service.

Nursing staff were developing their awareness of psychological approaches when working with patients. Senior nurses had attended training in the Maudsley Model of Anorexia Nervosa Treatment in Adults. This helped staff in their therapeutic approach to tackle the cognitive, emotional, relational and biological aspects of treating patients living with anorexia nervosa. Patients at the service now received support to understand their distress, thoughts, behaviour and coping mechanisms, in line with National Institute of Health and Care Excellence guidelines.

Staff had worked together to implement a new therapeutic activity timetable for patients that aligned with professional guidelines. This included occupational therapy and psychology staff, the physiotherapist and the dietician. Staff and patients were clear on the purpose of each therapeutic activity because each was supported by an evidence base and aims and objectives. They had also collaborated with patients to develop a 'do's and don'ts summary for each patient at meal times. This helped new staff and agency staff understand how best to support patients during meal times, for example, by playing music during meal times for specific patients.

Staff followed the Management of Really Sick Patients with Anorexia Nervosa (MARSIPAN) clinical guidelines when treating patients, which facilitated safe re-feeding, risk management and monitoring.

Staff ensured patients had good access to physical healthcare specialists as needed and made referrals to local hospital teams when required. A physiotherapist worked across the hospital two days per week and supported patients to understand common issues in people living with eating disorders such as osteoporosis. They also helped identify patients at risk of falls and complete a falls risk assessment to help minimise this risk.

A dietician worked on Sunrise ward three days per week. They completed nutritional and hydration assessments for each patient. They also worked with patients to prepare individual meal plans and help minimise the risks of re-feeding or under-feeding syndromes. The occupational therapist also carried out Eating and Meal Preparation Skills Assessments (EMPSA) with each patient and developed individualised goals around planning meals, buying food, preparing and cooking meals.

Staff supported patients to lead a healthy lifestyle by discussing healthy attitudes towards exercise, promoting healthy foods and supporting patients to reduce their smoking when necessary including prescribing nicotine replacement therapies.

Staff had started to implement the 'Safewards' model on the ward, which aims to minimise incidents of violence and aggression on mental health wards by employing various techniques. Staff had started by introducing 'know each other' folders, which aimed to help break down barriers between staff and patients and promote therapeutic, meaningful relationships. Each profile contained an introduction to the staff member and outlined their likes and dislikes.

Outcome measures were used by staff to help ensure their treatment interventions were having a positive effect on patients' recovery. For example, health of the nation outcome scales (HONOS), the model of human occupation screening tool (MOHOST) and the Eating Disorder Questionnaire (EDQ) were used.

Staff members completed regular audits to help ensure the service operated to a consistent quality. A three-monthly quality care audit was completed by staff, which helped detect gaps in patients care plans and assessments. Timely action was taken to address these.

Skilled staff to deliver care

Requires improvement

Specialist eating disorder services

The ward team included or had access to the full range of specialists required to meet the needs of patients on the ward. A proposal to secure funding for a permanent psychologist and physiotherapist was under review as at the time of the inspection because these staff were currently employed on a temporary basis.

Managers made sure they had staff with the range of skills needed to provide high quality care. They supported staff with appraisals, supervision and opportunities to update and further develop their skills. Some managers were receiving ongoing support to improve and sustain the quality and content of individual and group supervision sessions. Managers provided an induction programme for new staff.

Further work was needed to ensure that all staff were able to access regular team meetings that appropriately addressed the work of the ward.

Staff from the full range of mental health disciplines provided input to the planning and delivery of patient care and treatment. This included doctors, nurses, an occupational therapist, psychologist, physiotherapist, dietician and pharmacist. Staff from each discipline contributed meaningfully to multi-disciplinary decisions about patients' care.

During the last inspection in June 2019 staff did not have the right skills and knowledge to safely meet the needs of patients, which led to incidents such as delayed feeding which caused distress to patients. During this inspection this had improved. All staff have the necessary experience and training to safely and effectively meet the needs of patients requiring treatment for eating disorders. Fewer short-term staff were used on Sunrise ward and agency staff were subject to the same supervision and training as permanent staff.

Specialist training was available to staff to help them develop the skills and knowledge required to meet the needs of patients requiring treatment for eating disorders. For example, staff were trained in managing and identifying the signs of re-feeding syndrome.

The provider had introduced various competency checks to help ensure staff could effectively apply the skills they had learnt about during training. For example, a 'minimum you need to know about eating disorders' workbook had been introduced, which covered areas including managing meal times and identifying the signs of re-feeding syndrome, had been introduced. Staff completed an assessment to judge whether they were competent to apply this knowledge.

During the last inspection in June 2019 new and temporary staff did not always complete a thorough induction to the service before they started working. This had improved at this inspection and all staff completed a detailed, comprehensive induction before they started working on Sunrise ward. Leaders used a tracking system to ensure new staff were on-track with completing all their required training and induction checklists. The induction involved an introduction to environmental risks, ligatures and the safe use of observation, managing patients' needs relating to their eating disorder, and other operational processes.

During the last inspection in June 2019, although staff on Sunrise ward received regular supervision, this was not always of good quality. During this inspection 93% of staff received regular clinical supervision which took place monthly. Some improvements had been made to the quality of supervision sessions. Long-term agency staff were now supervised the same as permanent staff. Discussions about personal wellbeing and development needs were discussed in a more supportive way. However, leaders reported they were continuing to work with some supervisors to improve the depth of discussion during supervisions sessions, as well as encouraging case discussions during monthly group clinical supervision in future, which up to now had consisted of joint discussions about staff experiences working at the service.

Seventy-five per-cent of staff received an appraisal within the year leading up to the inspection. During the appraisal staff reflected on their personal development needs, contribution to service development and any leadership and management experience that needed to be developed.

During the last inspection in June 2019 staff on Sunrise ward had not been able to attend consistent team meetings. During this inspection this remained a priority area for improvement. Team meetings had been introduced in September 2019 but normally consisted of a general discussion with no standing agenda. There was no staff meeting during December 2019. This meant that systems for discussing governance issues, including learning from complaints and incidents with staff, were weak.

Leaders explained how they had acted to manage episodes of poor staff performance effectively. This included developing clear objectives to which staff who were under-performing needed to work towards. Although leaders acknowledged that some staff had left their posts since the last inspection, there were examples where they had improved the overall performance of some existing staff members who remained in post during this inspection.

Multi-disciplinary and inter-agency team work

Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care. The ward team had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation.

Staff in all disciplines worked well together and attended multi-disciplinary reviews together. Staff reported they felt respected by other staff and each felt that they had an equal say about patients' care and treatment.

The psychologist who worked on Sunrise ward was employed on a fixed term contract and the Physiotherapist was part of the provider's bank staff. The provider was actively seeking to recruit permanent staff to both posts.

Staff held regular and effective multidisciplinary meetings on the ward to review patient care and

treatment plans, medicines, risk and discharge planning. Patients were invited to attend the meeting and contributed to discussions.

Handover meetings took place each morning. Key information about each patient was shared between staff from different disciplines, including changes in risk and progress with their treatments.

Multidisciplinary staff collaborated with colleagues working for other teams and organisations to deliver effective care and treatment. For example, care-coordinators from community teams were invited to attend care programme approach meetings and were involved developing plans for smooth discharge from the ward. Staff also made efforts to keep in close contact with patients' GPs to keep them updated about their progress.

Adherence to the MHA and the MHA Code of Practice

Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice and discharged these well. Managers made sure that staff could explain patients' rights to them.

All staff had received training in the Mental Health Act (MHA) and could access support with understanding and interpreting the MHA as needed. A MHA administrator worked in the hospital and could be asked advice. They worked closely with the corporate MHA lead for the provider.

Policies and procedures relating to the correct use of the MHA were easily available to staff via a shared drive.

An independent mental health advocate visited the ward every Thursday. They proactively introduced themselves to new patients and met with them privately and hoped to start attending community meetings soon. Details about the advocacy service were clearly displayed on the ward.

One patient was detained under the MHA at the time of the inspection. Their rights had been communicated with them appropriately on a regular basis.

Details of leave granted under Section 17 of the MHA were clearly communicated with the patient and included on the wipe board in the staff office so all staff were aware of patient leave arrangements and we did not identify any examples where leave had not gone ahead as planned.

Staff stored copies of patients' detention papers and associated records including leave form in paper files. These were securely stored and readily accessible to staff who needed access to them.

A six-monthly audit of the MHA was completed by the MHA administrator. This audit consisted of a check that detention paperwork was stored in an orderly manner, that Section 17 paperwork was stored appropriately and that detained patients' rights under Section 132 were reviewed with the patient regularly and that a record was kept showing whether the patient had understood their rights. For informal patients, a check was completed to ensure their rights under Section 131, was also undertaken.

Good practice in applying the MCA

Requires improvement

Specialist eating disorder services

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

All staff had received training in the Mental Capacity Act (MCA) and had a good understanding of the MCA and its statutory principles. Staff accessed information on the application of the MCA with ease. The relevant policy was stored on a shared drive.

The hospital social worker was available for staff to ask for advice on the MCA.

Capacity assessments relating to consent to treatment had been completed and were detailed, clearly illustrating how the decision about whether the patient had capacity had been reached.

Staff supported patients to make decisions and always assumed they had capacity to do so in the first instance. When patients lacked capacity, staff made decisions in their best interests, which recognised the importance of the person's wishes, feelings, culture and history.

Are specialist eating disorder services caring?

Good

Kindness, privacy, dignity, respect, compassion and support

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

During the last inspection in June 2019 some patients did not feel that staff treated them with dignity or respect. This had improved at this inspection. The four patients we spoke with all explained that staff were kind, compassionate and caring. Themes from recent complaints were around individual miscommunications and omissions, rather than general staff attitude, which had been the case at the last inspection. The 'minimum you need to know about eating disorders' booklet for staff was especially helpful in outlining appropriate communication with patients during meal times. This had previously been something patients felt staff had not been compassionate about.

Staff communicated well with patients and we observed positive, supportive staff interactions. Staff explained that they were skilled at verbal de-escalation and utilising psychologically-informed approaches when communicating with patients.

Staff supported patients to manage their treatment, care and condition. For example, the pharmacist spoke individually with patients about the effects of their medicines.

The patients we spoke with said they felt safe on the ward, which was an improvement on the last inspection where patients felt unsafe because staff did not pay close-enough attention to patients.

However, one patient reported they felt threatened with being detained under the Mental Health Act if they did not adhere to their individual goals. Staff were actively supporting this patient with the complaints process and trying to provide reassurance about the circumstances where the Mental Health Act would be used and why.

Involvement in care

Involvement of patients

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

Staff used the admission process to inform and orient patients to the ward and to the service. Patients received a welcome handbook on admission, which provided details about different staff members, the therapies on offer, the rights of informal patients and how to complain. All four patients we spoke with felt they had been thoroughly welcomed to the ward.

Staff involved patients in their care planning and risk assessment. All four patients we spoke with had their own copies of their care plans and had taken part in discussions about plans for their treatment. Each patient had a primary nurse who they met with weekly.

During the last inspection in June 2019 patient feedback was not always listened to or acted upon. This had

improved at this inspection. Patients were encouraged to provide feedback at weekly community meetings and could also give feedback to staff at any other time. A you said we did board was displayed on the ward which outlined actions that had been taken in response to patient feedback, such as requests for specific snacks. We attended a community meeting where staff provided updates on issues discussed at previous meetings. A comments box was also available for patients to anonymously provide feedback.

A patient evaluation survey had been completed in December 2019. This showed that 95% of patients felt safe or very safe on the ward, 75% of patients found staff compassionate and caring, and all patients had copies of their care plans.

Staff acted on feedback raised by patients. For example, senior leaders had listened to feedback from patients that staff did not have the authority to adjust patient meal plans when the dietician was on leave. Senior leaders listened to the feedback and made sure arrangements were in place to allow reasonable adjustments to meal plans to be made in the dietician's absence.

Staff were currently working to appoint a patient as member of the provider's people council. This meant they would attend a six-monthly regional meeting to discuss the wider work of the provider on behalf of patients from the service. At present staff attended this meeting on behalf of patients.

Since the last inspection staff had worked to improve the ward community meetings, which had previously felt quite formal. An icebreaker activity was now included, and everyone was encouraged to participate in the discussion.

Staff collaborated with patients both in their individual care and in developing the ward community. For example, one patient regularly facilitated a creative arts group for other patients.

An advocate attended the ward every Thursday and all patients could speak to them for advice or support.

Involvement of families and carers

Staff kept families and carers up-to-date about progress with their loved one's care.

One patient reported that their family were routinely contacted by staff about their progress and had attended a recent care programme approach meeting and taken part in the discussion.

Carers handbooks were given to carers and family members. This contained an introduction to the treatment of eating disorders, as well as an overview of the different staff roles on the ward. A carers group was scheduled for February 2020, where carers could discuss ways to best support someone living with an eating disorder. The service was planning to implement a carers survey to better understand their experience of the service.

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

(for example, to feedback?)

Good

Access and discharge

Bed management

Staff managed beds well. A bed was available when needed and that patients were not moved between wards unless this was for their benefit. Discharge was rarely delayed for other than clinical reasons.

The ward had 14 beds. Seven patients were being treated on the ward at the time of the inspection because a condition was imposed following the last inspection in June 2019 which limited the number of patients who could be treated on the ward.

Staff reported that average length of stay was decreasing. Six of the seven patients had been with the service for a few months. This was because the provider was now focussing on accepting patients with a primary diagnosis of eating disorders whose needs they could safely meet, rather than patients with more complex needs relating to dual diagnoses as had been the case at the last inspection.

There was no need for patients to be moved between wards unless this was justified on clinical grounds, for example, if they required treatment for deteriorating physical health in an acute hospital. Discharges were well planned and happened at appropriate times of day.

Discharge and transfers of care

Requires improvement

Specialist eating disorder services

Staff planned for patients' discharge, including good liaison with their care co-ordinators and care managers, to ensure a smooth transition between services.

Progress had been made since the last inspection to find alternative, more appropriate placements for some patients whose needs could not be adequately met by the service. This generally related to patients who had complex needs relating to dual diagnosis of eating disorders and other significant mental health conditions.

One patient's discharge was delayed during this inspection. Staff were continuing to work closely with commissioners to find a more suitable placement for them following an unsuccessful attempt at sourcing an alternative placement which had fallen through in Autumn 2019.

Staff supported patients with transfers between services. For example, staff accompanied patients who required treatment at general hospitals.

The facilities promote recovery, comfort, dignity and confidentiality

The design, layout, and furnishings of the ward supported patients' treatment, privacy and dignity. Each patient had their own bedroom and could keep their personal belongings safe. There were quiet areas for privacy.

Bedrooms had no more than one patient staying in them at the time of the inspection, partly because a restriction on the number of patients staying on the ward remained in place. The provider planned to eradicate shared bedrooms during its re-development of the building which was due to be complete by August 2020.

Patients were able to personalise their bedrooms and store their possessions in lockable cabinets. Patients did not have keys to their own bedrooms but could ask staff to lock their bedroom doors at any time.

Patients had access to a range of rooms and equipment to support their treatment and care. This included activity rooms, meeting rooms, lounge areas and a sensory room where massage therapy took place.

Patients could use their own mobile telephones and access the internet without restriction, unless there were specific risks that meant access to the internet should be monitored. Staff worked closely with patients to promote self-protection from abuse on social media. Patients without their own devices could borrow a cordless landline telephone or access the ward computer to use the internet. At the time of the inspection staff were working to resolve a poor wi-fi issue with this computer.

Access to outside space on the ward was limited. There was no ward garden, although a terrace area was accessible from the first floor. This area was used under supervision by staff to safely manage environmental risks on the terrace.

Patient access to drinks and snacks was carefully monitored and agreed on an individual basis in accordance with patient meal plans.

During the last inspection in June 2019 there were not enough activities to keep patients occupied at weekends. During this inspection, there were no therapeutic timetabled activities at weekends. Six of the seven patients were informal and could leave the ward at any time. Staff promoted self-directed activities at weekends and patients felt that they were adequately supported to plan for meaningful activity at weekends. A noticeboard displayed details about events happening in the local area and local attractions such as gardens and museums that patients could visit. Staff also facilitated section 17 leave for detained patients at weekends.

Patients' engagement with the wider community

Staff supported patients to remain engaged with activities in the wider community. Some patients continued to take part in education courses and staff supported them to study and attend college.

Staff actively supported patients to keep in touch with people who mattered to them including family members and friends.

Meeting the needs of all people who use the service

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

Patients were able to access to drinks and snacks in accordance with their individual meal plans.

Staff individually assessed the mobility needs of all patients on referral, to ensure the environment could appropriately

meet their needs. This was because people were required to climb stairs. Patients did have personal emergency evacuation plans in place to ensure they could leave the building promptly in an emergency.

Information about different treatments and local services was displayed for patients to refer to. Interpreters could be accessed to translate this information, or to support patients during assessments or meetings.

Staff supported other individual patient needs. For example, a group of patients had attended an LGBT pride event with staff to celebrate LGBT diversity. Patients' spiritual needs were carefully considered and a multifaith calendar was used to mark various religious events throughout the year.

Staff were sensitive to patients' dietary needs. Staff considered religious needs relating to food, for example, a Kosher meal plan was available for a Jewish patient. Staff also considered vegan and vegetarian diets. Staff remained alert to the need to discuss specialist diets in relation to a patients' eating disorder when formulating meal plans.

Listening to and learning from concerns and complaints

The service treated concerns and complaints seriously, investigated them and learned lessons from the results. However, further work was needed to ensure that themes from informal complaints were captured and reviewed and that complaints were dealt with in a timely manner.

During the last inspection in June 2019 staff did not handle complaints appropriately and the provider did not analyse themes or trends in complaints. This had mostly improved at this inspection. Details of the complaint procedure was displayed for patients to see and staff supported patients through the complaints process. Complaints were acknowledged and ultimately responded to in writing. Complaint responses were compassionate and addressed all areas the complainant had initially raised in their complaint.

Staff had recently started analysing the themes from complaints. The hospital compliance officer had completed an analysis of themes during 2019, which was presented to staff at the integrated governance meeting we attended. The top theme in recent complaints was around mis-communication from staff.

However, staff did not routinely record informal complaints to obtain insight into emerging issues and the provider had no way of analysing emerging themes and trends from these. This was an ongoing issue that had been identified during the last inspection.

Complaints were not always responded to in a timely manner. Since June 2019, three out of six complaints across the hospital were responded to outside the agreed 20-day response timeframe.

Are specialist eating disorder services well-led?

Requires improvement

Leadership

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

During the last inspection in June 2019 we found there was a lack of nursing leadership on Sunrise ward and leaders did not have the skills to safely manage and reduce patient safety incidents. During this inspection the quality of the hospital leadership had improved significantly.

The hospital was now led by a registered hospital manager who had been in post since August 2019, and by a service development lead who was new in post during the last inspection. Both these leaders had extensive experience managing hospitals and working with patients with eating disorders.

A new eating disorders service lead had been appointed to Sunrise ward in September 2019. They had good knowledge, skills and experience to perform their role and had a thorough understanding of how the service was working to deliver high quality care. Although the eating disorders service lead was an occupational therapist by background, they worked collaboratively with a clinical specialist nurse on the ward and were therefore able to effectively lead the multidisciplinary team, including nursing staff.

The provider supported leaders to obtain a leadership qualification. Other training for leaders was also available,

for example HR processes and effective performance management. Ward managers also attended support days with regional peers to discuss good practice in terms of leadership.

Vision and strategy

Staff knew and understood the provider's vision and values and how they were applied in the work of their team.

The service had a vision for what it wanted to achieve and a strategy to turn it into action. They were aligned to local plans and the wider health economy. Managers made sure staff understood and knew how to apply them.

The provider's core values were integrity, trust, empower, respect and care. These had been communicated with staff via posters and the providers intranet system, and staff demonstrated them in their day-to-day work.

Staff also had opportunities to discuss the future strategy of the service at service development meetings.

Culture

Staff felt respected, supported and valued. They felt the service promoted equality and diversity and provided opportunities for career development. They could raise concerns without fear of retribution.

During the last inspection in June 2019 staff did not feel supported or respected. Staff members from different disciplines did not work well together and patients had reported that staff did not support them and were not compassionate. During this inspection the provider had acted to improve the poor culture on the ward and there had been a high level of staff turnover, so many of the staff working on the ward had not been in post during the last inspection.

Staff felt supported and able to make suggestions or raise concerns without fear of retribution. Open forums were now in place where leaders actively encouraged staff to talk about their experiences working at the service and to suggest any improvements. Specific discussion surgeries were facilitated by the service development lead and by the HR manager. Leaders also encouraged staff to talk openly about culture and ideas for improvement during staff development days.

Staff also described a change in leadership style, whereby leaders were more visible on the ward and took an active role in patient care, whereas previously staff felt observed by leaders who stood at a distance from them.

Staff knew about the procedure for whistleblowing if they did not feel comfortable raising an issue with their manager.

Leaders discussed how they had used performance management to support and encourage staff to improve their performance through setting goals staff members should work towards.

The provider recognised staff success in the service. For example, an employee of the month was displayed in the main reception area. Staff reported that leaders thanked them for their hard work regularly.

Governance

Whilst governance systems had improved since our last inspection, further work was needed to ensure these were robust and effective in driving safety and improvement of the service and were fully embedded into practise.

Further improvements were needed to continue to strengthen the overall governance of the service. For example, an over-complicated system was in place to record incidents, which involved an electronic system, a paper-based reporting book and additional reporting books for incidents of restraint and rapid tranquilisation. The quality of ligature risk assessments varied across the building.

Not all staff had regular opportunities to meet, discuss and learn from the performance of the service. Not all staff had regular opportunities to meet, discuss and learn from the performance of the service. There was still a lack of structured team meetings on Sunrise ward. This meant that regular staff working on the ward did not have an opportunity to systematically come together to discuss governance issues including learning from incidents.

Further work was needed to ensure that themes from informal complaints were captured and reviewed and that complaints were dealt with in a timely manner.

The provider had made good progress in improving the areas for improvement outlined during a CQC MHA review visit a few weeks before the inspection. This included improvements to the storage of reports completed by

Allied Mental Health Professionals, recording the time at which patients received nasogastric feeding and ensuring the relevant treatment authorisations were attached to patient medicine charts.

Although the staff induction process was thorough and comprehensive, some staff reported this was difficult to follow and keep track of because the induction as made up of numerous different checklists and records stored in different places.

A review was underway looking at administration provision and how administrators could better support minute taking at various minutes to help improve the quality of non-clinical record keeping at the service.

However, some significant improvements in governance systems had been made since the last inspection. Leaders had carefully prioritised the areas that needed to be improved in terms of safety and impact. For example, stabilising the local leadership and improving staff culture had been the first improvement priority.

A clear structure of meetings was in place and staff told us about the process for key safety and performance information being shared upwards and downwards within the service. Senior staff attended a monthly integrated governance meeting, which we attended during the inspection. The structure of this meeting had recently been improved to better capture various elements of service performance. Staff discussed recent incidents and complaints and what could be learnt from them. Staff also reviewed data relating to complaints and incidents, discussing trends and the use of restrictive interventions on the wards. The service-level risk register was also reviewed during the integrated governance meeting.

A section of the integrated governance meeting was used to discuss corporate level learning across the provider, however, staff struggled to think of examples of learning from incidents in other services within the provider when asked. The corporate learning section of the integrated governance meeting was predominantly used to communicate the provider's organisational changes.

Management of risk, issues and performance

Staff concerns matched those on the service-level risk register, which largely related to the quality of the service. This risk register did not contain information about the risks associated with the service being in special measures, such as potential financial risk.

The service had a continuity plan in place, which was ready to be invoked in the event of an emergency which compromised the safe delivery of the service.

The service had made very positive improvements to the service over a short space of time. The provider therefore needed to continue to ensure there were robust systems to continually improve the service and sustain the improvements already made.

Information management

Ward teams had access to the information they needed to provide safe and effective care and used that information to good effect.

During the last inspection in June 2019 staff completed different parts of patient care and treatment records on different paper and electronic systems. The nursing office on Sunrise ward was also untidy and disorganised, which meant that staff struggles to locate the records they needed. During this inspection this had improved. Care plans were now completed on an electronic system along with risk assessments and progress notes. Although some other documentation including detention paperwork and medicine records were still kept on paper, these were now stored in an orderly and secure manner and could easily be accessed by staff.

Information governance systems were secure and promoted confidentiality of patient information.

Performance information was available to managers. This included live data relating to training and supervision compliance, staff induction progress and meaningful activity per patient.

Staff made notifications to external bodies as needed.

Engagement

The service engaged well with patients, staff and local organisations to plan and manage appropriate services. It collaborated with partner organisations to help improve services for patients.

Requires improvement

Specialist eating disorder services

Staff, patients and carers had access to up-to-date information about the work of the provider. Regular bulletins were also sent to staff if there were updates about the service. Meeting minutes were also readily made available to staff to review and community meeting minutes were displayed for patients to review.

Patients on the ward had recently completed a survey and staff planned to develop a carers survey in the next few months.

Staff engaged with external stakeholders including NHS improvement, teams within NHS trusts and commissioners.

Learning, continuous improvement and innovation

Staff engaged actively in local quality improvement activities.

All staff were committed to continually improving services. For example, occupational therapists on Sunrise ward had launched a new, evidence based therapeutic activity programme. They had involved staff from other disciplines in developing this new approach. Nursing staff were also developing their psychologically informed approach to supporting patients.

We did not identify examples of research projects. However, the team on Sunrise ward were working to introduce the 'Safewards' initiative. This aimed to reduce incidents of violence and aggression by first developing more meaningful, therapeutic relationships between staff and patients.

Sunrise ward was not currently accredited by a professional body, but staff were considering the standards they needed to meet to apply for accreditation in the future.

Requires improvement

Personality disorder services

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

Are personality disorder services safe?

Requires improvement

Safe and clean environment

Safety of the ward environment

The patient call alarm system had been deactivated and patients could not call for help from staff if they needed to. There was no dedicated space on New Dawn ward for patients to receive treatment and the clinic room was small and used solely for the storage of medicines. A new treatment room was planned as part of the hospital's redevelopment.

All wards were clean, well furnished, well maintained and fit for purpose.

At the last inspection in June 2019 we found that staff did not ensure that daily environmental risk assessments were completed. At this inspection we found improvements. Staff completed and regularly updated thorough risk assessments of all ward areas and removed or reduced any risks they identified. Where any risks were identified these were reported and followed up.

The layout of the ward meant that staff could not easily observe patients. Staff assessed risks to patients and staff arising from the layout of the ward and mitigated these through individual patient risk assessment, the observation of patients and regular security checks. Since the last inspection the provider had installed some larger convex mirrors so that staff were provided with a good overview of their surroundings. Closed-circuit television was in use in the corridors and communal areas. Where individual patients were identified as being at risk, increased observations, including one to one support were used.

At the last inspection in June 2019, we identified that the ward ligature risk assessment was not clear, accurate and did not detail who was responsible for managing the risk. We also identified that staff did not know how to use the ligature cutters on the ward. At this inspection we found improvements. The ligature risk assessment had been updated and recorded the actions required by staff to safely mitigate each risk identified. For example, if a patient presented with a risk of suicide or self-harm staff could increase the level of observations as detailed in their risk assessment. The ward had a ligature heat map in the nursing office which identified ligature anchor points throughout the ward. The service provided photographs of potential ligature anchor points and new staff received a ligature orientation to the ward. Staff we spoke with told us they had been trained in suicide prevention and were able to describe when to use the different types of ligature cutters on the ward. Ligature cutters were available on the ward and staff knew where to locate them in the event of an emergency.

Staff carried emergency call alarms. These were tested daily to ensure that they worked in the event of an emergency.

During the last inspection in June 2019 call alarms in patient bedrooms were not working and patients could not use these to summon assistance from staff. During this inspection call alarms remained de-activated and therefore unusable. Staff did not consider whether call alarms would be suitable for specific patients by considering individual patient risks.

Staff had training on responding to medical emergencies, which included simulations of emergencies to help prepare them to effectively respond to such incidents.

Maintenance, cleanliness and infection control

The ward was visibly clean.

At the last inspection in June 2019 we found that maintenance issues on New Dawn Ward were not being addressed in a timely way. During this inspection we found improvements. The service had employed a maintenance person who was on site. Patients confirmed that maintenance issues were now being addressed in a timely manner. Areas we identified at the last inspection such as the broken window by the lift were addressed. The ward was due to be refurbished as part of the upcoming overall hospital refurbishment/redevelopment.

At the last inspection we identified that sofas in the communal lounge were torn and a potential infection control risk. At this inspection we found that all the furniture on the ward was maintained and fit for purpose. Patients reported they were involved in choosing sofas for the lounge.

We observed that staff followed infection control procedures including hand washing. The ward conducted a monthly infection control audit.

Clinic room and equipment

At the last inspection we identified that emergency drugs were dispersed throughout the ward and were not being checked safely. We also identified that emergency equipment such as oxygen cylinders were not maintained. During this inspection this had improved. We found that the clinic room was fully equipped, with accessible resuscitation equipment and emergency drugs which were easy to access. Staff regularly audited the ward's emergency drugs, equipment and 'grab bag'. Emergency equipment such as oxygen cylinders were maintained and available for use. Staff told us if any emergency drugs or equipment were used staff replaced them immediately with stocked items and then reordered the items to replenish the stock.

The clinic room appeared clean and tidy. During the last inspection it was found that some of the equipment for monitoring physical health was not calibrated. During this inspection this had improved. All clinical equipment had been calibrated and a record was kept to prompt staff when calibration was due.

However, the clinic room did not have adequate space to treat or examine patients. Patients were treated in their own bedrooms or had to use the treatment room on Sunrise ward. The building redevelopment plans for 2020 include a shared treatment room for both wards situated on the ground floor.

Safe staffing

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

Nursing staff

The service had enough nursing and support staff to keep patients safe. Staff felt safe working on the ward and told us that staffing levels were adequate. Patients told us that staff were always available. The staffing establishment for the service was six whole-time equivalent registered nurses. The establishment for non-registered nurses (health care assistants) was nine. The service had low vacancy rates. The ward reported an overall vacancy rate of 0.1% for non-medical staff at 31 October 2019. At the time of this inspection the ward had three registered nurse vacancies. The ward manager told us that these posts had been filled and the new nurses were currently going through the organisation's HR processes. Three members of staff had left in the previous 12 months.

The day shift had a minimum of two registered nurses and two unregistered nurses (health care assistants). The night shift had a minimum of two registered nurses and one non-registered nurse. The ward used a matrix for planning shifts to ensure the correct number of staff were available according to patient numbers and needs. The manager was able to adjust staffing levels daily to take account of patients' needs. If any patient required one to one observation additional staff would be booked.

The sickness rate for the ward was 3.3% between 1 November 2018 and 31 October 2019. Staff told us managers supported them if they needed time off for ill health.

The ward made use of bank and agency staff when required. The ward had a pool of regular bank and agency

staff who were familiar with the service. Staff had the autonomy to book bank or agency staff when required. The manager made sure all bank and agency staff had a full induction and understood the service before starting their shift.

The manager could adjust staffing levels according to the needs of the patients. The ward planned ahead by booking any additional staff needed to escort patients for external activities or meetings.

Staff were always present on the ward. Patient said that staff were always available. Patients told us that they rarely had their escorted leave, or activities cancelled, even when the service was short staffed. Patient said that they had regular one to one sessions with staff. The service had enough staff on each shift to carry out any physical support or interventions safely.

Staff shared key information to keep patients safe when handing over their care to others. Staff held handovers at the start and end of each shift. The multidisciplinary team reviewed patients at a meeting each morning.

Medical staff

The service had enough daytime and night time medical cover and a doctor available to go to the ward quickly in an emergency. There was a full-time consultant psychiatrist and a full-time specialty doctor. The service operated an out of hours on-call duty rota. A duty doctor could attend quickly in the event of a medical emergency. Consultants were available on-call out-of-hours.

Mandatory training

Staff had completed and kept up to date with their mandatory training. Mandatory training included basic and immediate life support, prevent, prevention and management of violence and aggression and safeguarding individuals at risk. Since the last inspection all non-registered nurses (health care assistants) had been trained in intermediate life support. All staff we spoke with confirmed they had access to, were up to date and had completed mandatory training.

Staff participated in emergency scenario training. The service conducted at least one emergency scenario training simulation per month. The service reported on the outcome of these simulations and identified areas for improvement. This ensured staff would have the practical capabilities and skills needed in an emergency.

Assessing and managing risk to patients and staff

Some incidents of restraint were not recorded in line with the providers policy and procedure.

Staff assessed and managed risks to patients and themselves well and followed best practice in anticipating, de-escalating and managing challenging behaviour. Staff used restraint and seclusion only after attempts at de-escalation had failed. The ward staff participated in the provider's restrictive interventions reduction programme.

Assessment of patient risk

Staff assessed risks to patients and themselves well. Risks to patients were assessed, monitored and managed. Staff completed risk assessments using recognised tools; the short-term assessment of risk and treatability (START) tool and the historical clinical risk management assessment (HCR-20).

We reviewed the care and treatment records of three patients. Each patient had a detailed person-centred risk assessment completed upon admission. Their assessments included a risk history and assessment of risks associated with patients' mental and physical health and social history. Risk assessments were updated regularly, and as risks changed, for example following incidents or changes in physical or mental health presentation. Staff we spoke with were knowledgeable about individual patient risks and the plans in place to manage patient safely.

Management of patient risk

The risk assessments we viewed were comprehensive and detailed the strategies in place to manage identified risks. For example, where a patient was at risk of lithium toxicity regular blood tests were carried out.

Staff identified and responded to changing risks to or posed by patients, for example where there was a risk of self-harm this was mitigated by an increase in observations. Since the last inspection the service had introduced a daily risk review meeting. At this meeting, the multidisciplinary team reviewed each individual patient's risk rating and management plan. This enabled them to work proactively to manage patient risk and ensure that up to date information was available for all staff working on the ward. Risk assessments were also reviewed during

multidisciplinary meetings, care programme approach meetings, following incidents or more frequently if there was a change in the patient's presentation and/or circumstances.

Staff monitored the physical health of patients regularly using Modified Early Warning Score (MEWS) charts. MEWS scores were discussed at the daily risk meeting and at MDT review meetings.

We observed one multidisciplinary ward round. At this meeting we saw that patients were involved in discussions about their risk management plans and safety. Patients we spoke with confirmed they were involved in the development of their risk management plans.

Some patients had chosen to describe their moods and the actions they wanted staff to take in response by developing picture boards and mood charts which patients placed on their bedroom doors. For example, one patient described what they wanted staff to do when they experienced a 'flashback'. This helped staff better understand how patients were feeling and how to support patients in a personalised manner. Staff told us that this was particularly helpful in understanding patients' current mood and applying suitable interventions when needed.

Staff followed the provider's policy and procedures when carrying out observations. The multidisciplinary team assessed the level of observation patients required. Staff were familiar with the different levels of observation they used for patients. Observation levels were clearly displayed on the patient board in the nursing stations, staff discussed risk and observation level during morning handover. All staff completed an engagement and observation training and competency check.

Staff followed the provider's policies and procedures when they needed to search patients or their bedrooms to keep them safe from harm. Staff searched patients when they returned from leave and risk assessed those patients that needed regular searches due to the risk presented.

Use of restrictive interventions

The service had six incidents of restraint between 1 May 2019 and 31 October 2019. During this period none of these incidents were of prone restraint and none resulted in the patient receiving rapid tranquilisation.

Staff made every attempt to avoid using restraint by using de-escalation techniques. Staff applied practices from the 'Safewards' model to reduce the need for restraint. Staff stated that they tried to talk to patients and use their rapport to address patient concerns when patients were distressed. Staff restrained patients only when all attempts to de-escalate failed and when it was necessary to keep the patient or others safe. Staff had been trained in the use of correct techniques when using physical interventions.

Staff were not always clear about their responsibilities in relation to regular physical health monitoring following the administration of medicines by rapid tranquilisation, although this was detailed in the provider's medication policy.

Staff did not always record incidents of restraint consistently across all documents. We reviewed six incident records. In two of these records, the use of forearm restraint holds had not been appropriately recorded, in line with the providers policy and procedure. We raised this with the service manager who acknowledged that all documents should be consistent in referring to forearm holds as restraint. The service manager highlighted this to the ward manager and ward staff.

The provider had a strategy to reduce restrictive interventions and the third phase of this strategy to cover the period 2020-2022 was being drafted at the time of the inspection. Restrictive interventions including numbers of restraints, prone restraints and rapid tranquilisation were reviewed each month during the hospital integrated governance meeting. A reduction in restrictive interventions had been observed.

A nominated staff member was a restrictive practice champion and they had delivered training to staff about what constituted a restrictive intervention. They also attended a three-monthly regional reducing restrictive practices board to discuss new approaches to managing complex situations and reduce the need to use restrictive interventions. Staff also received preventing and management of violence and aggression training, which staff hoped would help reduce the likelihood that they would need to use restrictive interventions.

Safeguarding

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

Staff kept up-to-date with their safeguarding training with 92.3% of relevant staff having completed the provider's safeguarding individuals at risk training. Staff were aware of how to access support and guidance around safeguarding.

Staff understood how to protect patients from abuse. Staff felt confident in reporting safeguarding alerts and could give clear examples of how to protect patients from harm. For example, staff told us about a safeguarding alert that was raised regarding a patient's self-harm. Staff recorded the incident, discussed it with the patient, discussed it with the multi-disciplinary team and the hospital's social worker. The social worker worked closely with the local authority safeguarding team and traced all safeguarding referrals. Staff worked with the patient to update the patient's risk assessment and care plan and built in discussions to try to understand what led to the incident. Staff also discussed and recorded interventions that might help the patient in the future manage self-harm behaviours.

Staff knew how to recognise adults and children at risk of or suffering harm. Staff worked in partnership with external agencies such as local authority and NHS teams to ensure patients and any members of the public were protected from harm.

Staff access to essential information

Staff had easy access to clinical information and it was easy for them to maintain high quality clinical records.

During the last inspection in June 2019 we found that the provider did not ensure that staff had easy access to essential information needed to deliver safe care and treatment. There was a mixture of electronic and paper records which were stored in various places and staff had difficulty locating patient records and information. During this inspection this had improved. Now all information needed to deliver patient care was available to all staff, including agency staff. Staff still used a combination of electronic and paper records however this was now effectively organised. The electronic record was the main patient record and included, care plans, risk assessments and daily progress notes on the patient. All staff we spoke with were clear where information on patient care and treatment was located.

However, staff told us that the current systems for incident reporting were quite time consuming and often they were recording in three different places. This could lead to errors in transferring data or finding accurate information when needed. The senior management team told us they were intending to move to a fully electronic patient record system soon, but they had not yet been given an implementation date.

Medicines management

The service used systems and processes to safely prescribe, administer, record and store medicines. Staff regularly reviewed the effects of medicines on each patient's physical health.

During the last inspection in June 2019 we found that medicines were not always being managed safely. Controlled drugs were not being managed in line with relevant legislation. During this inspection this had improved. The service now stored, recorded and audited controlled drugs in line with relevant legislation and the provider's medicines policy.

Staff followed systems and processes when safely prescribing, administering, recording and storing medicines. We checked medicines administration records for five patients. Records showed that patients' medicines were reviewed weekly during ward round meetings. Patients' told us that they discussed their medicines with staff, and staff provided advice to patients about their medicines.

Staff stored and managed medicines and prescribing documents in line with the provider's policy. Review of stock medicines showed that medicines held on the premises were within their expiry dates. The service's pharmacist supported staff to ensure that medicines were stored safely and audited.

Staff reviewed the effects of each patients' medicines on their physical health according to NICE guidance. There was a policy in place for the monitoring of any high dose anti-psychotic treatment as well as the risk of harm from anti-psychotic treatment. At the time of the inspection, no patients were prescribed high doses of anti-psychotic medicines.

Track record on safety

Between 12 November 2018 and 30 August 2019, the service reported eight serious incidents for New Dawn Ward. Five of these incidents related to self-harm, two

incidents related to safeguarding concerns and one of these incidents related to a patient's death. This unexpected death was still under investigation at the time or our inspection.

Reporting incidents and learning from when things go wrong

Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

Staff knew what incidents to report and how to report them. Staff raised concerns and reported incidents in line with the provider's policy. Staff told us that they would report any incident of harm, potential harm and/or risks to safety.

Staff knew how to report serious incidents. Staff were aware of serious incidents that occurred on the other ward and discussed learning from serious incidents in team meetings and handovers.

Staff understood the duty of candour. Patients felt that staff were open and said that staff gave them clear explanations when things went wrong.

Staff and patients were debriefed and supported by the senior managers and ward manager after any serious incident. For example, following a death on the ward staff had been provided with individual and group support. Staff were aware that the provider could provide them with counselling if this was required. Staff reported that they had weekly reflective practice and were given the opportunity to reflect and learn from serious incidents as a team.

Staff received feedback from investigation of incidents. We saw evidence of feedback and improvements to patient care being discussed in team meetings. When appropriate, managers followed up on incidents through individual supervision and by ensuring the staff member received further training and support.

There was evidence that changes had been made because of feedback from investigations of incidents. For example, following a death on the ward involving a ligature, the service started a process to have all the ward windows changed to ensure they were ligature free. This was due for completion by the end of February 2020. All windows were currently locked. Where any windows were open, staff supervised those areas. Two patient rooms had new ligature free windows installed which could be opened and closed without posing a ligature risk. The service had also introduced a post home visit debrief process to help staff assess patients when patients return from leave. This process gave staff and patients an opportunity to reflect on how leave went and ensured staff provided adequate levels of support after patients returned from leave. In addition to this, all support workers were now trained in immediately life support.

Are personality disorder services effective?

(for example, treatment is effective)

Good

Assessment of needs and planning of care

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

Staff completed a comprehensive mental health assessment of each patient on admission or soon after. There was a holistic approach to assessing, planning and delivering care and treatment to support patients on the ward. We reviewed three care and treatment records. All three patients had detailed and timely assessments of their current mental state, previous history, physical healthcare needs and risk behaviours. A doctor had reviewed the patient on the day of admission. Assessments were completed by medical, nursing, psychology, physiotherapy and occupational therapy staff.

All patients had their physical health assessed soon after admission and this was regularly reviewed during their time on the ward. Staff assessed and supported patients with their physical health needs and worked collaboratively with specialists when needed. Comprehensive physical assessments were completed and plans for on-going monitoring of health conditions and healthcare investigations were developed. This included regular monitoring of blood samples, heart rate, pulse, urine tests,

temperature, weight monitoring and electrocardiogram (ECG). An ECG checks the hearts rhythm and electric activity and is important to ensure patients receive the right medicines.

All patients were registered with a general practitioner and could access other specialists such as optician, dentist, dietician and chiropodist.

Staff developed a comprehensive care plan for each patient that met their mental and physical health needs. Staff developed care plans that met patients' needs. Care plans were personalised, holistic, recovery-oriented and regularly reviewed. Care plans reflected the views of patients and their relatives about their care and treatment.

Best practice in treatment and care

Staff provided a range of care and treatment interventions suitable for the patient group and consistent with national guidance on best practice. They ensured that patients had good access to physical healthcare and supported patients to live healthier lives.

Staff provided a range of treatment and care for patients based on national guidance and best practice. Staff followed National Institute for Health and Care Excellence (NICE) guidance for supporting people with personality disorders and prescribing medicines. The service was able to provide psychological interventions in line with NICE guidance. This included access to psychological therapies on a one to one and group basis. The service employed a part-time clinical psychologist and a part-time assistant psychologist. The staff worked with patients to support their recovery using Dialectal Behavioural Therapy (DBT), a specific type of cognitive-behavioural psychotherapy, and Schema Focused Therapy, along with several other interventions such as drama and art therapy to improve the patients' recovery journey.

An occupational therapist worked on New Dawn ward. They were supported by one full-time and one part-time occupational therapy assistants who worked across both wards. Patients could access an extensive therapy programme and were encouraged to attend the daily planning meeting. Staff offered the same activities individually to patients on enhanced observations who could not attend a group.

The ward used the 'Safewards' model (an evidence-based approach to conflict and containment) interventions on the ward. Some of the interventions included clear mutual expectations using talk down and knowing each other. One patient described how they used a calm down box they had prepared when they were distressed. The patients on the ward ran a mutual help group on the ward every evening.

Staff identified patients' physical health needs and recorded them in their care plans. Staff monitored patients' physical health regularly recording vital signs and reported any changes to the multi-disciplinary team or escalating it to the ward doctor. Patients told us that the staff addressed any physical health concerns they had.

Staff met patients' dietary needs. Nutrition and hydration needs were assessed as the patients were admitted.

Staff supported patients to live healthier lives. This was through supporting them to take part in programmes and healthy living advice. Fresh fruit was available on the ward. Since the last inspection the service had employed a physiotherapist who supported patients with exercise and boxing classes. Patients could obtain dietary advice from the hospital dietician.

Staff used recognised rating scales such as Health of the Nation Outcome Scales (HONOS), Model of Human Occupation Screening tool (MOHOST) and Beck's Depression Inventory to assess and record severity and outcomes. The psychologists used a variety of outcome measures, including clinical outcomes in routine evaluation (CORE), million clinical multiaxial inventory (MCMI) and difficulties in emotion regulation scale (DERS). Staff measured patients progress and effectiveness of treatment at each ward round and against individual recovery goals.

Skilled staff to deliver care

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

The team had access to a full range of specialists to meet the needs of the patients on the ward. This included occupational therapists, psychologists, a dietician, physiotherapist, art therapist and a drama therapist.

The manager made sure staff had the right skills, qualifications and experience to meet the needs of the patients in their care, including bank and agency staff. The manager ensured staff received specialist training for their roles. All staff had undertaken training in basic Dialectical Behavioural Therapy (DBT) and three nurses were scheduled to undertake the intensive DBT course. Staff reported that the DBT approach was not yet fully embedded due to the number of new staff coming into the service, but felt it was well supported and would become part of the ward's values full practice over time. All staff had undertaken suicide and risk training. One of the nurses on the ward was due to undertake family therapy training to add to the therapies available on the ward.

The manager ensured each new member of staff received a full induction to the service before they started work. New bank and agency staff working on the ward for the first time were provided with an induction. New staff went through an induction checklist covering area such as ligature risks, the ward environment policies, guidelines and expectations.

During the last inspection in June 2019 we found that supervision records were brief and did not detail any discussions regarding incidents, learning from practice or professional development. Staff reported that they did not find supervision to be supportive or helpful and they felt personal issues would not be kept confidential. During this inspection we found that this had improved. The manager now ensured all staff were provided with supervision and appraisal of their work performance. We reviewed supervision records for six staff and found discussions and reflection on learning from incidents, personal development, wellbeing, patient interactions, and applying DBT. We saw evidence of appraisal records which included personal development plans and performance objectives. Staff reported to us that they found their supervision and appraisals as useful tools in reflecting and developing their practice.

The manager made sure staff attended regular team meetings or gave information from those they could not attend. For the last 12 months New Dawn Ward held nine team meetings. On two occasions the team meeting was postponed due to ward demands and on one occasion the team meeting was replaced with a training day for the team.

Multi-disciplinary and inter-agency team work

Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care. The ward had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation.

Staff from different disciplines worked together as a team to benefit patients. Staff held regular multi-disciplinary meetings to discuss patients and improve their care. External professionals from other teams that were involved in patient care were invited to ward rounds and care programme approach meetings. This included care coordinators, social workers and community team managers.

Staff made sure they shared information about patients and any changes in their care. The ward's handover meetings occurred at the beginning of each shift. Staff discussed patients' current presentation and any changes in risk levels, incidents and safeguarding concerns, and planned activities.

The team had effective working relationships with other teams in the organisation. The manager attended a monthly meeting with the other ward manager and senior managers.

The team had effective working relationships with external teams and organisations. We saw evidence of communication updates between the ward team and external care coordinators and funding agencies recorded in patients' records.

Adherence to the MHA and the MHA Code of Practice

Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice and discharged these well. Managers made sure that staff could explain patients' rights to them.

Staff had a good understanding of the Mental Health Act (MHA) 1983 and its code of practice. All staff had received training in the MHA.

Staff reported that they could easily access support and legal guidance from the hospital MHA administrator. The MHA administration team would alert the ward if a patient's section was due to expire or their rights needed to be explained. Policies and procedures relating to the use of the MHA were readily available to staff on the intranet.

Requires improvement

Personality disorder services

Patients had access to an independent mental health advocate. Their contact details were displayed in the ward and they visited the ward once per week.

Staff explained to patients their rights under Section 132 of the MHA in a way they could understand. This was clearly documented on admission and repeated on a regular basis.

Monthly audits of the MHA were completed by an MHA administrator. This audit provided assurance that patients' Section 17 leave forms were in order, alerted staff to upcoming section expiry dates, ensured that treatment authorisations were in place and that patient rights under Section 132 were explained to patients in a timely manner.

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

At the time of the inspection there were no informal patients on the ward. However, the service displayed a poster highlighting that informal patients could leave the ward freely.

Good practice in applying the MCA

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

Staff had a good understanding of the Mental Capacity Act (MCA) and provided examples of instances when capacity assessments relating to specific decisions would be required.

Policies and procedures relating to the use of the MCA were available to staff on the intranet system. All staff had received training in the MCA and deprivation of liberty safeguards (DoLS).

There were no DoLS applications made in the last six months. There was a clear policy on MCA and deprivation of liberty safeguards, which staff could describe and knew how to access.

Staff knew where to get accurate advice on the MCA and deprivation of liberty safeguards. The Mental Health Act administration team provided advice to staff on the MCA when required.

We saw detailed capacity assessments relating to consent to treatment. The capacity of individual patients was discussed on a decision specific basis at multi-disciplinary meetings and ward round meetings.

Staff supported patients to make decisions and always assumed they had capacity to make decisions in the first instance. When patients lacked capacity, staff made decisions in their best interests, which recognised the importance of the person's wishes, feelings, culture and history.

Are personality disorder services caring?

Good

Kindness, privacy, dignity, respect, compassion and support

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

Staff treated patients with compassion, kindness and dignity. We observed positive and caring staff interactions with patients. Staff treated patients with compassion and kindness. They respected patients' privacy and dignity. They understood the individual needs of patients.

We spoke with four patients. Patients reported that staff were respectful and provided them with help, advice and emotional support when they needed it. All patient care and treatment records were written respectfully when describing patients.

Patients reported that staff helped them manage and understand their care, condition and treatments. Daily log records we viewed detailed discussions that had taken place with patients with various members of the Multi-Disciplinary-Team (MDT). Patients participated in discussions about their care during MDT ward rounds.

Staff reported that they felt comfortable in raising any concerns about disrespectful, discriminatory or abusive behaviour without fear of the consequences.

On the last inspection in June 2019 patients raised concerns about staff not being discreet and not maintaining confidentiality of information about patients.

Requires improvement

Personality disorder services

During this inspection this had improved. Staff were aware of confidentiality issues when talking with patients and discussing patients within the team. They ensured conversations of this nature took place in appropriate settings.

Involvement in care

Involvement of patients

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

Patients were involved and encouraged to be partners in their care. Staff orientated patients to the service when they first arrived.

Patients we spoke with confirmed they were involved in developing their care plan and risk management plans. They told us their views were listened to, for example a patient reported that they did not agree with some wording on a care plan which was then changed. We observed an MDT meeting and observed that patients and staff worked together to make decisions about care and treatment, for example we observed discussions about reducing observation levels and how this could be managed safely.

At the last inspection in June 2019 we found that patients' feedback and concerns were not promptly addressed by the provider, particularly around maintenance issues. During this inspection we found that this had improved. Staff supported patients to give feedback about the service they received, either directly to staff, via the community meeting or comments box. Community meetings were held twice a week and the minutes showed that feedback and concerns were discussed and actioned. Where there were delays or where suggestions were not feasible this was discussed. Patients confirmed that staff listened to feedback about the service and made improvements. For example, detained patients who did not have leave raised concerns about not being able to have their hair cut. In response to this staff arranged for a monthly visit by a mobile hairdresser. The 'you said, we did' board identified that patients had fed back that they wanted a games room, and this had been facilitated by staff in changing the quiet room.

Staff ensured patients had access to advocates to have their voice heard.

Involvement of families and carers

Staff informed and involved families and carers appropriately.

Family members and carers were invited to ward round meetings and care programme approach meetings. Patients we spoke said their family members were involved in their care if their wanted. Patient records showed that staff contacted families and carers to provide updates and included details of family visits and input.

The assistant psychologist ran a family and friends' group throughout the year so that they could understand personality disorder and how to support their family member. We reviewed post group feedback forms from family members who had completed the course in 2019. These were very positive and family members reported that they had a better understanding of personality disorders.

Are personality disorder services responsive to people's needs?
(for example, to feedback?)

Good

Access and discharge

Bed management

Staff managed beds well. This meant that a bed was available when needed and that patients were not moved between wards unless this was for their benefit. Discharge was rarely delayed for other than clinical reasons.

The service managed the use of beds well. At the time of the inspection the ward had eight patients. Bed occupancy on the ward was 90% between 1 May 2019 and 31 October 2019. Staff felt that this was due to the lack of suitable provisions in the boroughs that referred to the service. Places were funded by clinical commissioning groups in the areas where patients lived permanently. Patients were mostly out of area at the time of the inspection, with only one patient from London.

Admissions came through a centralised assessment team. This team was external to the ward but sat within the organisation. This team screened all admissions and undertook face to face assessments. After the assessment,

the multidisciplinary team met and discussed whether the person was appropriate for the service. This meant the ward's MDT was able to assess suitability of the referral with a member of the MDT then going to assess the individual.

The average length of stay of patients between 1 May 2019 and 31 October 2019 was 547 days.

The service had clear admission and exclusion criteria for referrers.

The service planned all admissions and discharges. Admissions and discharges took place at an appropriate time of the day.

Discharge and transfers of care

At the time of the inspection the service had one delayed discharge in the past year. This was due to a lack of accommodation that could support the patient's needs in the patient's home borough.

Staff carefully planned patients' discharge and worked with care managers and coordinators to make sure this went well. Staff created tailored discharge plans for each patient. However, staff noted that it was sometimes difficult to get patients' care coordinators from outside of London to attend care programme approach meetings and multidisciplinary meetings to facilitate discharge.

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

The facilities promote recovery, comfort, dignity and confidentiality

The design, layout, and furnishings of the ward/service supported patients' treatment, privacy and dignity. Each patient had their own bedroom and could keep their personal belongings safe. There were quiet areas for privacy.

The food was of a good quality and patients could make hot drinks and snacks at any time.

The design, layout, and furnishings of the ward supported patients' treatment, privacy and dignity. Each patient had their own bedroom, which they could personalise. We saw that many patients had personalised their rooms with pictures and other keepsakes.

At the last inspection in June 2019, we found that the water temperature was low and the water pressure was low in one of the shower rooms. This had been reported for over a year and not addressed. During this inspection we found that this had improved. All the showers on the ward now worked appropriately and staff and patients told us that most maintenance issues with promptly addressed.

Patients had a secure place to store personal possessions.

Staff used a full range of rooms and equipment to support treatment and care. Therapy rooms and the occupational therapy kitchen were located on the ground floor.

There were quiet areas for privacy. The ward had a quiet room for patients to use and a room where patients could meet with visitors in private.

Patients could make phone calls in private. Patients were permitted unrestricted access to their own mobile telephones once this was risk assessed.

The service had a small garden that patients could access with staff support.

At the last inspection we saw that the patients did not have access to activities at the weekend. At this inspection we found improvements. The occupational therapy assistant had started to work over weekends to help ensure weekend activities were facilitated. The groups activity schedule for the ward included groups and activities on Saturdays and Sundays. A weekend planning meeting was held during the week, so patients could input and feedback on the planned activities.

Patients' engagement with the wider community

Staff supported patients to stay in contact with the people that mattered to them. Patients told us that they were in regular contact with family and friends through telephone contact, visits to the ward and visits in the community. Where patients consented, families and carers attended care programme approach meetings and ward rounds.

Staff supported patients with activities outside the service, such as visiting family members and community activities. Staff supported patients to access the wider community. For example, the occupational therapist described how they were supporting a patient to undertake a volunteer role in the local community horse-riding centre.

Meeting the needs of all people who use the service

Requires improvement

Personality disorder services

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

The food was of a good quality and patients could make hot drinks and snacks at any time.

The ward was located on the second floor with lift access. At the last inspection in June 2019, staff and patients reported that the lift was often broken. During this inspection we found that this had improved. Staff reported that the lift was generally working, and the maintenance team responded quickly when it was not working.

Each patient had been assessed for their mobility by the physiotherapist. Where patients had been identified with a mobility need a personal emergency evacuation plan (PEEP) was in place.

Staff made sure patients could access information on treatment, local services, their rights and how to complain. Notice boards contained a range of information for patients. This included information about the activity programme including therapeutic activities, treatments, local services, advocacy and how to complain. However, patients told us that the patient Wi-Fi system was not currently working and had only been intermittently working over the last six months. We raised this with the service manager and senior managers. They were aware of the issue and escalated the concern with the organisation's IT team.

Information leaflets could be made available in different languages at the patient's request.

Patients had a variety of meal choices that supported their dietary requirements. This included foods to meet patients' individual religious needs such as halal or kosher foods. Patients told us the quality of food was fine and better than other services they had been in.

Patients could access appropriate spiritual support upon request. Staff were aware of patients' protected characteristics and were supportive of patients who were LGBTQ+.

Listening to and learning from concerns and complaints

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team and the wider service. However, further work was needed to ensure that themes from informal complaints were captured and reviewed and that complaints were dealt with in a timely manner.

The service treated formal complaints seriously, investigated them and learnt lessons from the outcomes. Between 9 November 2018 and 16 September 2019, the service overall received 11 complaints. Five of these complaints were upheld and four were partially upheld. Patients complained about the quality of their care and treatment, staff attitudes and lost property. At the last inspection in June 2019, we found that the provider did not analyse complaints by ward or themes. During this inspection we found that the compliance manager now analysed complaints. For 2019 the top themes were quality of care, poor staff communication and attitude of staff. These themes were discussed at the integrated governance meetings.

Patients knew how to complain and felt able to do so. Staff displayed the complaints process on the noticeboards around the ward.

When patients complained, staff provided them with feedback from investigations. For example, the ward manager would write to the patient and verbally discussed the outcome with them.

Records showed the managers discussed formal complaints with staff at their monthly team meetings.

However, response time for complaints was not in line with the provider's timeframe. Since June 2019, three out of six complaints were responded to outside the agreed 20-day response timeframe.

Staff did not routinely record informal complaints to obtain insight into emerging issues and the provider had no way of analysing emerging themes and trends from these. This was an ongoing issue that had been identified during the last inspection.

Are personality disorder services well-led?

Requires improvement

Leadership

Requires improvement

Personality disorder services

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

Leaders had the skills, knowledge and experience to perform their roles and had a good understanding of the services they managed. The service manager supported the ward manager in developing the skills and understanding to manage the ward. They understood their responsibilities and knew the team well. They were aware of the key risks and challenges and were open in sharing them.

During the last inspection in June 2019, we found that many staff were unfamiliar with senior Cygnet managers which indicated they rarely spent time on the ward. We found that this had improved. During this inspection staff said that the senior managers in the service were visible and approachable. Staff told us that the senior managers were very hands on and supported the ward during incidents and busy periods.

At the last inspection staff at ward level did not feel there were suitable development opportunities. During this inspection we found that this had improved. Staff reported that development opportunities were available, including opportunities for staff below team manager level. Senior managers told us that the service was now proactively trying to develop current staff.

Vision and strategy

Staff knew and understood the provider's vision and values and how they were applied in the work of their team.

The service's senior management team had successfully communicated the vision and values of the organisation to the frontline staff. Staff felt positive about the organisation's vision and values and found it easy to apply them in their work with patients.

Managers made sure staff understood the service's values and knew how to apply them. Staff said that they discussed the organisation's values of integrity, trust, empower, respect and care often in supervision and team meetings. Staff delivered care in accordance with these values. We observed staff treating patients with respect and care in different settings and situations such as ward round meetings, group activities and general interactions.

Culture

Staff felt respected, supported and valued. They reported that the provider promoted equality and diversity in its day-to-day work and in providing opportunities for career progression. They felt able to raise concerns without fear of retribution.

At the last inspection in June 2019, staff said that morale was poor, and things felt unstable due to a lack of communication and transparency from the provider. Staff felt unsupported by senior managers and said they were unresponsive to feedback. Staff talked about a split between the senior leadership team and multidisciplinary team. Staff on New Dawn Ward also reported concerns with working on Sunrise ward. During this inspection we found that this had improved. Staff felt respected, supported and valued. Staff we spoke to said they felt happy at work. They described good morale and said they felt supported and valued by the senior managers and part of the larger team with no concerns with working on Sunrise Ward. Hospital manager reported regular clinics for staff to come and discuss any issues, and ward away days with a learning focus. A HR business partner for the organisation ran regular clinics for staff to discuss HR matters. Senior managers also told us about their work with individuals to support them to improve their performance.

Senior managers told us that there had been a culture shift since the last inspection with the culture now friendly and open. Staff we spoke to confirmed this. Staff reported that they felt positive about their jobs and since the last inspection morale, hospital leadership, team dynamics and communication between team members had improved. Staff said these changes had made them feel positive and empowered about working for the provider and the ward team. Staff felt confident in raising issues without fear of retribution and that any concerns were addressed and taken seriously. Staff knew how to use the whistle-blowing process.

Staff felt that the ward culture was now supportive of career development.

Governance

Whilst governance systems had improved since our last inspection, further work was needed to ensure these were robust and effective in driving safety and improvement of the service and were fully embedded into practise.

At the last inspection we found that provider's systems were not always being operated effectively to monitor and

improve the quality of the service, or people's experience of receiving care. During this inspection we found that whilst improvements had been made, further consolidation and embedding was required. For example, an over-complicated system was in place to record incidents, which involved an electronic system, a paper-based reporting book and additional reporting books for incidents of restraint and rapid tranquilisation. This presented a risk that valuable information relating to incidents might not be captured in the correct place and feed in to useful analysis of past incidents.

Although the staff induction process was thorough and comprehensive, some staff reported this was difficult to follow and keep track of because the induction as made up of numerous different checklists and records stored in different places.

Staff were unable to identify learning from incidents that had occurred in the wider organisation or how it may relate to the services they were providing.

Our findings from the other key questions demonstrated that governance processes had improved. There were systems and procedures to ensure that the premises were safe and clean; there were enough staff; staff were trained and supervised; patients were assessed and treated well; referrals were managed well; incidents were investigated and learned from.

Senior clinical managers discussed pertinent issues such as incidents, staffing, feedback from patients and performance at monthly integrated governance meetings. This system ensured key messages and learning were communicated from service level to the provider and vice versa. In addition, managers attended monthly head of department meetings to check the clinical performance of the wards. Staff discussed best practice, medicines management and physical health. This supported the delivery of safe and effective care.

New Dawn Ward held regular staff meetings where key information about the service was shared. There was a clear framework of what must be discussed to ensure that essential information, such as learning from incidents, safeguarding, staff training and complaints, were shared and discussed. In addition, members of the multi-disciplinary team met regularly on the ward to discuss best practice and complex cases.

Staff had implemented recommendations from reviews of incidents, complaints and safeguarding alerts at the service level.

Staff on the ward conducted clinical audits. The audits were sufficient to provide assurance and staff acted on the results when needed. The results of these audits were shared with staff during ward team meetings and supervision.

Management of risk, issues and performance

The managers used systems to identify, understand, monitor, and reduce or eliminate risks that were mostly effective. They ensured risks were dealt with at the appropriate level. The service had a local risk register which the manager added to. Risks included the management of ligature points and staff recruitment and retention.

The provider ensured they carried out the necessary checks on staff prior to employment. We checked the personnel files of eight staff across the service and found that each had appropriate checks in place. This included two references from a previous employer to check an employee's experience and skills to carry out their job role. The service had systems in place to check that all staff received a criminal record check. This meant managers could be confident that staff were suitable to work with vulnerable adults.

The service had a business contingency plan for emergencies. The plan detailed processes and procedures for staff to carry out in the event of major staff absences, loss of electricity, a loss of information technology systems, severe travel disruption, adverse weather and a terrorism threat.

Information management

Ward teams had access to the information they needed to provide safe and effective care and used that information to good effect.

The service collected reliable information and analysed it to understand performance and to enable staff to make decisions and improvements. The service had a dashboard that held pertinent data about the service, for example, discharges and length of patient admissions. The information systems were integrated and secure. The managers had access to information to support them with their management role. This included information on the performance of the service, staffing and patient care.

Requires improvement

Personality disorder services

Information was recorded in a combination of an electronic record system and paper records. For patient care and treatment records this was managed effectively, however for some areas such as incident reporting this required improvement.

The service notified the Care Quality Commission of notifiable incidents, including incidents involving the police.

Engagement

The service engaged with patients and staff to plan and manage appropriate services. The provider issued regular bulletins to staff. The service emailed news about important changes, as well as learning from serious incidents, directly to staff members. Team meeting minutes and clinical governance meeting minutes were available to read. The service website provided information on the services offered by the hospital.

Patients and carers had opportunities to give feedback about the service. For example, patients gave staff feedback in weekly community meetings and on the service's 'you said, we did' boards.

The assistant psychologist ran a family and friends' group throughout the year so that they could better understand personality disorders and how to support their family member.

Learning, continuous improvement and innovation

Staff were not engaged actively in local quality improvement activities.

Whilst staff could not describe any specific quality improvement initiatives taking place, they spoke about improvements to the service relating to the change in culture across the service.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure patients have access to patient call alarms to get help from staff if needed. **Regulation 12(1)(2)(a)(b)**
- The provider must embed effective governance systems to improve the quality of the service and how effectively it is monitored. **Regulation 17(1)(2)(a)(b)**

Action the provider SHOULD take to improve

- The provider should continue to ensure its systems are effective at sustaining the significant improvements that have been made to the service over a short time.
- The provider should continue to review the space available to treat or examine patients on New Dawn ward.
- The provider should ensure the process for robustly monitoring patients' physical health vital signs after receiving medication via rapid tranquilisation is clear for staff to follow.
- The provider should ensure they respond to complaints within the timeframe set out in their complaints policy.
- The provider should follow-through with its plans to make alterations to its environment to eliminate the potential for shared bedrooms on Sunrise ward.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

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