Cygnet Hospital Wyke

Quality Report

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Date of inspection visit: 2 to 4 June 2019
Date of publication: 09/08/2019

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

Ratings

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

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

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

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

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

Summary of findings

Letter from the Chief Inspector of Hospitals

I am placing the service into special measures.

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

Ted Baker
Chief Inspector of Hospitals

Overall summary

The Care Quality Commission are placing this service into special measures.

Due to the concerns we found during this inspection, we used our powers under section 31 of the Health and Social Care Act to take immediate enforcement action and placed conditions on the provider's registration in relation to regulation 12 (safe care and treatment) and regulation 17 (good governance). Because of the enforcement action we have already taken, the ratings for the safe and well led key questions are limited to a rating of inadequate.

The enforcement action has concluded, and we are continuing to review this service with the provider in relation to the areas of improvement identified in this report.

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

- The provider was not delivering safe care. People were not safe and were at high risk of avoidable harm. Staff had not undertaken risk assessments of the care environment or mitigated those risks. For patients who were at a higher level of risk, staff did not follow processes and procedures to mitigate these through appropriate monitoring. The service used restrictive interventions that were not always proportionate to the risk posed, and staff did not keep proper records of restrictive interventions.
- There were blanket restrictions in place which were not proportionate to the risks presented, such as the monitoring of patients' mail and procedures relating to takeaway food and visiting arrangements.
- The provider was not delivering effective care. Not all patients had care plans which were holistic, and goal orientated, and none of the patient care plans we reviewed contained a detailed, goal orientated discharge plan. The provider did not offer sufficient therapeutic activity to patients such as clinical psychology and occupational therapy. Not all patients had the required physical health observations undertaken on admission to the service. The provider did not adhere to the Mental Health Act and Mental Capacity Act Codes of Practice. In patient files we reviewed we did not see evidence of staff undertaking and documenting any decision specific capacity assessments or best interest discussions with patients who staff had noted lacked capacity to make specific decisions. When these had been undertaken, the principles and guidance in the related Code of Practice had not been followed. Staff did not always make timely referrals for a second opinion doctor.
- The care provided was not always kind and respectful. During the inspection we observed behaviour from

Summary of findings

staff towards patients which was antagonistic and not always respectful and dignified. The carers and families of patients did not feel involved in the care of their relative.

- The service was not always responsive to the needs of individual patients. There was a lack of activity available for patients on Austen and Branwell wards.
- The service was not well led. When risks were highlighted to the service via external bodies, the provider did not act in a timely manner to make the required improvements. Processes and practices were not always taking place according to the provider's policies. There was little understanding or management of risks, and there were significant failures in performance management and audit systems and processes. Ward level audits were either not effective at identifying these issues or action did not take place to address the issues identified at all, or in a timely way.

Summary of findings

Our judgements about each of the main services

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

Summary of findings

Contents

Inadequate

Cygnet Hospital Wyke

Services we looked at:
Acute wards for adults of working age and psychiatric intensive care units

Summary of this inspection

Background to Cygnet Hospital Wyke

Cygnet Hospital Wyke is an independent mental health hospital provided by Cygnet Health Care Ltd. The hospital provides care for 51 patients across three different wards:

- Austen ward is a 14 bed male psychiatric intensive care unit.
- Branwell ward is a 19 bed acute mental health ward for men of working age.
- Anderson ward is a 18 bed acute ward for females of working age.

The hospital has been registered with the Care Quality Commission since November 2010 to carry out the following regulated activities:

- Assessment or medical treatment for persons detained under the Mental Health Act 1983
- Treatment of disease, disorder or injury.

The Care Quality Commission last carried out a focussed unannounced inspection of this hospital in November 2018. This was a focussed inspection of the safe and well led key questions and was undertaken in response to concerns relating to several serious incidents which had occurred at the service. Following this inspection, we took urgent enforcement action to ensure improvements were made to the safety and management of the hospital. This included placing conditions on the provider's registration to restrict the number of patients that could be admitted to the hospital until March 2019. At this inspection in November 2018 the provider was found to be in breach of four regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014:

- Regulation 13, safeguarding; the service did not report all allegations of abuse to the Local Authority.
- Regulation 12, safe care and treatment; the provider failed to assess the risks to the health and safety of service users receiving care or treatment and did not do all that was practicable to mitigate such risks. They did not ensure that the premises used were safe.
- Regulation 17, good governance; the systems and processes in place did not identify, monitor and manage risk to patients.
- Regulation 18, staffing; staff employed by the service had not received appropriate training as necessary to perform their role.

The provider was also in breach of Regulation 18 of the Health and Social Care Act (Registration) Regulations 2009, because they had not notified the Care Quality Commission of all the incidents at the service required by this regulation. The provider paid a fixed penalty notice in relation to this breach.

The Care Quality Commission last carried out a comprehensive inspection of this hospital in February 2018. At that inspection we rated the service as 'requires improvement' overall. At the time of this inspection, the hospital also provided care for older patients with mental health problems on Fairfax ward. This ward closed in August 2018. At this inspection the hospital was in breach of seven regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014:

- Regulation 9, person centred care; the care and treatment, statement of purpose and environment of Fairfax ward did not meet the needs of the patient group.
- Regulation 10, dignity and respect; there were blanket restrictions in place on Fairfax ward.
- Regulation 11, need for consent; patients on Fairfax ward were not always cared for within the provisions of the Mental Capacity Act.
- Regulation 12, safe care and treatment; infection control was not of good enough quality to keep patients safe on Fairfax ward.
- Regulation 13, safeguarding; acts to control or restrain patients were not always proportionate to the risk presented, and staff used planned prone restraint for the administration of intra-muscular medication.
- Regulation 17, good governance; governance systems did not ensure that the service assessed, monitored and mitigated risks and improved the quality and safety of services.
- Regulation 18, staffing; staff had not completed mandatory training.

Summary of this inspection

Our Mental Health Act reviewers had visited all three wards at the hospital since November 2017. At each visit concerns were raised regarding compliance with the Mental Health Act. Not all the concerns had been rectified according to the provider's actions plan submitted following these visits.

The hospital had a registered manager in place. The registered manager, along with the registered provider, is legally responsible and accountable for compliance with the requirements of the Health and Social Care Act 2008 and the associated regulations including the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and the Care Quality Commission (Registration) Regulations 2009.

Our inspection team

The team that inspected the service comprised four CQC inspectors and one Mental Health Act Reviewer, two of which were registered mental health nurses.

Why we carried out this inspection

We inspected this service in response to concerns shared by an anonymous whistleblower which included several serious allegations centred around the care and treatment of patients, and the culture within the staff team.

There had been a serious incident which involved significant harm to a patient.

We also followed up on the breaches of regulation from the previous inspections to check whether the provider had made improvements to the service as required.

How we carried out this inspection

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

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

Before the inspection visit, we reviewed the information that we held about the location.

During the inspection visit, the inspection team:

- visited all three wards at the hospital, looked at the quality of the ward environments and observed how staff were caring for patients
- spoke with 13 patients who were using the service
- spoke with five carers or family members of people using the service
- spoke with the registered manager, and managers for each of the wards
- spoke with 20 other staff members including agency staff, nurses, doctors, healthcare support workers, psychologists, social workers, and substance misuse practitioner
- looked at nine care and treatment records of patients
- reviewed human resources files
- reviewed all patient medication management charts
- observed operational meetings such as handovers and a morning meeting
- undertook observations of staff and patient interactions
- looked at a range of policies, procedures and other documents relating to the running of the service.

Summary of this inspection

What people who use the service say

We spoke with 13 patients who were using the service at the time of the inspection. Six patients raised concerns about their care. Their comments included that they had no access to clean clothing, staff did not listen, they did not know what an advocate was, staff were 'power hungry', staff were arrogant and pushed the need for patients to say 'please and thank you' for power and control. One female patient told us that following an incident a male staff member requested to complete physical health checks. They told us that they requested a female staff member due to their anxieties about this and this request was not undertaken. Four of the six patients who raised concerns were from Austen ward.

Other patients did make some positive comments about staff and used words to describe them as hard working, kind, caring, supportive, and responsive. Most patients we spoke with from Anderson ward, the female acute mental health ward, were complimentary about staff and described staff who took time to spend one to one time with them.

We spoke with five carers of patients admitted to the service during the inspection. Four carers said that staff were respectful and kind. However, one carer commented on staff being dismissive and that they made a complaint which was not taken seriously. Three out of five carers made comments that they had not been involved in the care of their relative such as by being invited to meetings and sharing copies of their care plans.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Inadequate

Because of the enforcement action we have already taken, the rating for this key question is limited to a rating of inadequate.

We rated safe as **inadequate** because:

- Care premises, equipment and facilities were unsafe. The ligature risk assessments in place did not include all areas of the hospital so did not mitigate risk to patients who might try to harm themselves. There were no environmental risk assessments in place at ward level, to highlight and mitigate risks such as the stairwell to the courtyard. The site environmental risk assessment did not include the patient smoking area. Equipment in clinic rooms was not calibrated and the clinic room on Austen ward was not clean.
- There was routine disregard of standard operating and safety procedures. Staff had not completed risk assessments for all patients and updated these following an incident. Staff had not undertaken observations of patients as per the provider's own policy and the patient's care plan, which had placed patients at risk.
- The service provided mandatory and required training to staff in key skills but did not make sure everyone had completed it. Not all staff were trained immediate life support.
- Staff did not follow best practice and the guidance in the Mental Health Act because they applied blanket restrictions which were not audited and reviewed. Some restrictions were not proportionate such as the monitoring of patient mail. We saw evidence of staff applying these blanket rules in a way that a patient may perceive as a 'punishment' and this had caused distress to patients.
- The use of restrictive practices such as prone restraint, rapid tranquilisation and seclusion did not follow best practice guidance. Staff did not record these interventions as per the provider's own policy. The recording of restrictive interventions did not evidence that they were always proportionate and least restrictive.
- People were at risk because staff did not always follow best practice guidance when managing medicines. Staff did not always review the side effects of anti-psychotic medications with patients when the British National Formulary limit was exceeded.

Summary of this inspection

- Opportunities to prevent or minimise harm were missed, and staff had not learned from these events and enhanced their practice in the observation and engagement of patients.
- The arrangements for out of hour's doctors were not sufficient. There was often a significant time delay in attendance to admissions and seclusion reviews.
- Staff did not always understand how to protect patients from abuse. We saw evidence of patients raising concerns about their safety which were not acted upon.
- Staff did not have easy access to clinical information and it was not easy for them to maintain high quality clinical records. This was because information was recorded in several different places.

However:

- The service had enough nurses and healthcare assistants, and safer staffing reports indicated a low number of shifts which were unfilled to the service's own planned levels.
- The service used systems and processes to safely prescribe, administer, record and store medicines.
- The hospital manager had introduced a daily situation report meeting to discuss with all managers; staffing, new admissions, incidents and escalating risks.

Are services effective?

Inadequate

We rated effective as **inadequate** because:

- Staff did not always assess the physical health needs of all patients on admission.
- Staff did not provide a range of care and treatment interventions suitable for the patient group and consistent with national guidance on best practice.
- Staff did not fully understand their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice and discharge them well in line with the Code of Practice, such as requesting reviews of patients treated under section 62. The provider had not ensured that they completed actions relating to the recommendations following visits from our Mental Health Act Reviewers.
- Staff did not fully understand the provider's policy on the Mental Capacity Act 2005 and the associated Code of Practice. They did not assess and record capacity clearly for patients who might have impaired mental capacity.
- Patient care plans were not holistic, and recovery orientated; they used professional language which was not in the words of the patients.

However:

Summary of this inspection

- Staff used recognised rating scales to assess and record severity and outcomes.
- Staff were supported with supervision and appraisal in line with the provider's policy.
- Staff developed individual care plans, which they reviewed regularly through multidisciplinary discussion and updated as needed.
- The employed individual professional staff from a range of backgrounds to support patients. However, there was limited availability of therapy.
- Staff understood and carried out their responsibilities under the Mental Health Act to explain patient's rights to them.

Are services caring?

Inadequate

We rated caring as **inadequate** because:

- We observed behaviour from staff that was antagonistic, and patients being treated in a manner likely to cause them distress.
- The way staff spoke with, and about patients was not always respectful and kind.
- Carers did not feel involved in care and treatment and were not always invited to take part in discussions about their relative. We did not see evidence that staff had undertaken or signposted carers to a carer's assessment.
- Patient community mutual help meetings did not take place regularly, and when they did, there was not always a completed action plan.

However:

- Most patients and carers described staff as professional, approachable, helpful, and understanding.
- The provider had developed 'our say' meetings to enhance patient involvement and feedback to the service.

Are services responsive?

Requires improvement

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

- None of the patient care plans we reviewed contained a goal orientated plan for discharge.
- The service treated concerns and complaints seriously, investigated them and shared findings with patients and staff. However, there was no evidence of learned lessons from the results and action plans to prevent reoccurrence.

Summary of this inspection

- There was a lack of activity for patients on Branwell and Austen wards. Patients, staff and carers raised concerns about this. Patients reported being bored with the activity plans patients had in place were generic and there were not enough activity staff to meet the needs of all patients.

However:

- The service met the needs patients who used the service who had a protected characteristic. Staff helped patients with communication, advocacy and cultural and spiritual support.
- Each patient had their own bedroom with an en-suite bathroom and could keep their personal belongings safe. There were quiet areas for privacy.
- The food was of a good quality and patients could make hot drinks at any time.

Are services well-led?

Inadequate

Because of the enforcement action we have already taken, the ratings for this key question is limited to a rating of inadequate.

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

- The service had some systems and processes in place to monitor and assess risk. However, staff did not follow process and procedure in place, which had led to patients being at risk of harm.
- There was little understanding or management of risks and issues, and there were significant failures in performance management and audit systems and processes.
- The service was not acting or acting in a timely manner in response to risk or when improvements were needed, including in response to the findings at our last inspection. Many of the concerns we have raised during this inspection, have been raised on previous inspections of this service.
- Mental Health Act review reports have not been entirely acted upon and utilised as part of Mental Health Act monitoring at the service.
- Staff did not always evidence they worked in line with the values of the organisation. Leaders had allowed a negative culture to develop which was impacting on the ability of staff to deliver high quality, kind and compassionate care to patients.

However:

Summary of this inspection

- The hospital manager had made attempts to make changes to the service, and some of these were not entirely embedded at the time of the inspection.
- The managers felt supported by the provider in making decisions to maintain safety, such as in relation to admissions.

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.

Training in the Mental Health Act was mandatory for all staff.

The service had systems in place to ensure the proper implementation and administration of the Mental Health Act and Code of Practice; they carried out monthly audits to ensure continued good practice. The audit outcomes were above 95% on all three wards in May 2019.

All patient records we reviewed contained the relevant paperwork. Care records demonstrated that staff routinely explained to patients their rights under the Mental Health Act. Patients had access to section 17 leave as granted by the ward responsible clinician and doctors clearly recorded this in a file kept on the ward.

We reviewed the provider's Mental Health Act policy, the policy referenced relevant legislation including the Mental Health Code of Practice.

Staff supported patients to access an independent mental health act advocate when they lacked capacity.

However, staff did not always make appropriate referrals for second opinion doctors where required for patients who lacked capacity to consent to their treatment.

Staff had implemented blanket restrictions which were not in line with the Mental Health Act Code of Practice.

Our Mental Health Act reviewers had visited all three wards at the hospital since November 2017. At each visit concerns were raised regarding compliance with the Mental Health Act. Not all of the concerns had been rectified according to the provider's actions plan submitted following these visits.

Mental Capacity Act and Deprivation of Liberty Safeguards

Training in the Mental Capacity Act was mandatory for all staff.

Staff had a basic knowledge of the Act and told us that they would work with doctors and the social work team if capacity assessments and best interest discussions were required.

Compliance with the principles of the Act was a concern. In patient files we reviewed we did not see evidence of staff undertaking and documenting any decision specific capacity assessments or best interest discussions with patients who staff had noted lacked capacity to make specific decisions. When these had been undertaken, the principles and guidance in the related Code of Practice had not been followed.

We reviewed the provider's policy for the Mental Capacity Act. The policy was thorough and explained the principles of the Act and contained relevant guidance.

At the time of the inspection there were no patients on the wards under the authority of a Deprivation of Liberty safeguard.

There was no audit in place for adherence to the Act.

Overview of ratings

Our ratings for this location are:

Detailed findings from this inspection

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

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

Inadequate

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

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

Inadequate

Safe and clean environment

Safety of the ward layout

Cygnet Hospital Wyke had two acute wards for adults of working age; Anderson ward and Branwell ward. Branwell ward had 19 beds, Anderson ward had 18 beds and is for female patients, and Branwell ward is for male patients. Anderson ward opened in September 2018. The hospital also had one psychiatric intensive care unit, Austen ward with 14 beds for male patients.

The ward environment was not safe because staff had not completed and updated risk assessments of the whole environment. Also, environmental risk assessments for each ward were not in place at the time of the inspection.

There was a patient smoking area around the back of the hospital to the rear of the Branwell courtyard. This smoking area was not visible from the wards and was an area in which patients from the acute ward spent time without staff observation. Staff told us that all patients accessing this area were assessed as safe to have unescorted leave or would access it with staff support. This area, including the management and mitigation of risk, was not identified on the environmental risk assessment. Following the inspection, the provider assessed the risk in this patient smoking area and updated the environmental risk assessment. to include this patient smoking area.

Another area which was not included on the risk assessment and had unmitigated risks was the internal stair case from Austen ward to the courtyard, which patients had to use to access the courtyard. An incident had taken place where a patient was restrained in the courtyard and taken back to the ward using these stairs in restraint. We shared our concerns about this during our previous inspection and the provider had not taken steps to mitigate the risk.

However, since the last inspection the provider had put a security checklist in place on each ward. This was undertaken by staff at the start of the morning and evening shift, and included checks for keys, staff alarms, the security of equipment, that doors and windows were in good working order, and the temperatures of fridges and clinic rooms.

Staff could not clearly see all areas of the wards. Austen and Branwell ward had 'L' shaped layouts which did not allow staff a clear line of sight to observe patients. On Anderson ward the ward formed a 'T' shape which also created blind spots where staff could not see patients. However, the provider had installed mirrors to increase lines of sight for staff in these areas. All three staff offices were in central parts of the ward and were glass fronted, which allowed staff to observe patients on corridors and in communal lounges.

Areas of all wards contained ligature points including the communal areas, and patient bedrooms and bathrooms. A ligature point is something that a patient intent on self-harm could use to tie something to in order to strangle themselves.

The ward managers had completed a ligature risk assessment of each ward. These had been updated within

the last six months. The ligature risk assessments we reviewed stated that 'items identified above will not be replaced or removed but can be managed locally through nursing intervention such as therapeutic observations. Staff confirmed that they were allocated to observe patients at intervals throughout the day and night.

However, the ligature risk assessments were incomplete on Branwell and Anderson wards. On Branwell ward the exercise equipment in the patient courtyard was not entered onto the risk assessment. On Anderson ward, the communal patient bathroom which was open access to patients was not on the risk assessment.

Also, whilst each ward had an accessible ligature point map in the staff office which gave a visual guide to staff of ligature points on the ward, one staff member who we spoke with (who had worked at the service for three months could not tell us what the map referred to).

This was a serious concern because the assessment of ligature risks at the hospital was highlighted during previous inspections, there had been one ligature related death on Branwell ward in the last twelve months and on Anderson ward, there were regular incidents of patients self-harming using ligatures. Following the inspection, the provider advised that there had been 24 incidents involving ligatures on Anderson Ward in the three-month period between 1 April 2019 and 30 June 2019; none of these incidents had involved a fixed point.

Following the inspection the provider amended the ligature assessments as required.

All wards complied with the Department of Health guidance on eliminating mixed sex accommodation because they were male or female only wards.

Staff carried call alarms and we saw these working during our inspection. There was a system in place for staff to check their alarms were working at the start of each shift. Call systems were also available in communal areas and patient bedrooms.

Ten of the patients we spoke with said that they felt safe, and that they felt their belongings were safely locked away. However, of the other three patients who were from Austen ward, one patient said they didn't feel safe around certain staff on the ward and the other patients said that they didn't feel safe because lots of people were not following the smoking rules and that they didn't feel safe around other patients; they described the ward as noisy, loud and stressful and said that they struggled to find space for quiet time.

Maintenance, cleanliness and infection control

During the inspection visit we observed that communal ward areas and patient bedrooms were clean with well-maintained furnishings on Anderson and Branwell ward. Patients from these wards agreed that they were clean.

During the inspection Austen ward was clean. However, patients commented that the ward was dirty. One patient said that that the bath was dirty and the toilet was leaking. Another patient said they had reported the ward being unclean to staff who said they would 'do it tomorrow'. We also saw comments about the ward being unclean with litter and soiled towels in the ward's team meeting minutes, with no recorded action taken to address this.

Staff adhered to infection control principles including handwashing. However, on Branwell ward aprons used in clinical procedures were not stored in the clinic room but in the cleaning cupboard on the ward so were not easily accessible.

Seclusion room

Staff had two available options to escort patients to the one seclusion room available on site.

The room met with guidance contained within the Mental Health Act Code of Practice. There were two clear areas for staff to observe patients and a two-way intercom to aid communication between patients and staff. The room contained a clock which was visible to patients, so they could orientate themselves with the time of day, and an en-suite bathroom area. There were no visible ligature points within the room and staff could provide patients with ligature proof clothing should this be required.

The seclusion room had its own dedicated outdoor space.

Clinic room and equipment

Clinic rooms were fully equipped with accessible resuscitation equipment. Equipment was not always clean and well maintained.

Each ward had its own dedicated clinic room and on Anderson and Branwell wards they were clean. However,

the clinic room on Austen ward was dusty, which meant that it had been some time since it was last cleaned. There were no records of cleaning in place for any of the clinic rooms; staff told us that the night shift nurse was responsible for cleaning.

Clinic rooms were fully equipped with the required items for the physical healthcare of patients. Equipment was calibrated by an outside contractor on a yearly basis. However, there was no evidence of the calibration of blood pressure monitors and blood glucose machines on any of the wards; these were not included in the contractors most recent visit. This meant that staff could not be sure they were working correctly.

There was no examination couch present in the clinic room on Branwell ward, staff told us that physical examinations or procedures would be undertaken in patient bedrooms.

Each ward had an emergency grab bag, which contained items to treat patients in a medical emergency. Staff told us that they checked these daily. On Austen ward equipment such as airway tubes had been removed from their sterile packaging. The provider told us that the wards did not stock emergency medications such as adrenaline. However, there was a stock of a antidote (Flumazenil) on Anderson ward which was not held on other wards. Staff told us that this was a mistake and should not be held on site.

Safe staffing

There were enough staff to meet the needs of patients, and low numbers of shifts which were not filled to the required levels. The service used a high number of agency staff.

At the time of inspection, the hospital had several vacancies and a high turnover of staff, reporting 29 staff leavers since December 2018. The hospital had a continuing programme of recruitment.

The total nursing establishment was 30 whole time equivalent nurses and 61 whole time equivalent health care support workers. At the time of inspection there were 19 whole time equivalent nurses in post. A further nine qualified nurses were in 'pre-employment checks' (30%). Exempting the nursing staff in pre-employment checks, there were two vacancies for qualified nurses (7%). There were 55 health care support workers in post, two in pre-employment checks and three vacancies (5%).

On Austen ward, the psychiatric intensive care unit, there were ten whole time equivalent qualified nursing posts, and 19 whole time equivalent health care support worker posts. There were five nurses in post and five in pre-employment checks. There were two vacancies for health care support workers.

On Branwell ward there were ten whole time equivalent qualified nursing posts, and 21 whole time equivalent health care support worker posts. There were six nurses in post, three in pre-employment checks and one vacancy. There was one vacancy for a health care support worker on this ward.

On Anderson ward there were ten whole time equivalent nursing posts and 23 whole time equivalent healthcare support worker posts. There were eight nurses in post, one in pre-employment checks and one vacancy. There were 21 health care support workers in post and two in pre-employment checks.

The hospital used an internal staffing ladder to estimate the number of staff required per shift. The tool based the number of staff required according to the number of patients admitted to the ward. Ward managers were able to enhance staffing levels if the acuity of the patient group required this.

All three wards were staffed throughout the day and night by a minimum of two registered nurses regardless of the number of patients admitted to the ward. The number of support workers increased according to the number of patients admitted up to a maximum of five support workers during the day, and four at night when the ward reached 13 patients on Austen ward, and above 18 patients on Anderson and Branwell wards.

Staffing levels on Austen ward had increased by one healthcare support worker at night when the ward had reached 13 patients admitted. In November 2018 staffing levels for 14 patients were two qualified nurses and five health support workers during the day, and two and three at night. There had been no changes to the staffing levels on Branwell and Anderson ward since our last inspection.

Ward managers were able to enhance staffing via the use of bank and agency staff when required to meet patient need. There was a high use of agency staff in the service. Data provided by the service showed that between December 2018 and May 2019 there were 22062 hours worked by nursing staff and 43240 hours worked by health care

support workers. Bank and agency staff accounted for 37% of the qualified nursing hours and 5% of health care support worker hours (42% total). Bank and agency staff accounted for 45% of total hours worked on Anderson ward, and 41% on Branwell and Austen wards.

The service provided data showing the use of bank staff, contracted agency staff and agency staff across all three wards. Contracted agency staff were qualified nurses who were employed by an agency but who were offered long term contracts at the service. In response to our concerns about the use of agency staff and their knowledge of the service and patient group, the provider had entered into these contracts and the contracted agency staff had undertaken Cygnet's mandatory training and induction and completed clinical supervision and attended team meetings as permanently employed staff would. Patients did not raise any concerns about the use of agency staff when we spoke with them. However one patient commented that they had seen one staff member sleeping during a night shift; they were not able to tell us who or when this was.

The data provided allowed us to work out average uses of bank and agency staff for the last six months across all three wards:

Anderson:

- 0% use of bank staff to cover registered nursing hours
- 15% use of agency staff to cover registered nursing hours
- 23% use of contracted agency staff to cover registered nursing hours
- 1% use of bank staff to cover health care support worker hours
- 5% use of agency staff to cover health care support worker hours

Austen

- 0% use of bank staff to cover registered nursing hours
- 9% use of agency staff to cover registered nursing hours
- 25% use of contracted agency staff to cover registered nursing hours
- 1% use of bank staff to cover health care support worker hours
- 5% use of agency staff to cover health care support worker hours

Branwell

- 8% use of bank staff to cover registered nursing hours
- 13% use of agency staff to cover registered nursing hours
- 18% use of contracted agency staff to cover registered nursing hours
- 1% use of bank staff to cover health care support worker hours
- 2% use of agency staff to cover health care support worker hours

The provider told us that staffing was not a risk to the service and stated that 1.5% of shifts were not filled to establishment levels in March, 1.9% in April and 1.5% in May.

Because shifts were usually filled to the required levels, there were enough staff to carry out physical interventions.

We spoke with 24 staff during the inspection, three of these staff commented that there were not enough staff on shift on support patients, including taking patients out for leave and activities. All these staff were from Branwell ward.

All the patients apart from three that we spoke with said there were enough staff on the wards to meet their needs, spend one to one time with them and respond in an emergency. One patient told us that staff seemed overstretched, another said they spent a lot of time doing too much paperwork, one patient told us that they felt patients could go unnoticed for long periods of time. Two of these patients were from Branwell ward, and one from Austen ward.

Data provided by the service showed that sickness rates has steadily decreased month on month from 11% in December 2018 to 2% in May 2019. The average sickness rate over this period was 5%.

Medical staff

There was not adequate out of hours medical cover to attend the ward within 30 minutes in a psychiatric emergency, or within one hour of a new admission to Austen ward and two hours of a new admission to Branwell ward.

Each ward had a dedicated team of medical staff. On Branwell and Austen wards there was a 0.7 (whole time equivalent) consultant psychiatrist and a full-time

speciality doctor. On Anderson ward there was a full-time consultant and full-time speciality doctor in post. This meant that there was adequate support to the wards during daytime hours.

Out of hours the hospital was part of an on-call rota in the local area. Doctors on this on-call rota could not always attend the site in a medical or psychiatric emergency or within one hour of admission of each patient as per the provider's own policy. Although there had been no incidents of psychiatric emergency for us to assess at the time of the inspection, we found that staff had logged eight incidents between 9 April 2019 and 2 June 2019, where the Doctor had not attend the service in line with the provider's own policy.

The provider was monitoring this as we had raised this as a concern at our last inspection of the service. During the inspection, we observed a handover meeting when a staff member reported that the on-call doctor had not answered the phone when they sought advice regarding a patient with chest pain. Staff escalated this to emergency services. One patient on Austen ward told us that they did not see the doctor until the fourth day of their admission.

The provider also employed a registered general nurse to support patients with their physical health needs.

Mandatory training

Not all staff had received the required mandatory training in immediate life support. This training is important when restrictive interventions are used with patients such as restraint and rapid tranquilisation, and when caring for patients prescribed anti-psychotic medications and patients who regularly harm themselves. This course should be completed by all clinical staff members; 50% of staff had completed this course on both Anderson and Branwell wards, and all staff on Austen ward had been trained.

Cygnet Health Care Ltd had a training compliance target of 95%. The service provided compliance rates for 19 mandatory and statutory training courses. Compliance rates were below the provider target in 16 of the 19 courses and the overall compliance rate was 88%. Courses below the provider's own compliance target were:

- 93%: Dealing with concerns at work
- 93%: Infection control
- 93%: Introduction to monitoring physical health
- 92%: Equality and diversity
- 92%: Food safety at Cygnet
- 92%: Mental Health Act awareness
- 92%: Mental Capacity Act/Deprivation of Liberty Safeguards in principle and in practise
- 91%: Information governance awareness
- 91%: Protecting our health and safety
- 89%: Basic life support and automated external defibrillation
- 89%: Prevention and management of violence and aggression - personal safety
- 88%: Safeguarding individuals at risk
- 87%: Prevention and management of violence and aggression - initial teamwork / promoting safe and therapeutic services
- 87%: Responding to emergencies
- 67%: Immediate life support and automated external defibrillation
- 47%: Safeguarding level 3 – adults and children at risk

The service advised that the level three safeguarding training was a new course eligible to qualified staff that was currently being rolled out provider wide; this accounted for the lower rate of compliance at the time of the inspection.

Courses above the compliance target were:

- 100%: Pharmacy eLearning for nurses and doctors
- 100%: Fire warden/marshal training
- 100%: Mental Health Act / Mental Capacity Act / Deprivation of Liberty Safeguards

Assessing and managing risk to patients and staff

Assessment of patient risk

Staff did not assess and manage risks to patients and themselves well. We had identified this as a serious concern at our previous inspections of the service.

Staff used a recognised risk assessment tool; the 'short term assessment of risk and treatability'. We looked at the care records of nine patients; eight had issues with the risk assessment documentation. Not all patients had a complete and accurate risk assessment within their care records and three of these records did not have initial admission risk assessments present.

We saw evidence of patient risk in admission and assessment information, incident recordings, and multi-disciplinary meetings which were not identified and managed via the patient's risk assessment. One patient had

expressed risks which included throwing hot drinks, calling the police and extreme distress, none of which were entered their risk assessment. Another patient had tied a ligature and engaged in high risk behaviour whilst on leave from the ward and neither of these incidents was present in their risk assessment.

Immediately following the inspection, we shared our concerns with the hospital manager who informed us that staff undertook an immediate review of the risks we identified in relation to these patients.

Management of patient risk

As staff had failed to complete thorough risk assessments, this meant that they were unaware of specific risk issues and could not identify, manage and respond to changing risks posed to, or by, patients appropriately.

The observation and engagement of patients had not improved since the time of our last inspection. Staff did not follow policy and procedure for the use of observation to minimise the risk from potential ligature points. Patient observation levels were dependent on the risk levels of patients when they were admitted.

The provider had developed a new observation process and procedure trained staff in this procedure. Managers undertook audits of closed-circuit television to check that this procedure was appropriately applied, and staff continued to report incidents of missed observations via the internal reporting system to ensure lessons were learned from each incident. However, this had not made an impact on the number of errors.

There had been two reported incidents of missed observations for a period of hours in March 2019 on Branwell ward. We were seriously concerned to be notified that on 6 June 2019 and 8 June 2019 staff allocated to conduct one to one observation with a high-risk patient on Austen ward were found to be sleeping whilst on shift. In one of these incidents the patient had harmed themselves whilst not being observed.

There were blanket restrictions in place on all wards which were not individually risk assessed. The Mental Health Act Code of Practice defines blanket restrictions as "rules or policies that restrict a patient's liberty and other rights, which are routinely applied to all patients, or to classes of patients, or within a service, without individual risk assessments to justify their application." Where blanket restrictions are identified as necessary and proportionate, there should be a system in place to review them regularly, with an overall aim to reduce restrictive practice.

Each ward also had a list of contraband items which included alcohol, drugs, weapons, cling film, chewing gum, foil, clothes hangers and energy drinks. Whilst some of these were usual for this type of service, this list was not audited or reviewed by the service.

Austen ward had a blanket restrictions audit in place which was last reviewed on 29 March 2019. There were several restrictions in place and we saw evidence that staff had discussed some of these with patients and made changes according to feedback. However, there were some which were not in line with the Mental Health Act and associated Code of Practice. We were seriously concerned to find that the blanket restrictions log stated, 'mail is opened in front of staff to ensure no contraband is concealed'. Section 134 of the Mental Health Act (1983) states that the withholding of mail is only allowed in high security psychiatric hospitals, and only then by agreement of the hospital managers.' Patients' privacy and dignity was compromised by the enforcement of this blanket procedure.

The log also stated that rigid visiting hours were not in place, however the hospital had a policy which stated that visits should be pre-booked 24 hours in advance. We observed staff discussing the enforcement of this rule with a family who visited unannounced.

The log also stated that there was a blanket restriction to prevent patients from ordering a takeaway more than once per week and with an upper value limit of £15. This had been discussed at the ward community meeting in March 2019 and a decision to increase this to twice per week was discussed with patients. The reason for this restriction was noted as "physical health promotion, risk of contraband items being brought onto the ward, prevention of more vulnerable patients being targeted by those who do not have access to money."

We reviewed an incident which had occurred on 2 June 2019 where a patient had ordered a takeaway outside the agreed nights in the 'takeaway policy'. Staff had, on delivery of the takeaway attempted to reiterate the takeaway policy with the patient. Due to their frustration, the patient became agitated and distressed, which resulted in them being restrained and secluded.

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

Inadequate

The blanket restriction audit for Anderson ward was last updated in January 2019. There were several restrictions in place which were not included on the audit. This included locked doors to some rooms including the sensory room and accessible bathroom, use of plastic cups, the counting of cutlery, and all hair straighteners being kept in the salon. Issues affecting other wards such as the visiting policy were also not included on the audit.

The blanket restriction audit for Branwell ward was last updated in December 2018 and was of poor quality. It only contained four items; the use of metal cutlery, portion size, wifi and e-cigarettes. The actions were unclear, for example they said 'discuss with clinical manager' with no other action or outcome. There were several blanket restrictions missing from the audit, including locked doors, the use of plastic cups, counting cutlery, the visiting policy, and the contraband list.

Patients commented on some blanket restrictions; one patient from Austen ward told us that they were surprised at how secure the ward was. Other patients commented on the use of plastic cups and cutlery. A member of staff said that they wouldn't want their relative to be cared for at the service because of all the rules.

Signage at the hospital stated that it was 'smoke free'. However, patients admitted to Branwell and Anderson ward were able to access an outdoor smoking area unescorted providing they had been assessed as having 'grounds leave'. Patients could also be escorted to this area with staff. Staff did offer smoking cessation advice, including offering patient's electronic cigarettes.

Staff followed the provider's search policy. They conducted searches on admission with patients' permission to support the removal of any unsafe items and medication. Searches were then only carried out when an individual risk was identified.

Informal patients could leave the wards at will. Staff understood this and posters explaining this right were visible to patients.

Use of restrictive interventions

The service provided data on the use of restrictive interventions from December 2018 to May 2019. The data showed there had been a slight further decrease in the use of restrictive interventions since the six-month period reported on the previous inspection.

Between December 2018 and May 2019 there were 250 uses of restraint compared to 277 uses of restraint between May 2018 and October 2018. Anderson and Austen wards accounted for 76% of the incidents of restraint with 93 incidents on each ward during the reporting period.

Of the 250 incidents of restraint 42 of these had been undertaken with patients in the prone (chest down position). Of the numbers of prone restraint, 24 of these had taken place on Austen ward, 14 on Anderson, and four on Branwell ward.

At our previous inspections of this service, we were concerned about the use of prone restraint because staff used prone restraint in most rapid tranquilisation episodes. National Institute for Health and Care Excellence guidance (NG10) recommends avoiding prone restraint, and only using it for the shortest time possible. The Mental Health Act Code of Practice states that "unless there are cogent reasons for doing so, there must be no planned or intentional restraint of a person in a prone position". This is because there is an increased risk of patient asphyxiation when this method is used.

In three of the eight records of rapid tranquilisation we reviewed three had taken place in the prone position, and one had no recording of the technique used. All three of these incidents took place on Anderson ward and there was no evidence recorded of why prone restraint was used rather than other methods. On Branwell ward, all rapid tranquilisation had been administered in standing or side positions to enhance safety. The provider told us in February 2018 that this was a training issue but had not fully addressed the concern by the time of this inspection.

There were 39 uses of seclusion compared to 47 uses of seclusion in the previous reporting period. Austen ward accounted for 84% of the total incidents of seclusion with 31 incidents on this ward. There were six incidents of the use of seclusion on Branwell ward (13% of the total) and one incident on Anderson ward (3%).

The number of uses of intramuscular rapid tranquilisation remained the same with 44 uses in both reporting periods. Anderson ward accounted for 54% of the total incidents of the use of intramuscular rapid tranquilisation, with 24 incidents on this ward. There were 14 incidents on Austen ward (32%) and six on Branwell ward (14%)

We reviewed the recording of the use of rapid tranquilisation with eight patients between 15 April 2019

and 31 May 2019. Recording was poor quality and not in line with national guidance. The provider's policy on monitoring of post rapid tranquilisation stated that staff should follow national guidance:

"National Institute for Health and Care Excellence guidance (10) recommends that observations should be monitored at least every hour until there are no further concerns about the service user's physical health status. Monitoring should be done every 15 minutes if the British national formulary maximum dose has been exceeded or if the service user appears to be asleep or sedated, has taken illicit substances or alcohol, has pre-existing physical health problems or has experienced any harm because of the restrictive intervention. NB. Any deviations from this guidance are to be recorded in the service user record detailing the rationale for this and the alternative interventions recommended to ensure service user safety."

Staff were confused about this guidance as four of the recordings stated that observations were hourly, three stated every fifteen minutes and in one record this was not recorded. This meant that there was an inconsistent approach from staff because they did not record their decision as to why hourly or fifteen-minute observations had been undertaken. Two of these records did not follow the hourly or fifteen-minute observation guidance and observations were undertaken at random intervals. One record had no recorded observations or status of sedation. In three records the guidance was not followed because the observations stopped after the patient was noted to be either asleep or sedated.

Staff had not followed guidance when a patient was given intra-muscular medication which had a long-term effect. The provider's own policy stated:

"Post-dose monitoring for Clopixol-Acuphase is very different; due to the length of action and potential side effects, follow up should last longer and clinical observations should be carried out on a regular basis for 72 hours". This patient's clinical observations were stopped after 26 hours of administration. The last physical health observations were taken after 22 hours. Observations had stopped when the service user was asleep.

The majority of staff told us that restraint was used in line with the Mental Health Act Code of Practice, as a last resort and was proportionate to the risk presented. Patients agreed with this view and told us that they not been restrained unnecessarily or seen inappropriate episodes of restraint. The restraint records we reviewed demonstrated that this was the case.

However, we reviewed the restraint records of six restraint episodes with patients which had occurred between 20 May 2019 and 2 June 2019. We had some concerns about staff recording in relation to restraint; three of six episodes did not note whether a patient debrief took place following the incident, and three of six episodes did not note whether physical observations were undertaken following restraint.

Also, one staff member and one patient told us that they felt restraint was sometimes used when it was unnecessary to so, such as for the administration of non-essential medications. Another patient had contacted an advocate to raise concerns about injuries being caused in restraint which was being investigated by the service at the time of the inspection. We reviewed an incident which occurred on Austen ward on 9 April 2019 where a patient had been restrained by staff; the restraint was undertaken because the patient was making 'superficial cuts to their forearms with a snapped plastic spoon'. There was not a rationale recorded as to why restraint was a proportionate response to this risk.

We reviewed the seclusion records of three patients which had occurred between 21 May 2019 and 2 June 2019. All three episodes of seclusion appeared to be proportionate to the risk presented by the patient at the time. None of the episodes were managed in line with guidance in the Mental Health Act Code of Practice. In one record, the doctor did not attend until two hours after the commencement of seclusion. The Code of Practice states "the first medical review should [attend] within one hour of the commencement of seclusion".

In two records, there was not a medical review every four hours. The Code of Practice states "continuing four hourly medical reviews of secluded patients until the first (internal multi-disciplinary team) has taken place".

In all three records there was no recording of whether the patient's family member or advocate had been informed of the seclusion.

The Code of Practice states that there should be an internal multi-disciplinary team as soon as is practicable after seclusion begins and an independent multi-disciplinary team after eight hours of consecutive or 12 hours of

intermittent seclusion. Two of the three seclusion episodes lasted nine hours or more, there was no independent multi-disciplinary team, and the multi-disciplinary team which was noted was not a full multi-disciplinary team because it consisted of a health care support worker and one doctor. The third patient's seclusion episode lasted six and a half hours and there was no multi-disciplinary team review.

We were also concerned that one patient was noted to be calm on waking at 4.30am and not released from seclusion until 9:50 am, plus there was no recording of who terminated the seclusion.

Safeguarding

Staff were trained in safeguarding, and an enhanced safeguarding course was being rolled out to qualified staff at the time of the inspection. They told us that they knew how to report safeguarding and how to spot the signs of abuse. One patient who had been involved in a safeguarding incident on Anderson ward told us that following the incident she felt supported and protected by staff.

However, we saw evidence that staff did not always act on safeguarding concerns. One patient had reported to staff that they felt at risk from their neighbours and described being bullied. Staff did not report this to the Local Authority safeguarding team until we made them aware of this matter during the inspection. We were concerned because this patient was about to be discharged to another service.

The hospital had a policy in place for children visiting the service and this would take place outside of the wards in communal visiting areas and was risk assessed. There had been one incident in the last six months when an agency worker had allowed a visitor with a child on to the ward without an assessment of risk.

The hospital had an in-house qualified social worker who was able to offer support and advice to staff in relation to safeguarding concerns.

Staff access to essential information

The information required to deliver patient care was available and accessible, but held in different places, which made the system difficult to follow and audit.

Patient records were kept in a mixture of paper and electronic records whilst the service continued to migrate towards and entirely electronic system. Patient daily notes were on the electronic system, risk assessments and care plans were printed in paper care files and records of incidents, seclusion, restraint and rapid tranquilisation were kept in paper booklets on each ward. This meant it was difficult to track patient's care journey.

We saw the impact of this during the inspection, because we could not locate three of nine patient risk assessments in their ongoing care file. The provider told us that these were present but located in different places.

The provider had some improvements since our last inspection by ensuring that all contracted agency staff and the senior nurse on site had access to the service's electronic system.

Medicines management

We reviewed the medication administration records of all patients.

Staff followed good practice in the prescription, storage and administration of medication. None of the medication charts we reviewed had omissions. We observed during handover meetings that incoming staff checked medication administration charts for the previous shift to allow early identification of errors or omissions. The service had weekly pharmacy audits undertaken by a contracted pharmacy provider. The pharmacist provided reports on Mental Health Act compliance, prescription charts and administration errors. The last audit was undertaken in June 2019; the most common error was Mental Health Act compliance with a 4.5% error rate.

However, we reviewed all incidents occurring at the hospital between 1 March 2019 and 30 April 2019. There had been 10 medication error incidents during this time. Five of these had occurred on Branwell ward, two on Austen ward and one on Anderson ward. Two of these incidents were concerning:

- one patient on Austen ward had medication omitted for five days and staff had not picked up this error
- during a medication audit on Branwell ward by an outside pharmacy, a box of controlled drugs and drugs liable for misuse were found, which were from a ward at the service which closed in August 2018.

Staff did not regularly review the effects on patients' physical health, in line with national guidance when they were prescribed high dose anti-psychotic medication.

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

Inadequate

Six of fourteen patients on Austen ward and three of 17 patients on Anderson ward had been prescribed anti-psychotic medication, at 100% of the British National Formulary limit. None of these patients had high dose monitoring in place. The provider's policy followed royal college of psychiatry guidelines and stated that staff should only conduct this type of monitoring with patients who exceeded the upper limit. Staff told us that this was why monitoring was not done with these patients. However, three patients on Anderson ward exceeded the upper limit when 'as required' medication was given, and this was noted on their medication charts. We could not locate the correct monitoring forms at the time of the inspection. We spoke with a doctor who told us that this would not be done for a one-off medication, only if the medication was given regularly.

Staff did review the physical healthcare needs of patients prescribed anti-psychotic medications via electrocardiograms and by ensuring the correct blood testing was completed for patient's taking high risk medications. Patients told us that staff regularly carried out observations and tests on their physical health. We spoke with patients with long term physical health conditions who felt that these needs were being met.

Track record on safety

The service did not have a good track record on safety. Between 20 May 2018 and 30 October 2018 there had been seven serious incidents at the hospital which included the deaths of two patients. Both patient deaths are being investigated by the coroner and the Care Quality Commission are considering criminal enforcement action in relation to one serious incident which involved a patient falling from the hospital roof.

As of 20 May 2019, there had been a further six serious incidents occur at the service. Two related to information governance breaches, one related to a needlestick injury to staff, and one related to a patient having an amputation to their finger following an infection developing after an incident on Austen ward. Following the inspection, the provider confirmed that the serious incidents relating to information governance and needlestick injuries were reported and downgraded from serious incidents.

In addition, there had been one allegation of harm during restraint, and one incident of two patients becoming involved in a sexual relationship on site. These were being investigated at the time of the inspection and we were unsure if they had been categorised as serious incidents.

The service was also involved in several post discharge death reviews at the request of the coroner.

Reporting incidents and learning from when things go wrong

There was a system in place for staff to report incidents. Staff knew how to use the system and how to report incidents. Following an incident staff completed initial 24 and 72-hour reports. These were reviewed by the risk manager who decided whether a serious incident review was required in conjunction with the corporate patient safety committee.

Between 1 March 2019 and 30 April 2019 there were 461 incidents at the service, 150 of these incidents related to violent incidents of a patient on another patient / alleged or attempted abuse. This equated to 33% of all incidents. Incident numbers were significantly higher in March and the most incidents occurred on Anderson ward. This had reduced by April 2019.

Staff told us that they had opportunities to learn about and from incidents in handovers, supervision and team meetings. The service also had a lessons learned log. We reviewed the log from April, which discussed incidents from March 2019. It contained themes from incidents, serious incidents, national learning, and contained recommendations. We could see that changes had been made in response to incidents for example the environmental security checks had been enhanced following an incident of a slate falling from the roof.

The service had made improvements to the way in which incidents were reported and reviewed. The hospital manager had developed a 'situation report' meeting which took place each morning at the hospital. The meeting involved a representative from each ward and all incidents were discussed including actions taken, any changes required and who these should be reported too. The Care Quality Commission have seen a significant improvement in the notification of incidents to us since our inspection in November 2018.

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

Inadequate

The service had held a serious incident learning event to follow up with staff on the learning and actions following on from a spate of serious incidents occurring in 2018.

The Duty of Candour regulation explains the need for providers to act in an open and transparent way with people who use services. It sets out specific requirements that providers must follow when things go wrong with care and treatment. The provider had a Duty of Candour policy in place and staff understood this and could describe the meaning of the policy. The service had applied this policy appropriately to one incident in March 2019.

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

(for example, treatment is effective)

Inadequate

Assessment of needs and planning of care

Staff completed a mental health assessment of the patient after admission. However, this was not always in a timely manner.

We reviewed the care records of nine patients admitted to these wards at the time of the inspection. Of the nine care records we reviewed, six assessments had been completed within 24 hours of admission, one within 48 hours of admission one was completed six weeks after admission and one a month after admission. Staff told us that these care plans were held in the patient's decanted file. All but one care plan had been updated regularly by staff, this care plan was last updated on 30 March 2019.

Care plans were individual, based on the needs of each patient. Most patients had care plans in relation to sections 'my mental health' and 'my safety planning'. Where patients had additional needs such as long-term health conditions, or substance misuse, patients also had care plans in place to meet those needs.

All the care plans we reviewed contained the thoughts and views of the patients where they had wished to participate in the process. On Anderson ward, one patient told us that they were supported to re-write their own care plan when they had disagreed with some of the content. Patients knew about their care plans and most were able to tell us that they had seen a copy.

However, care plans were not holistic and focussed on solely the treatment to be delivered rather than all issues impacting on the patient. We also saw the use of clinical language in patients' care plans, particularly when goals for recovery were being identified. One patient had a goal noted to 'stop hearing voices' and another care plan said that a patient would know they had recovered when they were 'discharged to their local area.'

We were concerned that care plans did not contain management plans for all the risks identified in the risk assessment process. For example, one patient had a significantly violent history and did not have a care plan which addressed the management of their challenging behaviour.

Staff did not always assess patients' physical health needs in a timely manner after admission.

The service had an admission policy which described that on admission to the service, patients had a medical assessment with the admitting doctor. They then had a baseline physical health screening assessment with a doctor and a nurse and following this (within seven days) a physical health intervention plan. Three patient records we reviewed did not have the correct physical health observations recorded on admission. One patient had no physical health assessment, one refused these on admission and this was re-attempted seven days later which the patient again declined and there was no further evidence of staff trying again, and one patient had no recorded baseline observations.

Staff used the modified early warning scores system weekly to record patients' physical health observations. Where patients had long term physical health conditions, they had a specific care plan to support these needs. Staff received support in meeting these needs from the registered general nurse based on site. The nurse was responsible for liaising with other external professionals as required. Patients also had regular electrocardiograms, blood tests and drug screening where this was required.

Best practice in treatment and care

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

Inadequate

The service did not provide a full range of treatment and interventions suitable for the patient group in line with national guidance.

Patients had limited access to psychological therapies, and occupational therapy. There was a 0.75 (whole time equivalent) psychologist working across all three wards. This reduced their ability to offer significant input and one to one therapy with patients. The service also had one occupational therapist and three occupational therapy assistants to deliver therapy to the whole hospital.

The patient care plans we reviewed did not contain positive behaviour support frameworks and planning. The provider told us that they used a method of 'my safety planning' with patients which was a model of positive behaviour support. However, this was not present in the care plans we reviewed. Care plans did not discuss patients' preferences, sensory needs or reasons for behaviours that challenge, and there was no evidence that staff had discussed them with patients and their families. The psychologist was unable to provide psychological formulation, and the care plans we reviewed contained no evidence of psychological and occupational therapy input or planning.

Policy and procedures used by staff referenced current guidance such as the Mental Health Act Code of Practice and National Institute for Health and Care Excellence guidance on short term management of violence and aggression (2015). The service managed medication with a range of guidance.

Staff used recognised rating scales to assess and respond to patients' physical health including the modified early warning score system. The service also monitored patients' nutrition and hydration. The service used a variety of other measurement and outcome tools to support treatment and care including the Health of the Nation Outcome Scale.

The service undertook a variety of audits and had employed a quality compliance lead to undertake these and improve practice where improvements were required. The hospital had an annual clinical audit programme which included the following;

- weekly medication audit
- monthly care records and physical health audit
- monthly closed-circuit television audit
- monthly health and safety audit
- monthly restraint audit
- monthly engagement/observation audit
- monthly seclusion audit
- monthly Mental Health Act sudit
- quarterly search audit
- quarterly infection control audit
- six monthly blanket rules audit
- six monthly deprivation of liberty safeguards audit
- annual information governance audit
- annual ligature audit
- annual safeguarding audit
- annual suicide audit
- annual patient survey report
- annual carer survey report

The management team met monthly for a governance meeting where outcomes of audits conducted each month were discussed and reviewed.

Nursing staff were responsible for a range of ward level clinical audits. These included clinic room checks, medication record checks and checks of emergency grab bags and the safety of the ward environment. These audits were not always effective because we identified several errors in these areas which had not been identified by ward staff.

Skilled staff to deliver care

Patients had access to a limited resource of specialists required to meet the needs of patients.

This included psychiatrists, speciality doctors, nursing staff, health care support workers, activities co-ordinators, a social worker, registered general nurse, substance issue practitioner, occupational therapy staff and psychology staff.

We spoke with 24 staff during the inspection; they had the required levels of skills and experience via the provider's mandatory training, induction and supervision programmes to meet the needs of patients.

Staff across all wards had taken part in additional training to enhance their skills, this included; dialectical behavioural therapy, autism training, boundary training, autism awareness, wound care and baseline observations, documentation, engagement and observation and recovery star.

Staff told us that there were regular ward level team meetings where they could discuss ward performance and learn from themes emerging from incidents and complaints. There was a standardised agenda for each

meeting which included; feedback and a copy of the minutes from the senior management meetings, health and safety feedback, staff representative feedback, serious incidents and shared learning, the overarching local action plan, safeguarding, incidents, reducing restrictive practice, security, infection control, audits and compliance, physical health, training and supervision.

We reviewed the team meeting minutes for each ward and found that they were poorly attended by staff and varied in quality between wards. The provider told us that low numbers of staff attendance was due to the shift patterns of staff, but that meeting minutes were shared with all staff.

Austen ward monthly team meetings had low attendance. There were three meetings between 22 February 2019 and 26 April 2019, which had been attended by fourteen staff in total. The team had discussed relevant matters including audits, incidents and serious incidents. They had also discussed ways to improve ward practices.

Anderson ward had similarly low numbers of staff attending with a total of 18 attendees between three meetings in January, February and April 2019. The ward had also held a nursing team meeting in April 2019. The Anderson team meeting minutes were high quality, staff discussed improvements to practice, findings from ward level audits and patient feedback.

The most recent team meeting on Branwell ward was on 31 May 2019. There were low numbers of staff attending meetings in December 2018, January, February and March 2019 with 23 staff attending all four meetings. We noted that much of the agenda on Branwell ward was incomplete, staff had not discussed reducing restrictive practice, and local or national serious incidents in any of the meeting minutes we reviewed.

Staff told us that they had opportunities to debrief following incidents. Austen ward had introduced an end of the day reflection session. We did not observe this take place during the inspection, the provider told us that this takes place in the nursing office not in the handover room.

Staff were appraised and supervised. Data provided by the service showed 100% compliance with clinical supervision and appraisal on Anderson and Branwell wards from December 2018 to May 2019. Compliance with clinical supervision was 93% on Austen ward.

Multi-disciplinary and inter-agency team work

Staff held regular and effective weekly multi-disciplinary meetings.

Patients, and patient care coordinators from the community were invited to input into these meetings. Carers told us that they had not been invited to these meetings.

Meetings were detailed, and staff discussed medication, incidents and discharge and made plans for treatment. However, information discussed in these meetings was not always transcribed into patient care and treatment plans.

During the inspection we observed two handover meetings. Staff shared relevant information regarding areas such as risk, incidents, physical health and medication for each admitted patient.

The service had started to develop effective working relationships with the local authority. They were meeting with them monthly to discuss incidents and safeguarding concerns. This had not taken place for several months due to staffing issues within the local authority, although the provider stated that a meeting had taken place in May 2019.

Adherence to the MHA and the MHA Code of Practice

Staff did not always understand their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice and discharge these well.

However, we found that one patient was being treated under section 62 of the Mental Health Act whilst awaiting a visit from a second opinion doctor since 20 March 2019. The service had not made this request and at the time of the inspection, this meant that the patient remained under this section for emergency treatment with no review from an external person. Following the inspection, the provider confirmed that this was an error and this patient was now being treated informally and their section had been rescinded.

Our Mental Health Act reviewers had visited all three wards at the hospital since November 2017. At each visit concerns were raised regarding compliance with the Mental Health Act. Not all the concerns had been rectified according to the provider's actions plan submitted following these visits.

- A visit to Austen ward in February 2019 raised several concerns including; patients being unclear on their

rights, access to wifi, blanket restrictions, one patient did not have a care plan in place four days after admission, one patient did not have physical health monitoring in place. The provider had submitted an action plan to address these concerns. Some of these concerns were still an issue at the time of the inspection.

- A visit to Anderson ward was undertaken in October 2018. The visit raised concerns about a lack of discharge planning, patients not being aware of their rights, patients being unable to close their observation panels, and patients not being able to choose whether male staff completed their observations at night. The provider had submitted an action plan to address these concerns. Some of these concerns were still an issue at the time of the inspection.
- A visit to Branwell ward was undertaken in November 2017. Concerns were noted in relation to the incorrect use of section 62 for emergency treatment and the 'you said, we did' board being out of date. On this ward, these concerns had been rectified at the time of the inspection.

Managers made sure that staff could explain patients' rights to them. At the time of the inspection 92% of staff had received training in relation to the Mental Health Act.

Staff told us that if they required any additional support with the application of the Act, they would contact the Mental Health Act office or more senior colleagues.

Staff had access to the provider's policy regarding the Mental Health Act and associated Code of Practice which was up date and contained the relevant information.

During the inspection we saw information for patients was clearly displayed, such as their right to leave the ward if they were informal patients, how to access an advocate, how to contact the CQC, and how to make a complaint.

In all records we reviewed staff had explained patients their rights under the Mental Health Act and recorded this clearly.

All patients had their capacity to consent to their treatment assessed on admission. We found that these assessments were poor quality because the capacity assessment section on the forms was empty and the doctors had not completed a narrative explanation for their decision-making regarding capacity to consent to treatment.

Consultant psychiatrists prescribed section 17 leave to patients as required, and patients knew what leave they were entitled to.

The service undertook monthly Mental Health Act Audits. The last audit had taken place in May 2019. Anderson ward was 95% compliant, Branwell and Austen wards were 100% compliant. The error identified on Anderson ward was in relation to consent to treatment certificate not being present in the patient's file.

Good practice in applying the MCA

Staff did not always support patients to make decisions on their care for themselves. They did not understand the provider's policy on the Mental Capacity Act 2005 and did not always assess and recorded capacity clearly for patients who might have impaired mental capacity.

At the time of the inspection, the provider stated that 92% of staff had received training in the Mental Capacity Act. The provider had a Mental Capacity Act policy which was up to date and accessible to staff.

Staff told us that they had a basic understanding of the Act. However, we saw examples where staff had not undertaken the required actions to assess the capacity of patients. In one example, staff felt a capacity assessment was required but conducted this without the patient being present. Another patient was refusing medication and treatment for a physical health condition and staff did not assess their capacity to refuse this treatment. This demonstrated a lack of understanding about staff's requirements and responsibilities under the Act.

The service did not undertake audits in relation to the Act.

The service had not made any applications for Deprivation of Liberty safeguards.

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

Inadequate

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

Inadequate

Kindness, privacy, dignity, respect, compassion and support

Staff attitudes and behaviours when interacting with and discussing patients was not always kind, respectful and dignified.

We observed a staff member behave in an abrupt and antagonistic manner towards patients on Branwell ward. They also expressed inappropriate body language such as pointing. This staff member also shared personal details about patients in this open forum such as their agreed leave status. Other staff were present and did not intervene or challenge this behaviour.

We observed a handover meeting on Austen ward where we heard staff laugh when a patient's name was mentioned. At the same handover a senior staff member waited until the end of a meeting to ask an agency staff member who they were. Staff at this meeting spoke in a negative tone about patients' families arriving for 'unannounced visits' and raising concerns about missing visits. Staff also referred to a patient using their manners as 'surprising'.

We also found evidence of unnecessary restrictive practices which had caused distress to patients. One patient had ordered a takeaway and which staff had not collect straight away because this was not ordered within the 'takeaway policy' and staff reiterated this rule before agreeing to collect it. The patient became irate and was restrained and secluded. One staff member also told us of their concerns that a patient was restrained for the application of a foot cream on Anderson ward. We observed during a handover meeting staff discussing that a patient bedroom on Austen ward was to remain 'locked off' to prevent them accessing their ensuite bedroom. There was no explanation of why this meant the patient could not access their whole bedroom. We reviewed an incident report which stated that a patient on Austen ward on 10 April 2019 was told that they would 'eat after their peers as they had been verbally threatening and abusive throughout the day towards peers and staff'. The patient became irate about this decision and was restrained and secluded by staff because of their behaviour. This recording of this incident made it appear that this rule was enforced to 'punish' the patient for their behaviour rather than to maintain safety or for therapeutic reasons.

We spoke with 13 patients during the inspection, four patients raised concerns about their care. Their comments included that they had no access to clean clothing, staff did not listen, they did not know what an advocate was, staff were 'power hungry', staff were arrogant and pushed the need for patients to say 'please and thank you' for power and control. One patient told us that following an incident a male staff member requested to complete physical health checks. They told us that they requested a female staff member due to their anxieties about this and this request was refused. Following the inspection, the provider told us that the male staff member remained at the patient's door. Four of the six patients who raised concerns were from Austen ward.

During the inspection we heard concerns from staff about the treatment of patients on Anderson ward. Between 8 October 2018 and 29 May 2019, the Care Quality Commission have received five whistleblowing complaints all of which refer to a poor culture, low morale and concerning staff behaviour.

Immediately after the inspection, the provider acted to address our concerns about patient care. This included independent reviews and visits to the service by staff from external services delivered by the provider and experts by experience.

We spoke with five carers of patients admitted to the service during the inspection. Four carers said that staff were respectful and kind. However, one carer commented on staff being dismissive and that they made a complaint which was not taken seriously.

During the inspection, we observed some staff treat patients with compassion and kindness and respect for privacy and dignity. Patients from Anderson ward were complimentary about the behaviour of staff towards them and described times that they spent one to one time with them supporting them to settle through difficult times.

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

Inadequate

All staff we spoke with during the inspection told us that they would raise concerns about disrespectful behaviour towards patients and had a good understanding of the whistleblowing policy.

Staff maintained patient confidentiality of records by using an electronic system which was password protected to store patient records. Paper records were held in locked staff offices.

Staff directed patients to other services where appropriate.

Patients were supported by advocacy services who visited the wards regularly.

Staff had a good understanding of the individual cultural, spiritual and religious needs of patients. We observed one patient talking with staff on Anderson ward about shopping for Eid and how staff would support a home visit to celebrate the festival.

Involvement in care

Involvement of patients

The service had a variety of initiatives in place to support patients to be involved in their care, and in the running of the service. However, this was not embedded throughout the service.

Patient involvement in care planning was evident in all records we reviewed. However, the language used to formulate recovery goals was clinical and not always written in the words of the patient.

Staff enabled patients to give feedback about the service. Each ward held community meetings to which all patients were invited and asked to offer feedback about any concerns about the ward. We reviewed mutual help and community meeting minutes. These followed a set agenda of items such as; a round of thanks, round of news, round of suggestions, round of requests and offers, food, restrictive practice and activities.

On Branwell ward nine of these fortnightly meetings had taken place between 4 February 2019 and 9 May 2019. We could not find evidence that a meeting had taken place since 9 May 2019. Comments about leave and a lack of activities were the most common points of discussion along with patients requesting more access to sports, and the gym. Patients had complained about boredom and about night staff eating takeaways on days when patients were not allowed.

On Anderson ward, four of these meetings had taken place between 2 January 2019 and 14 May 2019. We could not find evidence that a meeting had taken place since 14 May 2019. On 2 January 2019 one patient had requested that staff do not 'slam the door in our faces on the nurse base'. There was no evidence that this had been followed up or action taken. The minutes also stated that the meeting was not for 'personal comments about staff', it stated that this 'affects their confidence and the care and treatment they can provide'. Patients had also commented on disliking male staff observing them when using the shower or changing.

On Austen ward there had been two meetings between 9 November 2018 and 3 May 2019. Most of the minutes were blank, there were no actions recorded and no follow up from previous meetings. Smoking rules and activities were the main points of discussion. The provider explained that the ward was closed between December 2018 and January 2019 which was the reason for there being no meetings during these months.

Anderson and Branwell wards had a 'you said we did board' to describe the changes made because of patient feedback. The board on Austen ward was empty. The provider told us that this was because the board was recently replaced.

The service had held 'our, say, people's council' meetings in February and March 2019. All patients were invited to these meetings. The meetings discussed actions from previous meetings, and any concerns or compliments from each ward in turn. They also discussed food, maintenance and estates. Repeated concerns from these meetings related to wifi access and activities. We noted that that actions from both meetings were the same with no updates on completion.

Staff allowed patients to give feedback about their care plans and risk assessment.

The most recent patient survey was not due at the time of the inspection.

The wards had an admission process which orientated each new patient to the ward. Patients were given an admission pack to support this. Patients we spoke with told us that they had a good introduction to the ward when they arrived.

Involvement of carers

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

Inadequate

The service enabled carers to give feedback via a family and friends survey. The results had not been collated by the time of the inspection.

During the inspection we spoke with the carers or relatives of five patients. Three out of five carers commented on communication difficulties with the service. None of these three carers had seen their relative's care plan and two said that they had not been invited to meetings or care reviews.

Due to the nature of the service whereby most patients stayed for short periods, the service did not hold carer's meetings or forums.

We did not see evidence of staff undertaking or signposting to carers assessments in the records we reviewed.

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

Requires improvement

Access and discharge

Bed management

The service provided data relating to bed occupancy for each ward between 1 December 2018 and 30 May 2019. The average bed occupancy for Anderson ward was 72%, for Austen ward 46% and Branwell ward 83%. Austen ward was not fully opened to admissions until March 2019 following the enforcement action taken by the CQC and the voluntary action taken by the provider to close this ward to admissions on a temporary basis following the inspection in November 2018.

The highest bed occupancy levels were on Anderson ward which reached 95% in March, April and May 2019. Branwell ward reached an average of 98% between March and May 2019.

The service accepted admissions from a range of NHS trusts and clinical commissioning groups 24 hours per day. At the time of the inspection there were more than 15 different responsible authorities commissioning beds from the service. The service admitted patients from outside of their local area, or within the local area dependent on the referrals they received.

The service had a national Cygnet Health Care referral line. Staff were expected to respond to requests for admission to all three wards within a two-hour target. The hospital used a risk scoring system to assess a patient's risk level and decide whether the ward could meet that person's needs. In response to concerns at previous inspections, the hospital had made some improvements to their admission processes. This included the addition of a 'senior nurse on site' role. This person would oversee all admissions to the service to ensure any new admissions were manageable for the service. The hospital manager told us that the provider was supportive if staff felt that admissions could not be managed due to the complexity or acuity of current patients.

The service had one readmission to the service within 28 days which was on Austen ward in March 2019.

We were concerned about how long patients waited to be assessed by a doctor on arrival at the service. The provider had a policy that this took place within one hour on Austen ward and two hours on the acute wards. In March and April 2019, since the service was fully opened to admissions, there had been 12 admissions where this target was not achieved. One patient arrived at Branwell ward at 10:45 in the morning but was not formally assessed and admitted by a doctor until 22:15 at night.

Patients were not admitted to beds belonging to other patients who were on leave from the ward. Male patients could move between the acute wards and the psychiatric intensive care unit during their admission. This was done in a planned way with multi-disciplinary team involvement.

Discharges and transfers of care

The service did not monitor data in relation to delayed discharges of care.

Between 1 December 2019 and 30 May 2019, the service had admitted 210 patients and discharged 175.

The average length of stay for patients was 33 days on Branwell ward, 26 days on Anderson ward and 25 days on Austen ward.

None of the patient care plans we reviewed contained a discharge plan which demonstrated that discharge was planned from the time of admission. Staff told us that discharge may be discussed in multi-disciplinary team meetings.

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

Inadequate

Where possible, staff planned for patient discharge and liaised with patient's families and care co-ordinators in the community; this was done at an appropriate time of day. However, sometimes patients were recalled by their commissioners to beds in their local area, which was often positive for patients but was out of the control of the service and not always done at the appropriate time of day.

The facilities promote recovery, comfort, dignity and confidentiality

Patients on Austen ward had access to a variety of facilities, rooms and equipment which included a dining room, lounge, quiet lounge, activities of daily living kitchen and games room. Patients also had access to laundry facilities which they could use with staff supervision according to their risk assessment.

On Branwell ward patients had access to a dining room, lounges, activities of daily living kitchen and a visitors' lounge. Patients also had access to laundry facilities which they could use independently.

Anderson ward had been recently refurbished and the environment was bright and airy. Patients had access to a lounge, sensory room, and dining room and activity room.

Patients could use a gym, therapy room and visitors' room in the communal areas of the hospital, either independently or with staff escorts depending on their individual risk assessments. Patients told us that they felt frustrated that gym sessions were stopped at twenty minutes and there were not enough staff to complete inductions, patients could not access the gym without an induction.

Patients on all wards had access to outside space and patients on Branwell ward could use outside gym equipment in the courtyard.

Patients were able to make a phone call in private either using the ward telephone or their own mobile telephone.

Patients on both wards had access to hot and cold drinks and snacks throughout the day and night. Patients told us that food was of good quality.

Patients had their own bedrooms and were able to personalise them. Each bedroom contained secure storage. Patients had access to their own bedroom keys other than on Austen ward.

Patients' engagement with the wider community

Patients were encouraged to maintain contact with people who were important to them and were allocated leave to access the community where appropriate.

Meeting the needs of all people who use the service

The service did not meet the needs of all patients.

There was a lack of activities available for patients on Branwell and Austen wards. At the time of the inspection there was one activity co-ordinator working at the service. None of the patient care plans we reviewed contained a therapy plan. The activities in place on these wards were generic, each patient had an activity plan in place, however they rarely differed between patients. We spoke with patients who made complaints about the lack of activities on Branwell and Austen wards. We also spoke with three carers who told us there was a lack of activities available for patients on Austen and Branwell wards.

We observed one morning planning meeting on Branwell ward where the plan for the walking group was to visit the local shop. Patients asked if they could go somewhere more interesting and therapeutic and were told there were no drivers on shift and that one activity co-ordinator could not take patients on a walk to the local woods alone. Patients asked about cooking sessions, pool tournaments, trips out and access to educational activity; they were told they could use the computers to 'look at google' and that when activities were planned in the past patients did not turn up so they had stopped being organised.

On Anderson ward we observed staff undertaking craft activity and outings with patients. Patients told us they did arts and crafts, pampering sessions, cooking, walking, had trips to the cinema and shopping and had taken part in parties and karaoke.

Branwell and Anderson wards were accessible to patients with mobility needs because of their location on the ground floor of the hospital. Accessible bathrooms were available on both wards. Austen ward was located on the first floor of the hospital but had an accessible lift for patients with mobility needs.

Branwell and Anderson wards had a detailed patient information boards with information about patient rights, how to make complaints, treatments, health conditions and medications. The boards were empty on Austen ward. The provider told us that this was because the board was recently replaced.

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

Inadequate

Staff had access to interpreters who they could invite to the ward to support patients where English was not their first language. Staff had access to information for patients in languages other than English.

Catering staff were able to meet the needs of individual patients. Menu's had vegetarian options and staff cooked food on site so they could meet individual needs and preferences including cultural and religious needs.

The hospital had a spiritual room available to patients.

Listening to and learning from concerns and complaints

The service had a policy in place for the management of complaints, which had been followed in those we reviewed during the inspection.

Between 1 December 2018 and 30 May 2019, the service had received 13 complaints. Eight complaints were received in relation to Branwell ward, three from Austen ward and three from Anderson ward. None of these complaints had been referred to the Ombudsman.

We reviewed the most recent three complaints during the inspection. One complaint was from a patient on Branwell ward and related to access to section 17 leave and a complaint about medication. The patient had made the complaint via their advocate which was passed to the service. It was investigated by the ward manager, reviewed and responded to by the hospital manager. The complaint was partially upheld. The second complaint was in relation to missing patient items. The complaint was upheld, and the service replaced the patient's belongings. Although the complaint was upheld, and items replaced, there was no note of apology for this in the response to the patient. The third complaint was in relation to care and treatment and was not upheld, it related to a patient making a complaint about staff conversations. The complaint was investigated and the outcomes sent to the patient's advocate to discuss with them.

Between 1 December 2018 and 20 May 2019, the service had received 41 compliments. We reviewed the last five compliments all of which were sent to Anderson ward. They thanked staff for the care provided to them.

Patients and carers we spoke with told us that they knew how to make a complaint in written or verbal format. Patients spoke positively about being able to share concerns about their care and treatment via the advocacy service who visited regularly.

Staff knew how to handle complaints appropriately, following the service's internal processes.

The service had an overarching local action plan in place. The action plan formed the integrated monthly governance meeting. The monitoring of complaints and compliments was not included in the overarching local action plan we reviewed but was a standing agenda item in integrated governance meetings. This meant that there was limited oversight into the management, review and themes from complaints and compliments and monitoring of the actions required to implement learning and enhance the quality of care and monitor improvement.

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

Inadequate

Leadership

The hospital had a senior leadership team which consisted of a hospital (registered) manager, a clinical lead (this post was vacant at the time of the inspection) a quality compliance lead and medical director. They were supported by ward level managers, consultants and doctors. The service was also supported by a regional operations director, a regional quality assurance manager and the wider provider senior management team.

The hospital manager had been in post since November 2018; they started in post at the time of our previous focussed inspection. They had implemented several changes and additions to attempt to improve the quality of care at the service. The hospital manager told us that they felt supported by the operations director and by the provider's senior leadership team particularly regarding making decisions about the management of patient admissions and acuity.

However, staff gave mixed feedback about how visible and approachable the leaders were. We spoke with 24 staff, and four of these staff reported their immediate manager as unapproachable, abrupt or not dealing with issues and concerns.

In response to the concerns we raised at this inspection, the provider told us that they had brought in a requirement with immediate effect for ward managers to spend 50% of their time on the ward, providing support to staff and monitoring care and practice.

Leadership opportunities were available for staff to progress within the service, and there were several specialist roles and champion roles within the service. Staff had undertaken a variety of additional training.

Vision and strategy

The provider had identified five core values:

- integrity
- trust
- empower
- respect
- care

Staff were able to tell us about the values of the organisation and told us that these had been rewritten since the provider merged with another large service provider, and that they had been involved in this.

We observed some care practices which were not in line with the provider's values. However, when we discussed this with the provider, they took immediate action to address these concerns.

Culture

Staff did not feel respected and valued.

There was not a positive culture at the service. Staff told us this impacted on their motivation to complete their job role. During the inspection, a range of staff said the following things about the culture of the service:

- staff had discussed things of a sexual nature in front of patients
- managers did not act when concerns were raised
- one staff member was concerned about staff attitudes towards patients. They described that a patient's case notes stated that the patient 'threw a strop'.
- a ward manager spoke negatively about a patient's plans to attempt suicide
- some staff can be 'stroppy' towards patients
- the doctor is dismissive
- there is team splitting and they had felt bullied
- concerns are not taken seriously
- they feel anxious, and do not want to come to work
- they would not recommend the service to my family
- the culture is worse than before
- they are stressed and patients are stressed
- nothing has changed or improved.

This was also evident in the 2019 staff survey conducted by the provider. The results had been collated directly for the service with 74 respondents. The overall positive score had reduced from 74% in 2018 to 67% in 2019. There had been a 10.5% reduction in staff in answer to 'I enjoy working for Cygnet Health Care'. There had been an 8% reduction in the amount of staff who agreed that the care of service users was Cygnet's top priority (32% of staff did not agree). Staff had also responded negatively to 'in the last twelve months I have not felt unwell due to work related stress (48%), and 'I would recommend Cygnet as a place to work' (48%).

However, there had been a 10% increase from 51% to 62% of staff who agreed that 'there is a feeling of respect for each other'.

Managers were not always addressing poor performance effectively, which had allowed a poor culture to develop. Staff were not completing tasks as designated by leaders. Staff did not routinely attend team meetings to discuss concerns and learn from incidents and did not discuss improvements.

The service's staff sickness and absence rates were reducing over time.

The provider had an 'employee of the month' scheme where patients and staff recognised staff contributions and support, and they were rewarded for this.

Governance

All senior staff from ward manager level met for monthly integrated governance meetings. A standardised agenda was discussed; which included data on key areas of performance such as the use of rapid tranquilisation, restraint and seclusion.

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

Inadequate

Each agenda item had an attached action plan, which fed into the hospital's local overarching action plan. The local overarching action plan described actions required from incidents, inspections and concerns. This fed into ward level action plans which became the responsibility of ward managers.

Within the hospital, managers had attempted to implement effective systems and processes to ensure good governance. However, despite the introduction of additional training, competency testing and audit being put into place, some of the additional processes were not effective or embedded by the time of the inspection. This included the issues we identified on inspection such as concerns about environmental and ligature risks, observation and engagement, high dose anti-psychotic monitoring, the attendance of out of hours doctors to admissions, the recording of restrictive interventions, blanket restrictions, cleanliness, follow up of complaints, adherence to the Mental Health Act and Mental Capacity Act, and the appropriate monitoring of patient risk.

The provider had not taken timely enough action to respond to the serious concerns at our previous inspection of this service. Most of the concerns we raised during this inspection were directly repeated from previous inspections of this service.

The provider had not ensured that all staff had completed the required levels of mandatory training in immediate life support.

Management of risk, issues and performance

The service had a risk register which fed into the corporate level risk register. Managers discussed areas of risk and escalated these via the corporate risk manager as required. The local risk register contained six risks, which included recruitment of qualified nurses, physical healthcare provision, pending inquests, notice of decision, and closed circuit television. The highest level of risk related to a serious incident involving the death of one patient.

None of the concerns raised during our inspection were included on the service level risk register and not highlighted to us as concerns by managers.

Information management

The service used data to collate information about patient care; staff did not report that this was burdensome. The information collated supported managers with their role.

Staff had access to the equipment required to complete their role.

All patient records were held confidentially, they were readily available. The format of records was complicated as they were shared between paper and electronic records which made reviewing a patient's history of care and risks complex for staff.

Engagement

Staff had access to information about the service and the provider via internal bulletins and were provided with a monthly lesson learned log.

Patients were involved in their care and invited to regular meetings to discuss changes and improvements to the service put into place by the provider.

The service did not engage well with carers and families.

Leaders engaged with some external stakeholders such as commissioners and the advocacy service.

Learning, continuous improvement and innovation

Staff were given opportunities for enhanced learning and to build their skills.

The service's psychiatric intensive care unit had received accreditation from the Royal College of Psychiatry.

Branwell ward was part of the 'safe wards' network.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure care premises, equipment and facilities are safe, and that risks are identified, managed and mitigated.
- The provider must ensure that all patients have an up to date risk assessment, which is completed on admission, regularly updated and contains all presenting risk, with an associated risk management plan.
- The provider must ensure that staff follow the systems and processes in place, which are designed to protect patients and provide safe care and are effective and embedded.
- The provider must ensure that these systems are effective.
- The provider must ensure that clinical equipment is calibrated, clean and fit for purpose.
- The provider must ensure that the hospital is clean.
- The provider must ensure that all patients are observed in line with their care plan and in line with their own policy.
- The provider must ensure that all staff have completed the required levels of mandatory training.
- The provider must ensure that blanket restrictions in place are justified, proportionate, reviewed and in line with the Mental Health Act and associated Code of Practice.
- The provider must ensure that blanket rules are not applied in a manner that appears a method of punishment to patients or in a manner which causes them distress.
- The provider must ensure that the uses of restrictive practices are recorded in line with their own policy, and that they are always proportionate and least restrictive.
- The provider must ensure appropriate monitoring of patient's physical health on admission.
- The provider must ensure staff always monitor the side-effects on patients' physical health when prescribed high dose anti-psychotic medication.
- The provider must ensure there are a sufficient number of doctors available to attend to patients on admission and in a psychiatric or medical emergency in line with the provider's own policy.
- The provider must ensure staff act on indications of abuse and report accordingly.
- The provider must ensure the system for patient records allows staff to maintain high quality records.
- The provider must ensure the hospital provides adequate therapeutic interventions for patients.
- The provider must ensure staff understand their responsibilities in relation to the Mental Health Act and Mental Capacity Act and carry out its functions appropriately.
- The provider must ensure that patient care plans are holistic, recovery orientated and contain clear discharge planning.
- The provider must ensure that the care provided is dignified, respectful and kind. When this is indicated that this is not the case, the provider must ensure they take appropriate action.
- The provider must ensure that systems and processes designed to involve patients and their carers are taking place.
- The provider must ensure that there is a process to review and audit complaints and take action to make improvements.
- The provider must ensure that patients have access to suitable activities to support their recovery.
- The provider must ensure that timely action is taken when the Care Quality Commission raises concerns regarding breaches of regulation.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **How the regulation was not being met:** Care and treatment were not being provided in a safe way for service users. The service was not doing all that was practicable to mitigate such risks. Risk assessments were not completed and reviewed regularly. The premises and equipment were not safe and not used in a safe way. **This was a breach of regulation 12 (1) (2) (a) (b) (d) (e)**

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **How the regulation was not being met:** Systems and processes were not established and operated effectively. The service did not assess monitor and improve the quality and safety of the services provided. The service did not assess and monitor and mitigate the risks relating to the health, safety and welfare of service users. **This was a breach of regulation 17 (1) (2) (a) (b)**