Cygnet Hospital Sheffield

Quality Report

83 East Bank Road
Sheffield
S2 3PX
Tel:0114 279 3350
Website: www.cygnethealth.co.uk

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

Ratings

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

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

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

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

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

Summary of findings

Overall summary

We rated Cygnet Hospital Sheffield as requires improvement because:

- Although we noted some improvements since our previous inspections, there were still instances where the provider had not sufficiently addressed previous shortfalls as well as further areas of concern that we identified.
- The child and adolescent wards were not fully operating in accordance with the provider's own policy on 'same sex accommodation'. Haven ward required environmental improvements; these were underway at the time of inspection.
- There were low compliance rates of staff being trained in a number of key areas to help ensure the safe running of the service. In particular, both Spencer and Shepherd wards had low rates of staff trained in managing actual and potential physical aggression and basic and immediate life support.
- All wards, except for Haven ward, had not completed resuscitation simulations in accordance with hospital policy. Staff raised concerns about the accessibility of necessary medical supplies. We also found issues with fridge temperatures on all wards except Spencer, whereby temperatures were outside of recommended ranges with no evidence of staff taking action to address this.
- Not all care plans for patients on child and adolescent wards were holistic. They did not include clear information about interventions to manage patients at crisis point and their preferences in such situations. There was limited evidence that debriefs took place following individual incidents
- There were occasions of staff still using inappropriate terminology within care plans to end seclusion as opposed to a person centred approach. We found instances of where patients with long term health conditions did not have a care plan in place about the support they needed.
- Feedback from some patients across all wards was that they did not feel involved in the care planning process. Some felt information staff documented about them was not reflective of their needs and that staff did not involve them in any reviews of their care. Feedback from some patients across wards was that staff were not always caring.
- There was still a high use of agency staff within the hospital. This was more prevalent at night across all wards. There was higher agency usage on the child and adolescent wards where vacancies were the greatest. Some patients told us they felt uncomfortable approaching agency staff due to them not being familiar with their needs.
- There was no information on display on child and adolescent wards about how to make complaints. Complaints that had been investigated and concluded did not always offer a right of appeal to the complainant.
- Patient information was not stored centrally as the hospital used both electronic and paper systems to store information. Information was not always easy to locate and the use of several systems had the potential to cause confusion for staff. It also meant there was greater risk of staff not updating all relevant information.
- The service had undergone several changes of senior management which had led to some instability within the hospital. We found governance systems had been strengthened and the provider had made improvements in a number of areas. However, these new working practices and systems were not yet embedded. We still found shortfalls in areas of the service.

However:

- Our observations of interactions between staff and patients were positive. Staff treated patients appropriately, with respect and demonstrated good knowledge of their needs.
- There was positive feedback from some patients from all wards about staff and the service. There were forums available for patients to attend meetings and put forward their views of the service.
- Patients had risk assessments and management plans in place. Staff completed necessary monitoring of patients following episodes of rapid tranquilisation.

Summary of findings

- We saw evidence of changes to working practices and learning from serious incidents that had taken place. These included changes in policy and systems.
- Staff described good multidisciplinary meeting working which we observed in practice, and good relationships with external organisations. Staff teams reported good communication within their teams and regular meetings. Staff had regular supervisions and appraisals and felt supported within their roles.
- Haven ward, Peak View and Spencer ward had participated in the Royal College of Psychiatrists quality network reviews. All wards had achieved high scores for the criteria they were assessed against and received positive feedback.
- Monthly integrated clinical governance meetings took place where staff were able to discuss and review the performance of the wards and look at any themes, trends and learning.

Summary of findings

Contents

Requires improvement

Services we looked at:
Forensic inpatient/secure wards; Long stay/rehabilitation mental health wards for working-age adults; Child and adolescent mental health wards

Summary of this inspection

Background to Cygnet Hospital Sheffield

Cygnet Hospital Sheffield is an independent mental health hospital that provides low secure and locked rehabilitation services for women, and child and adolescent mental health services for male and female adolescents aged between 12 and 18.

The hospital has capacity to provide care for 55 patients across four wards. These are:

- Spencer: 15 bed low secure adults ward for female patients. There were 13 patients at the time of inspection.
- Shepherd: 13 bed long stay rehabilitation adults ward for female patients. There were 10 patients at the time of inspection.
- Peak View: 15 bed mixed sex acute ward for children and adolescents. There were 9 patients at the time of inspection.
- Haven: 12 bed mixed sex psychiatric intensive care unit for children and adolescents. There were four patients at the time of inspection.

The registered manager was no longer working at the service but had not deregistered with the Care Quality Commission at the time of our inspection. A hospital manager from another Cygnet Hospital was operating as the interim manager. The clinical manager was the controlled drugs accountable officer for the hospital.

The hospital is registered to provide the following regulated activities: Assessment or medical treatment for persons detained under the 1983 Mental Health Act; diagnostic and screening procedures and treatment of disease, disorder or injury.

We undertook a comprehensive inspection of Cygnet hospital Sheffield in June 2016. Following that inspection we issued the provider with six requirement notices. These related to:

- Regulation 10 HSCA (Regulated Activities) Regulations 2014: Dignity and respect
- Regulation 12 HSCA (Regulated Activities) Regulations 2014: Safe care and treatment.
- Regulation 13 HSCA (Regulated Activities) Regulations 2014: Safeguarding service users from abuse and improper treatment.
- Regulation 15 HSCA (Regulated Activities) Regulations 2014: Premises and equipment
- Regulation 17 HSCA (Regulated Activities) Regulations 2014: Good governance
- Regulation 18 HSCA (Regulated Activities) Regulations 2014: Staffing

We told the hospital it must make a number of improvements and should consider making improvements in other areas where we identified shortfalls but which did not constitute breaches of regulation. These can be found in our report of that inspection published in December 2016. The provider sent an action plan of the steps they were going to take in order to meet the requirements of the regulations.

We undertook two separate responsive focussed inspections of Haven Ward in October 2016 and in July 2017. These were both undertaken in response to serious incidents which had occurred on the ward. The inspection in October 2016 did not result in any further actions at that time. Following the inspection of July 2017, we issued the provider with three requirement notices. These related to:

- Regulation 12 HSCA (Regulated Activities) Regulations 2014: Safe care and treatment.
- Regulation 13 HSCA (Regulated Activities) Regulations 2014: Safeguarding service users from abuse and improper treatment.
- Regulation 17 HSCA (Regulated Activities) Regulations 2014: Good governance

We told the hospital it must make a number of improvements and should consider making improvements in other areas where we identified shortfalls but which did not constitute breaches of regulation. These can be found in our report of that inspection published in August 2017.

The provider sent an additional action plan setting out how they intended to meet the breaches identified in that inspection.

Summary of this inspection

At this inspection we found the provider had addressed the issues relating to some of the breaches but still did not meet the legal requirements of regulation 17. We also found evidence of further breaches of regulations.

Our inspection team

The team leader was Care Quality Commission inspector, Anita Adams.

In addition to the team leader, the team consisted of two other Care Quality Commission inspectors; an assistant inspector and a specialist pharmacist. An inspection manager also attended for one day of the inspection.

The team also included three specialist advisors. These were a child and adolescent mental health specialist nurse; a child and adolescent mental health clinical psychologist and a psychiatrist with experience in both child and adolescent mental health and adult mental health.

An expert by experience was part of the team whose role was to speak via telephone with parents and carers of patients on the child and adolescent wards. The expert by experience had personal experience of supporting someone using this type of service.

Why we carried out this inspection

We inspected this service to establish whether Cygnet Hospital Sheffield had made improvements following our last comprehensive inspection where we rated the service as 'Requires Improvement' overall. When we inspected the service in June 2016 of, we rated the key questions for safe as 'inadequate' and effective, caring, responsive and well led as 'requires improvement'.

We also reviewed actions the provider had taken following our focussed inspection of Haven ward in July 2017. We did not rate that inspection.

How we carried out this inspection

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

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

Before the inspection visit, we reviewed information that we held about the location, and sought feedback from stakeholders. We gave the provider 24 hours notice of our inspection so they could ensure patients and staff would be available to meet with the inspection team.

During the inspection visit, the inspection team:

- visited all four wards of the hospital, looked at the quality of the ward environment and observed how staff were caring for patients
- spoke with 18 patients who were using the service
- spoke with the interim hospital manager; the clinical manager; the operations director; the quality assurance manager and the quality and compliance manager
- spoke with the managers of each of the four wards
- spoke with 31 other staff members across all wards: including doctors, nurses, support workers, head teacher, occupational therapists, psychologists, social workers, mental health act administrators, a member of the housekeeping team and the hospital chef
- spoke with an independent mental health advocate

Summary of this inspection

- attended and observed 10 meetings involving professionals and patients.
- reviewed 14 care and treatment records of patients
- reviewed the personnel files for five staff members
- spoke with 16 carers and/or family members of people using the service
- carried out a check of the medication management and medication charts on all four wards
- reviewed a range of policies, procedures and other documents relating to the running of the service.

What people who use the service say

We spoke with 11 patients across both adult wards and seven patients across both child and adolescent wards. The majority of patients across all wards said the wards were clean and expressed no concerns with the environment.

Patients across all wards told us there was a higher use of agency staff at night. Patients on adult wards said that night staff often spent time in the office as opposed to being accessible on the wards. Most patients, a higher number of adolescent ward patients, said they did not feel comfortable in approaching agency staff as they did not know them well.

Three patients from the adolescent wards talked about their experience of restraint. All said it made them feel anxious and one patient said they understood it was in their best interests at times. The other two patients felt staff rushed in and one felt staff restrained them more so than other patients.

There was mixed patient experience of care planning across all wards. Some patients, from both adult and child and adolescent wards, felt this was an inclusive process and said they were able to contribute their views and have their care plans. Others felt staff did not involve them in the process of care planning with some saying they did not have the opportunity to review their care plans.

Patients gave variable feedback about whether staff were caring. Across all wards, some patients described staff as kind and approachable, whereas some described staff as not caring and dismissive.

Patients across all wards spoke about activities but their experiences were varied. Most patients reported either a lack of activities at evenings or weekends or staff not facilitating activities for them to undertake.

Patient experience of making complaints varied. Most patients on the adult wards said staff tried to resolve issues but a minority said they felt staff did not take complaints seriously. There was similar variance on the child and adolescent wards with patients having both positive and negative experiences.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Requires improvement 

We rated safe as requires improvement because:

- Haven ward required environmental improvements. A schedule of refurbishment work was underway at the time of our inspection but was not completed.
- The child and adolescent wards did not fully comply with their own policy on same sex accommodation and with applicable guidance.
- There was low compliance with required mandatory training in a number of key subjects necessary for the safe running of the service. Spencer and Shepherd wards had the least number of staff current with restraint training and life support training.
- On the child and adolescent wards there was little information about what support patients required if they were in a crisis or how staff should manage challenging situations. This included patients preferences in relation to the use of interventions such as restraint and seclusion should this be required.
- There were instances of medicines being stored outside of the recommended storage ranges on Haven, Peak View and Spencer wards. There was no evidence that staff had taken action to remedy this.
- The use of blanket restrictions had improved since our last inspection however patients on Haven ward were not allowed access to their mobile phones. This decision was not in accordance with policy and there was no individual patient rationale for this.

However:

- The wards were generally clean and infection control practices had improved on Haven ward.
- Although there were still vacancies across all wards which led to a continued high use of agency staff, staff felt in the main the staffing levels on the wards were suitable. Managers could adjust staffing levels to suit patient need. The provider was looking at ways of improving staff recruitment retention.
- Patients had risk assessments and management plans in place. Risk information was shared between staff and relevant professionals.

Summary of this inspection

- Haven ward had addressed and improved the process for patient observations and allocations. This had not yet been implemented on Peak View or elsewhere.
- Staff regularly monitored patients' physical health following the use of rapid tranquilisation.
- We saw evidence of learning from serious incidents such as changes in policy and working practices.

Are services effective?

Requires improvement

We rated effective as requires improvement because:

- Not all patients on the child and adolescent wards had care plans in place to cover holistic needs, including what therapeutic input they required. Some patients had no care plans about their physical health needs including patients on adult wards who had long term health conditions.
- The hospital had best practice tools in place to monitor and measure patient improvement however staff did not always use these correctly or consistently.
- On the child and adolescent wards there were instances of incomplete mental capacity assessments which meant it was not evident that the assessor had considered all necessary principles.
- Staff, particularly on the child and adolescent wards, did not always act upon the outcomes of Mental Health Act audits in a timely manner where issues were identified.
- Patient information was not held centrally as the hospital used both electronic and paper systems to store this. As a result, information was not always easy to locate and it had the potential to cause confusion for staff.

However:

- Staff on all wards received regular supervision and appraisals and told us they felt supported in their roles.
- Staff could access additional training and were supported by the hospital where they were undertaking further external training. Some staff felt training in psychological therapies would be beneficial to help them better support the patient group.
- Staff were involved in undertaking regular clinical audits of areas of the service.
- There was good multidisciplinary working in the hospital and good links with external agencies and organisations.

Summary of this inspection

Are services caring?

Requires improvement

We rated caring as requires improvement overall because:

- Patients across all four wards had mixed views of how staff treated them; some felt staff were not kind and caring towards them. Some patients did not feel comfortable approaching agency staff for support as they did not feel they knew them well.
- Some patients across all wards reported having little or no involvement in the care planning process and decisions relating to their own care.
- Patients had access to advocates but this service was not as well integrated on the adolescent wards as on the adult wards.
- Some parents and carers of patients on the adolescent wards felt communication was lacking and they had limited involvement in their relative's care.
- Patients on the child and adolescent wards did not have the opportunity to be present throughout the discussions that the multidisciplinary team had about them during their regular ward round meetings. Patients on the adult wards were not always present through the entirety of the discussions.

However:

- We rated the adult wards as good in this domain.
- We found that interactions and exchanges between staff and patients on all wards were positive, caring and respectful.
- Patients on all wards had community meetings where they were able to discuss aspects of the service, give feedback and contribute their views.
- Some patients, parents and carers gave good feedback about staff, the service and the care provided

Are services responsive?

Requires improvement

We rated responsive as requires improvement because:

- Complaints that had been finalised and concluded did not always include information about the rights of the complainant to appeal to the ombudsman.
- There was a lack of information for patients and visitors about how to complain on the adolescent wards. There was limited evidence of shared complaint learning between staff at ward level.
- Some patients reported limited activities and a lack of things to do, especially at evenings and weekends. There was a lack of individualised activities for patients.

However:

Summary of this inspection

- Managers of the child and adolescent wards had regular meetings with commissioners to discuss patient referrals, admissions and discharges.
- There was occupational therapy provision available to patients and activity groups patients could attend.

Are services well-led?

Requires improvement

We rated well-led as requires improvement because:

- There was no registered manager operational in post at the hospital but an interim manager was in place. There had been several changes of senior staff which had caused some instability across the service.
- Although the provider had undertaken work to address previously identified shortfalls, these were not yet embedded and sustained. We identified further areas of the service that were in need of improvements.
- The service did not always operate fully in accordance with all relevant policies. The adolescent wards did not comply with the policy for the practice of mixed sex accommodation and access to mobile phones.
- There was low compliance across the hospital in some areas of mandatory training.
- The provider used several systems to store patient information which posed a risk of omissions in information and staff not updating all records. This was a known issue that we had also identified at previous inspections.
- The provider's systems and processes had not identified that complainants were not always provided with necessary information.
- The system for recruiting new staff was not robust as there was a lack of evidence of verification of references in some instances.

However:

- Most staff reported positive changes implemented by the current management team and felt the hospital was improving. Senior managers recognised and acknowledged that further improvements were still required.
- Staff were knowledgeable about the hospital's visions and values and aimed to work in accordance with these.

Summary of this inspection

- Haven ward, Peak View and Spencer ward had participated in the Royal College of Psychiatrists quality network reviews. All wards had achieved high scores for the criteria they were assessed against.

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.

Mental Health Act documentation on the child and adolescent wards showed that medicines were prescribed in accordance with the provisions of the Mental Health Act in relation to consent to treatment. We reviewed Mental Health Act documentation in patient records and found this to be in order. One patient on the adult wards had been prescribed a sedative which was not included on the second opinion certificate. We raised this with the responsible clinician who took immediate action to review the person's treatment.

Two Mental Health Act administrators worked at the hospital; one for the child and adolescent wards and one for the adult wards. Ward managers and staff could contact the administrators for advice and guidance about the Mental Health Act.

The administrators undertook a number of audits of Mental Health Act documentation and sent a weekly report to each ward of their findings and associated action. There were instances of ward staff not acting on actions. For example, the weekly reports highlighted the need to ensure expired section 17 leave forms were removed from the nursing files. In the records we looked at on all wards we found this had not always been undertaken, particularly on child and adolescent wards. The audits also identified the child and adolescent wards as requiring the most actions to address shortfalls in documentation.

Staff regularly informed detained and informal patients of their rights as required under section 132 and section 131 of the Mental Health Act respectively.

Mental Health Act and code of practice training was mandatory training for staff. There was high compliance with this training on the child and adolescent wards. Training for staff on the adult wards was below 75%. However, staff we spoke with across all wards had a good understanding of the Act and resources such as the code of practice were available to them.

Independent Mental Health Advocacy services were available to patients. They were contracted to provide a set amount of advocacy input each week. Two advocates attended the wards. Patients knew about the advocacy services could access this service if they wanted to. One of the advocates reported that they had better integration with the adult wards and did not feel the child and adolescent wards were as receptive to their input.

Mental Capacity Act and Deprivation of Liberty Safeguards

As part of our inspection we looked at the provider's adherence to the Mental Capacity Act and the Deprivation of Liberty Safeguards. We do not rate providers on adherence to the act and associated guidance however; these form part of our overall judgements of the provider.

The Mental Capacity Act applies to people aged 16 and over. In order to establish decision making ability for young people under 16, competency is assessed under the guidance of Gillick competency. No one at the hospital was subject to a deprivation of liberty safeguard authorisation at the time of our inspection. These safeguards apply to individuals aged 18 and over.

Staff undertook Mental Capacity Act training as part of their induction and as part of Mental Health Act training. The hospital had also started to provide specific training in the Mental Capacity Act and Deprivation of liberty safeguards. Compliance with this training was low across all wards with the least amount of staff trained on the adolescent wards.

Staff had variable knowledge about the Mental Capacity Act and some felt more confident than others about application of the principles. All said they would seek support and guidance from colleagues with more understanding should they have concerns about patient's capacity.

The hospital had policies for application of the Mental Capacity Act and a capacity, competence and consent policy for children and young people under 18.

Detailed findings from this inspection

There was evidence of capacity to consent to treatment within patient records. There were also assessments present for other specific decisions.. On the child and adolescent wards we saw examples where these were not always fully completed to show how the assessor had arrived at their decision.

We saw evidence of signed consent from patients in instances such as agreeing to share information with other parties. Staff respected and acted in accordance with patients decisions,

Capacity assessments for consent to treatment were monitored as part of the monthly Mental Health Act audits that Mental Health Act administrators completed.

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Forensic inpatient/ secure wards	Requires improvement	Requires improvement	Good	Requires improvement	Good	Requires improvement
Child and adolescent mental health wards	Requires improvement	Requires improvement	Requires improvement	Requires improvement	Requires improvement	Requires improvement
Overall	Requires improvement	Requires improvement	Requires improvement	Requires improvement	Requires improvement	Requires improvement

Requires improvement

Forensic inpatient/secure wards

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

Are forensic inpatient/secure wards safe?

Requires improvement

Safe and clean environment

The ward layouts did not allow staff to observe all parts of the ward as the design meant a clear line of sight was not possible to all areas. Staff undertook individual observations of patients at regular intervals to check their location and safety on the ward.

Each ward had a ligature audit last completed in June 2017 with a six monthly review date. This identified potential anchor points and included control measures to try to reduce these. A copy of the audit was kept in the nurses office accessible to staff. A number of ligature cutters were located on each ward and the locations were included in the ligature audits. Staff made new starters on the ward aware of these as part of their security induction.

Spencer and Shepherd wards accommodated female patients only and therefore complied with guidance on eliminating mixed sex accommodation.

The clinic room on each ward was accessible only via the nurse in charge who was the sole key holder. This was in line with the provider's policy. Staff had concerns with this arrangement and the lack of access to supplies for staff should the nurse not be available. Staff also raised concerns about the lack of access to the physical health clinic outside of day time working hours. This where equipment such as weighing scales and height measure were kept.

We checked emergency equipment and found there were adequate supplies of oxygen and defibrillators with two sets of pads. Each ward also held adequate stocks of emergency medicines as set out in the hospital's resuscitation policy. The provider's resuscitation policy required emergency equipment to be checked at least weekly. Staff carried out regular checks to ensure emergency medicines and equipment were fit for use.

The resuscitation policy said simulation exercises should take place quarterly on each ward. The latest simulation exercise on Spencer ward took place in May 2017 and the outcome was a pass. We did not see evidence of simulations on Shepherd ward to meet the requirements to undertake these each quarter. The physical health lead advised that further simulations were scheduled and would take place on a rolling basis to meet the requirements of the policy.

Spencer ward had a seclusion room which had a main room with bed and bathroom separated by a door that could be unlocked by staff externally. An intercom allowed for verbal communication between staff and the patient. There was a window with a blind so patients had access to light and fresh air. Patients were able to see a clock. There were mirrors fitted in each room to help provide full visibility of patients whilst in seclusion. Staff could adjust the temperature to suit the needs of the patient. We saw the seclusion room door was not flush with the door frame so that when the door was shut there were right angled edges. There was a risk patients could potentially use this to self-harm although there had been no reported incidents where this had occurred. The week following the inspection, the hospital provided us with photographs to show some maintenance work they had undertaken to try to improve this issue.

Housekeeping staff cleaned each ward daily with a reduced service at the weekend. We saw completed cleaning rotas.

These did not include the clinic room and nurse station as night staff took responsibility for these areas as part of their duties. Patient rooms were deep cleaned when a patient was discharged. A member of the housekeeping team said they had enough time, equipment and supplies to fulfil their role and provided support to other team members, such as covering for absences. We saw the wards were generally clean, tidy and well maintained.

Clinic rooms had hand washing facilities and there was a supply of hand sanitisers located throughout the hospital which were available for staff, patients and visitors to use. On Shepherd ward, 79% of ward staff were current with mandatory infection control training. On Spencer ward, this was 57%. There had been no reported infection outbreaks however there was a risk that staff may not have appropriate skills to undertake effective infection control without up to date training.

Each ward was subject to an infection control audit in May 2017. This covered a range of areas including clinical practice, hand hygiene, waste management, environment and policies and procedures. Shepherd ward had scored a total of 93% Spencer ward had scored 94% which both equated to a rating of good. Each audit had an associated action plan with timescales to remedy shortfalls.

Health and safety meetings took place monthly at the hospital. These included discussions about accidents and safety incidents, environmental checks, infection control audits and other relevant areas. There was a current fire risk assessment in place and we saw evidence of regular service records and environmental checks of fire equipment, exits and emergency lighting. We did not see any significant maintenance issues within the wards. Staff reported any repairs to the hospital maintenance team.

Staff carried mobile personal alarms to request assistance if needed. Throughout our inspection we saw that staff used these to get support from their colleagues, such as to help manage incidents, and staff responded quickly. A staff member on each ward was allocated as the lead person responsible for security checks each shift and had a set schedule of security checks they were responsible for.

Safe staffing

Shepherd senior team consisted of a ward manager and two clinical team leaders all of whom were registered nurses and substantive employees. In addition, the staff team requirement to cover all shifts consisted of seven registered nurses and 15 support workers. There were vacancies for five nurses and three support workers within this complement. Two of the vacant nurse posts were filled by contracted agency nurses and the remaining three were filled by bank and ad hoc agency staff. The three vacant support worker posts were covered by bank and agency staff as required.

Spencer senior team consisted of a ward manager and two clinical team leaders all of whom were registered nurses and substantive employees. In addition, the staff team requirement to cover all shifts consisted of nine registered nurses and 23 support workers. There were vacancies for seven nurses and three support workers within this complement. Three of the vacant nurse posts were filled by contracted agency nurses and the remaining four were filled by bank and ad hoc agency staff. The three vacant support worker posts were covered by bank and agency as required.

Ward managers calculated required staffing levels using a matrix which corresponded with the number of patients on the ward. Rotas confirmed there was always a mixture of qualified nurses and support staff on each shift. Where additional resources were required, for example due to increased acuity and for patient escorts, ward managers were able to request additional staff support.

A resource assistant at the hospital co-ordinated staff cover for all wards. Wherever possible the hospital tried to use agency staff who were familiar with the ward. The hospital manager told us there was a more robust system in place than previously to ensure that agencies with a poor history were no longer being used.

Management recognised that recruitment and retention of qualified staff was a main issue affecting the hospital. As a result, the provider had looked at ways to incentivise staff to join and remain working at the service. These included a monetary bonuses, targeted recruitment and increased preceptorship placements. Preceptorship is a period of structured transition for newly-qualified nurses.

Nursing and support staff we spoke with told us they felt staffing levels were suitable most of the time however at busy periods this could be challenging. They confirmed extra staffing could be used where necessary, for example if patients required increased observations. Staff were visible on the wards throughout our inspection.

Requires improvement

Forensic inpatient/secure wards

Staffing rotas showed there was a higher usage of agency staff at night. This coincided with what patients told us about more agency staff at night. Five patients on Spencer ward and three on Shepherd said they were not comfortable speaking with agency staff as they did not know them well enough. Most of these patients also made reference to staff spending large amounts of time in the office at night as opposed to in communal areas and accessible. The hospital manager was looking at ways of trying to increase the numbers of substantive staff on nights, such as arranging annual leave in a way which did not leave higher reliance on agency staff at these times.

Both Spencer and Shepherd ward had a permanent consultant psychiatrist in post. They were able to provide appropriate medical appropriate cover to the wards as part of their roles. The hospital operated a rota of on call doctor cover for evenings and weekends. A hospital manager was also on call out of hours to provide support and advice to staff where required. At night, a nurse was designated as senior nurse on site and on call requests were escalated via this resource.

There was a range of mandatory training staff had to complete with necessary refresher training as required. Overall staff compliance with mandatory training for Shepherd ward was 74% and Spencer ward was 84%. The training matrix for both wards showed a number of key courses which had compliance rates of less than 75%. These included:

- Shepherd ward: Immediate life support 59%, basic life support 59% suicide prevention 18%, equality and diversity 18% and managing actual and potential aggression 53%
- Spencer ward: Immediate life support 67%, Risk management training 64%, suicide prevention 57%, infection control 69% equality and diversity 24% and managing actual and potential aggression 67%

Without completing and being up to date with necessary training, there was a risk that staff may not be equipped with the necessary skills and knowledge to provide safe and appropriate care.

Assessing and managing risk to patients and staff

There was one seclusion room on the adult wards which was situated on the low secure forensic unit, Spencer ward. In the six month period prior to this inspection there were 4 episodes of seclusion of Spencer Ward patients and one instance of seclusion of a patient from Shepherd ward.

Restraint data for the same six month period showed 55 instances of restraint on Spencer ward and 74 instances of restraint on Shepherd ward. The provider supplied us with prone restraint data for the six months prior to our inspection. Prone restraint is where a person is held in a front down restraint position. This poses an increased risk for the safety of the individual as it can cause compression of the chest and airways which can result in difficulties in breathing. Spencer Ward had 6 episodes of prone restraint and Shepherd ward had one. Staff told us prone restraint was only used as a last resort and always for the shortest amount of time possible. The maximum duration of any prone restraint was recorded as 3 minutes with the remainder being recorded as one minute or less. We spoke with the lead trainer at the hospital for managing actual and physical aggression training. They told us staff were taught prone restraint should be avoided wherever possible and said staff followed this principle.

The provider used a recognised risk assessment tool which was the Salford tool for assessment of risk. We reviewed six patients care and treatment records from the adult wards. Patients had up to date risk assessments and management plans. Staff reviewed these regularly and there was evidence that patients were involved in this process. Care plans included information about patients risks such as self-harm, self-neglect, aggression and risks in other areas. They included steps that staff should take to help the patient prevent engaging in this behaviour and what attempts to make to de-escalate this. Information was present about how to manage behaviour if patients engaged in these risks or were in crisis.

On Shepherd ward a quick risk guide of the patients on the ward was contained in a patient folder. This consisted of an A4 sheet of paper for each patient which included key information such as; observation levels, risk history, historical and current risk including in areas such as suicide, self- harm, arson, vulnerability and a number of other areas.

Staff on the wards worked in two separate groups on alternate shifts. One set of staff worked Monday until Thursday and the other set Friday until Sunday. Some

changes had been implemented to try to change this so staff worked as one whole team across varying shifts. For example, some staff worked twilight shifts across both shift groups which helped to improve communication. Management had requested substantive staff members work across both days and nights to try to eliminate the practice of alternate shifts groups.

Blanket restrictions are defined as a rule or policy which restricts a patient's liberty or rights which is applied to all patients routinely, or to classes of patients, or within a service without individual risk assessments to justify their application. Restrictions in place included certain items that were not allowed on wards due to the potential for harm. Staff assessed patients individually to identify whether these would be a risk to the individual or not and took action to reduce restrictions where possible, such as staff supervision. Shepherd ward functioned as a rehabilitation ward so had less restrictions that Spencer, a low secure ward. For example, Shepherd ward patients had access to their own mobile phones whereas Spencer ward patients had to use phones provided by the hospital.

There was variance in staff understanding of what constituted restrictive practices. The hospital had recently introduced a role of reducing restrictive practices lead to try to reduce restrictive practices across the hospital and improve consistency of staff knowledge. We spoke with the lead who was supported by the restrictive practice lead at provider level for the North, They very committed to developing their role. They told us about initiatives and further bespoke training they were hoping to undertake in this area. The hospital provided least restrictive training to staff.

Staff said verbal de-escalation and non-contact interventions would always be used prior to use of restraint. Information in records such as incident reports and daily notes supported this. All staff undertook training in managing actual and potential physical aggression. This consisted of a one day session for non clinical staff and a four day course for ward based staff. All staff had to have annual refresher training. At the time of our inspection 67% of staff on Spencer ward and 53% of staff on Shepherd ward of had completed their required training. This meant there were a significant amount of staff not current with their training; one staff member was shown to have last had their training in 2015. Where individuals were not up to date with their training, they were not expected to be involved in restraint of patients. As there were relatively low numbers of staff up to date, this had the potential to create a risk of having insufficient amounts of staff able to safely undertake restraints.

The hospital had a policy for the monitoring of patients following rapid tranquilisation, which was in accordance with national guidance. At our comprehensive inspection of July 2016, we found staff did not consistently complete monitoring of patient's physical health after rapid tranquilisation in line with best practice guidance. At this inspection, on review of records we found observations had been carried out and recorded as set out in the policy.

At our comprehensive inspection of June 2016, seclusion records on the adolescent wards showed instances of staff keeping patients in seclusion even when they presented as calm. Staff had recorded inappropriate objectives that patients should reflect on their behaviours in order to end seclusion. At this inspection we reviewed 16 seclusion records which included records for Spencer ward patients. There was appropriate rationale for the initiation of seclusion. However, we still found inappropriate reasons documented as part of the objectives to end seclusion. Three records included terminology that the patient should be 'remorseful' or 'reflect on their behaviour' alongside the need for appropriate goals such as reduction in aggression and violence. The Mental Health Act code of practice states that seclusion should not be used as a punishment. The inclusion of this wording indicated that staff were not undertaking a person centred approach when care planning patient goals to end seclusion. We did not see evidence of patients being kept in seclusion solely for these reasons.

The quality assurance manager undertook an internal review of the service in March 2017. The review identified other instances than the ones we saw, where staff stated patients in seclusion needed to show remorse of reflect on behaviour. This suggested the findings from the review had not impacted upon staff practice and still needed to be embedded. The quality assurance manager was in the process of reviewing and updating the seclusion and long term segregation policy and associated documentation. We saw a power point presentation that patients and ward staff had helped compile to contribute their views about seclusion.

Each ward had posters and flow charts on display about who to contact for safeguarding concerns. These included

details of external agencies such as the police and local authority. Staff identity badges included Cygnet safeguarding contact details and Care Quality Commission contact information.

The hospital had three named safeguarding leads and three safeguarding co-ordinators. There were two designated safeguarding link staff on each ward. We saw minutes of monthly 'safeguarding training and development meeting minutes'. These included discussions about any safeguarding incidents throughout the hospital so practice could be shared. We saw contact and communication with local authorities in relation to individual safeguarding matters.

Staff undertook regular safeguarding training. On Shepherd ward, 100% of staff were compliant with safeguarding children training and 88% with safeguarding adults. Spencer ward had 100% of staff trained in both safeguarding children and adults. Staff we spoke with told us they knew how to report any issues.

We checked the arrangements for the safe management of medicines. We reviewed six patient records and spoke with nursing staff responsible for medicines. Medicines were supplied by a pharmacy contractor under a service level agreement. We checked medicines stored in the clinic rooms and medicine refrigerators and found they were stored securely with access restricted to authorised staff. Staff recorded medicines fridge temperatures in accordance with national guidance. However, on Shepherd ward staff had recorded temperatures which were outside the recommended range on six occasions in June 2017 and had not recorded any action taken.

Controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse) were stored, managed, and recorded appropriately. We saw evidence of routine balance checks of controlled drugs.

The hospital had a clinical pharmacist who was employed by the pharmacy contractor. The pharmacist visited once weekly and performed a clinical check of all prescription charts. The pharmacist did not routinely attend multidisciplinary meetings or ward rounds due to time constraints. Pharmacist interventions were recorded on an electronic system which could be used to communicate with doctors and provided an audit trail of actions taken

Patients on the adult low secure wards were able to self-medicate dependent on individual risk and need. Staff reviewed this at multi-disciplinary team meetings.

At our comprehensive inspection in June 2016, we observed staff administer medicines to patients via a hatch. This had the potential to compromise privacy where patients may want to discuss their medication and there was no safeguard to ensure patients had taken it. At this inspection we found the service had taken action to improve this arrangement. The size and placement of the clinic rooms meant there were limitations on what structural work could be done to the room. As an alternative staff had put tape on the floor outside of the hatch with foot prints to designate an area solely for the patient receiving their medicines. Patients adhered to this arrangement and were respectful of the designated area. Posters advised patients to ask a staff member if they wanted to speak privately. A second staff member was required to be near the patient to ensure they took their medicines. Managers had undertaken random spot checks of this process across the wards to ensure staff adhered to this.

Track record on safety

The hospital had a policy which included serious incidents and the process for how staff should manage these. This involved the completion of a 24 hour report and 72 hour report of events leading up to the incident. Staff also used root cause analysis in order to investigate and from incidents. The findings from these were fed into relevant action plans.

Managers discussed serious incidents as part of their monthly governance meetings. These looked at the numbers of serious incidents for each ward and any learning from these.

We saw evidence of learning following a serious incident which had occurred on Spencer Ward in April 2017. The manager had undertaken a detailed root cause analysis. This led to a number of actions which had led to changes in policy and improved working with other agencies.

Reporting incidents and learning from when things go wrong

Staff reported incidents via an electronic reporting system. Staff we spoke with were confident about reporting

incidents. Staff undertook monthly triangulation audits; one area within these was to check that incidents documented in patient notes were reported on the incident reporting system.

We observed staff discuss incidents as part of handover, multidisciplinary meetings, care programme approach and professionals meetings. Staff said they received feedback and learning about incidents via email, communication books, reflective practice groups and team meetings. Managers undertook regular checks of incidents reported by staff. They discussed incidents as part of monthly governance meetings and said they shared key learning within their own teams. Staff tem meeting minutes we saw did not include any discussion of incidents. Shepherd ward staff meeting minutes included an on-going agenda item of incident reviews for staff discussion.

The hospital had a duty of candour policy and staff understood about the need to be open and transparent when mistakes were made. We saw examples of where responses to complaints and contact with patients had acknowledged where staff had made mistakes and given explanations about what had happened.

Debrief following incidents did not routinely take place and records did not show these were consistently offered. Staff had opportunity for debriefs and incident discussion in weekly reflective practice sessions. Debriefs were part of the monthly governance meeting agenda. This included reviewing numbers of incidents and numbers of associated staff and patient debriefs. Minutes showed there were a number of incidents documented each month with no debriefs recorded. The latest minutes stated there was a need to review these further on an individual basis.

Are forensic inpatient/secure wards effective?

(for example, treatment is effective)

Requires improvement

Assessment of needs and planning of care

We reviewed six patients' care and treatment records. These included an assessment of the patient's needs upon admission. The provider had a set number of standard care plans available for staff to complete which were present in patient records. We saw good examples of good detailed personalised information within individual care plans which provided information about the patient and their needs.

The provider's physical health policy stated all service users with a physical health problem must have a care plan outlining their condition with appropriate screening and interventions. During our inspection we reviewed four care plans for patients with long term physical health problems such as diabetes and asthma. In two cases we found these care plans were not complete or lacked sufficient detail. Although we did not identify the patients had not been supported accordingly in respect of the lack of these care plans, there was a risk of this happening.

Patients were required to have a physical health screen completed within 24 hours of admission to the hospital. Records showed physical health documentation and assessments were present in records. A GP attended the hospital on a weekly basis and staff could make referrals for patients where required. Patients at the hospital were registered with the local GP practice as temporary patients.

There was no single complete contemporaneous record for each patient. The hospital used both electronic and paper based systems to record and store patient information as was the situation at our last comprehensive inspection. The provider had introduced extra audits to help ensure staff updated records appropriately. However, as there were several places where information was kept made some information difficult to locate as well as taking extra time to find. It was also not apparent that some interventions were being undertaken. For example, from initial review of patient records it appeared as though staff did not monitor patient's physical health. On further investigation we saw checks were taking place but some information to demonstrate this was held separately by the physical health team using their own system.

Long term and permanent staff knew where to locate information but not all staff, such as agency workers, were familiar with, or had access to, all locations where information was stored. Some records such as multidisciplinary meeting records and care plans were also stored on a local computer drive that required a hospital log on. Hard copy care files contained a lot of paperwork and included out of date records, such as old leave forms, which also had the potential to cause confusion about what information was current.

Requires improvement

Forensic inpatient/secure wards

Best practice in treatment and care

Physical health monitoring was carried out in accordance with national guidance for patients prescribed antipsychotic medicines. The hospital had a physical health team comprising of a lead nurse and two support workers. The team managed blood tests and observations which are regularly required for patients taking antipsychotic medicines. The physical health policy stated patients should be screened for medication side effects using the Glasgow Antipsychotic Scoring System (GASS) tool. We found this tool was not used routinely to monitor patients for side effects arising from their treatment. Where frequent side effects were identified, we found staff had not always reviewed patient's treatment.

The hospital used the Modified Early Warning Score (MEWS) for monitoring of patients which allows for the regular monitoring and recording of blood pressure, pulse, temperature, conscious state and respiratory rate.

The hospital offered psychological therapies recognised by the National Institute for Health and Care Excellence. This included dialectical behavioural therapy and cognitive behavioural therapy.

We spoke with a member of the psychology team who told us that there were differing levels of value attributed to psychology between the wards. There was no process in place for the team to undertake formulation and complex case discussions of patients. There were difficulties on adolescent wards when patients were subject to delayed discharges. This could make it problematic in relation to focus on longer term work and goals. As length of stay was longer on adult wards, this allowed for more collaborative consistent working. The psychology department had recently increased staffing levels however this included the use of two locums.

Staff used a recognised scale known as the Health of the Nation Outcome Scale which is designed to measure the health and social functioning of people with severe mental illness. These were present in patient records but we did not see evidence staff reviewed these in order to measure specific outcomes.

At our last inspection of June 2016, there were a limited amount of clinical audits that took place. It was previously the responsibility of the quality and compliance manager to complete the majority of audits at the hospital. The hospital manager had diversified this to include other staff within the audit process and to make it part of everybody's role. Since our last inspection there was a more comprehensive audit program with a number of further audits scheduled until March 2019. Recurring audits included monthly CCTV audits to observe adherence of staff observations, Mental Health Act audits, clinic room audits, triangulation record audits, seclusion and long term segregation documentation audits among others. Staff undertook focussed audits in order to identify trends and areas for improvement. For example, the occupational therapy team had undertaken an audit in August 2017 to review the differences between uptake of activities across the wards.

Skilled staff to deliver care

The hospital employed a variety of mental health disciplines to provide care and treatment to patients. These included: consultant psychiatrists, psychologists, occupational therapists, social workers, physical health nurse, mental health and learning disability nurses and support workers. A pharmacist visited the hospital weekly which was a further resource available to staff and patients.

Staff we spoke with on the wards told us they received regular supervisions and annual appraisals. At the time of our inspection, 98% of Shepherd ward staff and 100% percent of Spencer ward staff had received regular supervisions. Records also showed that 87% of staff on Shepherd and 80% of staff on Haven ward had received an appraisal.

New staff members completed an induction period prior to commencing work on the wards. The induction program consisted of a variety of mandatory training. New staff were able to complete specialist child and adolescent mental health training. Staff told us they received training to help carry out their roles and could approach their manager to discuss additional training if required.

Some members of staff were self funding further education and told us the hospital had been accommodating in allowing them time off to study. The hospital was looking at reviewing training needs across the service to ensure these reflected clinical need but this had not yet started. Three staff commented they would find behavioural therapy training for ward staff beneficial to help them engage better with patients.

Managers were able to address staff performance issues via the supervision and appraisal process.

Requires improvement

Forensic inpatient/secure wards

Multidisciplinary and inter-agency team work

Multidisciplinary ward round meetings took place weekly on each ward with each patient being reviewed on a two weekly cycle. We observed part of the ward round on Shepherd with consent of the patients. The meeting was attended by a variety of professionals from the hospital including psychiatrists, psychologist, social worker, nurses, support workers and administration staff. Patients were present at the meetings. Discussions were documented and were patient centred with everyone present able to contribute..

Both Spencer and Shepherd wards held monthly staff meeting open to all staff members to attend. The minutes of these showed discussions covered a wide range of areas relevant to the service. Communication between wards was primarily via integrated governance meeting minutes which the ward managers attended. Some staff told us they were not always aware of what was happening in other areas of the hospital outside of where they worked.

Professionals of all disciplines spoke about positive communication and working relationships with both internal colleagues and teams outside of the organisations. This included organisations such as local authorities and a range of community services. Some allied health professionals within the hospital said they would like to be able to spend more time on the wards and felt this would help improve patient and team relationships further.

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

We reviewed Mental Health Act documentation in patient records including medical records. We looked at consent to treatment documentation and found medicines were prescribed in accordance with the provisions of the Mental Health Act in five out of six patients. One patient had been prescribed a sedative which was not included on the second opinion certificate. We raised this with the responsible clinician who took immediate action to review the person's treatment.

Two Mental Health Act administrators worked at the hospital; one for the child and adolescent wards and one for the adult wards. Each could support and provide cover for the other where required. The administrators told us that changes of responsible clinicians, especially on the adolescent wards, could pose challenges with regard continuity of information but there was good communication with the current doctors. Ward managers and staff could contact the administrators for advice and guidance about the Mental Health Act. The provider had a Mental Health Act administrator lead who the administrators could contact for their own support and guidance.

At our comprehensive inspection of June 2016, we found arrangements to monitor adherence of the Mental Health Act were not always effective as audits did not always identify shortfalls . We reviewed the arrangements were in place at this inspection and saw the administrators undertook a number of audits of Mental Health Act documentation. This included audits of drug cards, section 132 rights, section 17 leave forms, tribunal and discharge paperwork amongst other areas. They then sent a weekly report to each ward of their findings which ward staff were expected to address. Administrators followed their part of the process, but there were still instances of ward staff not acting upon actions. For example, the reports highlighted the need for staff to ensure expired section 17 leave forms were removed from the nursing files. Two care records we looked at still included old section 17 leave forms. However, most of the audits of the identified compliance in other areas.

Staff regularly informed detained patients of their rights as required under section 132 of the Mental Health Act. Care records showed this occurred on a monthly basis. This had improved since our last comprehensive inspection when records showed long periods of time between this occurring.

Mental Health Act and code of practice training was mandatory training for staff. The administrators provided this training to new staff and annual refresher training to existing staff. Fifty three percent of staff on Shepherd ward and 62% of staff on Spencer had completed this. Staff we spoke with had a good understanding of the Act and resources such as the code of practice were available. Staff told us they could contact the Mental Health Act administrators for further support if necessary.

Independent Mental Health Advocacy services were available to patients. They were contracted with the hospital to provide a set amount of input each week. There were two advocates who attended the wards, one for males and one for females. Patients we spoke with knew about the advocacy services could access this if they wanted to.

Requires improvement

Forensic inpatient/secure wards

Good practice in applying the Mental Capacity Act

The Mental Capacity Act 2005 is legislation which supports people to make their own decisions wherever possible; and provides a process for decision making where people may be unable to make decisions for themselves. The Mental Capacity Act applies to individuals aged 16 and over. No patients were subject to any Deprivation of Liberty safeguard authorisations. These safeguards apply to individuals aged 18 or over.

Staff undertook Mental Capacity Act training as part of their induction and as part of Mental Health Act training. Training in the Mental Capacity Act and Deprivation of liberty safeguards had become a mandatory stand alone training requirement for staff since our last inspection. However, only 35% of staff on Shepherd ward and 33% staff on Spencer ward were shown to have completed this.

Staff we spoke with had variable knowledge about the Mental Capacity Act and some felt more confident than others about application of the principles. All staff said they would speak to colleagues or their managers if they had any concerns about a person's capacity to consent to something. Staff were aware of resources they could access for further guidance.

The hospital had policies and protocols in place to provide guidance to staff for assessing capacity. These included guidance for application of the Mental Capacity Act.

There was evidence in care records of staff assessing patients' capacity in relation to specific decisions, including consent to treatment, and patients signing to agree their consent. Assessments related to the principles the Mental Capacity Act and the associated code of practice.

Care records included evidence of signed consent from patients for decisions such as sharing information with other parties and allowing the hospital to use their photos on records. We saw instances were patients had not given consent and staff respected this.

Capacity assessments for consent to treatment were monitored as part of the monthly Mental Health Act audits that administrators completed.

Are forensic inpatient/secure wards caring?

Good

Kindness, dignity, respect and support

We observed positive and appropriate interactions between staff and patients. When staff spoke with patients, they were kind and respectful in their exchanges. Staff we spoke with were knowledgeable about patients and were able to describe their individual needs. They could talk about patients backgrounds, likes and dislikes and their preferences

Feedback from patients on Shepherd ward was that the majority of staff were ok, with one saying they were really kind. Feedback from patients on Spencer ward was more mixed. Three patients said staff were kind and four felt staff were not particularly so. One felt staff were dismissive of how they were feeling and another said support workers were kind but staff higher up were not as caring.

We spoke with six carers of patients on the wards. All said that staff were professional and respectful within their communications with them.

The involvement of people in the care they receive

Staff orientated new patients on the wards to their surroundings and provided information about the service. This was undertaken as part of the admission process. No patients we spoke with raised any concerns with the information they received as part of their admission.

Patients had different experiences in relation to their involvement and participation in care planning. Four out of 11 patients reported not being involved with their care plans. One said they had been shown their care plans but they included incorrect information and they had not seen them again since. They told us reviewing these was difficult as their named nurse worked night shifts. Another disagreed with the content of their care plans and said staff had not involved them. Where patients said they were involved, they told us they met with staff on a regular basis and were able to review and contribute to their own care plans. They said they had the opportunity to make changes to these and could have a copy of their information.

Patients were invited to attend their multidisciplinary ward round meeting and if they chose not to, a staff member provided feedback following the meeting. The team

demonstrated good knowledge of patient's needs. We observed a meeting on Shepherd ward, with consent of the patients, and saw staff encouraged patients to put forward their views. Communication was polite and respectful and negotiations of actions were discussed in a mutual, non-pressurised way. Staff signposted one patient to a community group for support with a specific issue and the patient was encouraged to access other support networks. Attendees also discussed positive achievements of patients. One patient had an advocate present who put forward some concerns on their behalf. The team responded to these and confirmed with the patient they were satisfied with the outcome. We noted that staff did not discuss patients' risks with them and the team discussed these after they had left. This meant there was potential that staff may not obtain an accurate review of the patient's risk levels if they were not able to contribute their own views and experiences.

Morning planning meetings took place on the wards and we observed one take place on Spencer ward. This was attended by 12 patients and four staff members. The discussion included the plans for the day and patient requests for leave and activities and how these could be facilitated. Staff encouraged patients to contribute and put forward their views and requests. One new patient was unsure of the options and routine. Staff reassured the patient and helped prompt them and explain what was available.

Community meetings took place two weekly on the wards which were chaired by the patients.

All meetings were minuted and included agenda items such as maintenance, compliments and complaints, safeguarding, spirituality, development and improvements.

We spoke with one of the mental health advocates during our visit. They told us they visited weekly and introduced themselves to new patients. The advocate felt that communication was very good on the adult wards and reported that they felt much more included on the teams than on the child and adolescent wards. The advocate wrote a quarterly report about their findings which was shared with the hospital.

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

(for example, to feedback?)

Requires improvement

Access and discharge

Patients across both wards had long term stays at the hospital due to their enduring mental health needs. The service had a system in place for planned admissions onto the wards with timescales for responding to requests. Ward managers reviewed referral information and liaised with referrers to obtain further information where required. Ward managers had the authority to accept or reject referrals. They told us they would not accept referrals they felt were unsuitable, did not meet the criteria for the service or may have a detrimental impact on the current patient group. The hospital did not accept admissions into beds where patients were on leave from the hospital.

Both wards had different functions therefore accommodated different client groups. We did not see any patients moved between the wards. Decisions about patients moving wards and discharge were discussed and determined at multidisciplinary meetings and with input from other relevant external agencies. If a patient required more intensive care, or services the hospital were unable to provide, then patients could be referred to more appropriate services if necessary.

There was evidence of discharge planning in patients care records including to step down facilities in community. One parent of a patient we spoke with praised the staff for the work they had done with their family member to help integrate them into a new placement. Staff had undertaken a graded approach and supported the patient to spend increasing time at their new placement and help ensure they felt settled and supported.

The facilities promote recovery, comfort, dignity and confidentiality

There were various rooms and equipment available within the hospital. The hospital had a physical examination room on site which could be used when GPs visited patients. However, this room was also used as a search room which meant there was potential that patients would have to wait to be searched if the room was already in use. There were rooms to undertake individual and group therapy sessions

and laundry rooms which patients could use. There was a de-stimulation room available for patients on Spencer ward. There were rooms within the hospital and wards which could be used for visitors.

Patients on Shepherd ward were concerned about their privacy and dignity in relation to recently installed closed circuit television. One camera was situated in the clinic room on the controlled drugs cupboard. As the camera was able to move, patients were concerned the camera could see them, for example if they were having personal examinations or in a state of undress. The camera was due to be boxed in, in order to try to alleviate these concerns. We saw evidence of discussions between staff and patients to try to provide reassurance that their dignity would not be compromised in the meantime.

Patients had access to basic mobile phones on Spencer ward to make phone calls and receive text messages. They were able to access their own phones during section 17 leave where patients had this. Patients on Shepherd ward were able to have their own phones. Phone booths were available for patients to make telephone calls on the wards.

Patients on both wards had access to outdoor space. There were two gardens on Shepherd ward, one of which was accessed via the other through a gate which separated them. We received different information about what time the gate locked. One patient's experience was that this was locked earlier than staff said it was.

Patients could personalise their rooms with their own belongings. Each patient had a restricted cupboard in their room where their own personal restricted items could be stored. This was accessed by staff who could control what items patients could have from their cupboard dependent upon their risk.

The kitchen had been rated the highest five star rating by the local authority food standards agency. No one reported any concerns with the quality of the food. Patients could access refreshments such as drinks and snacks at all times of the day and night.

Each ward had dedicated occupational therapy input. Occupational therapists and assistants worked on a rota basis to cover weekends We spoke with the head of the occupational therapy department who gave us an overview of the therapies in place for patients. They told us about a 12 week rolling program that had been implemented since January 2017 and had received good feedback. A Monday morning group took place to look at different areas such as goal setting, self esteem, anger management amongst other areas. There was a scheme called recovery through activity which was mixture of theory and practical activities. Activities were designed to be a mixture of ward and community activities.

Patients did not have individualised therapy and activity plans in place. Ward activities took place as part of a set schedule and patients had the opportunity to participate if they chose to. Therapeutic programme and vocational activity was a set agenda item within patient community meetings.

Patients had mixed views about the activities on offer. Patients told us about some activities that took place but commented that there was little to do at times. Two patients said there was less to do at evenings and weekends, two others said extra assistants would be good to help facilitate more activities. The result of a recent occupational therapy audit had identified that Spencer ward had a better uptake of activities than Shepherd ward. There was an associated action plan to try to identify the cause for this and improve attendance. The occupational therapy team were due to review the data again at a later date.

Meeting the needs of all people who use the service

The hospital was accessible for people with physical disabilities and who required disabled access. Lifts were present which facilitated access to all wards.

Information leaflets about the hospital and other services were available on display for patients and carers. Alternative formats and languages were available upon request as required. Information about advocacy was displayed on the wards.

Staff had access to interpreters where required to support patients and their families and carers where English was not their first language.

Patients had a choice of foods and the chef told us they were able to provide food to meet any specialist diets or dietary requirements. Staff informed the chef if patients had any dietary needs to ensure their needs were accommodated.

A multi-faith room was available in the hospital off the wards which patients could access.

Requires improvement

Forensic inpatient/secure wards

Listening to and learning from concerns and complaints

The general manager at the hospital was responsible for logging and monitoring records of complaints and ensuring these met necessary timescales. At the time of our inspection there were four open complaints across the hospital under investigation which we saw logged on the inspection tracker.

There was information on display on the wards advising patients of how to complain. Complaints were a regular topic of discussions in patient community meetings as shown in the minutes. Patients we spoke were aware of how to make complaints but reported differing satisfaction levels. The majority of patients we asked felt staff took concerns and complaints seriously and tried to resolve issues locally where they could. Two patients felt staff did not take complaints seriously and one patient was concerned about repercussions from submitting a complaint.

Complaints were not always managed in accordance with policy and to ensure complainants rights were promoted. We looked at the complaint investigation documentation of eight recent complaints at the hospital. The complaint investigation outcome letters provided information about any actions the hospital had implemented as a result of the complaint; and an apology where it was acknowledged the hospital was at fault.

However, in six out of the eight letters, there was no information about the complainant's right to appeal, either higher up in the organisation or to the ombudsman if they were not satisfied with the outcome. The hospital's complaint policy stated,' Cygnet complainants in NHS funded services are entitled to refer their complaint to the Health or Local Government Ombudsman'. The hospital manager also confirmed that outcome letters should include reference about the complainant's right to appeal. Without such information present, complainants may not have been aware of their entitlements for further review of their complaints.

Details of complaints were included in each monthly ward data pack that were circulated to ward managers. Integrated governance meeting minutes showed they were also discussed within this forum, highlighting any noticeable themes and trends. Ward level staff meeting minutes did not show any on-going discussion between staff about complaints or learning from these.

Are forensic inpatient/secure wards well-led?

Good

Vision and values

Cygnet Hospital had a set of organisational values staff were expected to work in accordance with. These consisted of: helpful, responsible, respectful honest and empathetic. Staff we spoke with were aware of the organisations values and these were displayed around the hospital.

All staff we spoke with knew who the senior managers were. However not all staff had yet met them and some said they had not seen them on the wards. The new incoming hospital manager was not yet in post at the time of our inspection.

Good governance

The current training figures showed a number of courses where staff were not up to date with their mandatory training. The hospital had recently changed the system for recording staff training which had previously been outsourced to an external company. This now took place in house and had been implemented so the hospital could better identify when and what staff training was due.

Each ward had systems in place to monitor staff supervision and appraisals and information.

There was a system in operation to ensure that wards had sufficient numbers of staff and identify where extra resources were required. Managers reported that this worked well. A resource assistant had oversight for sourcing additional staff where these were required and was the main link with the staffing agencies the hospital used.

We reviewed the personnel files of four staff members who had recently commenced employment. These included information such as job descriptions, fitness for employment, interview notes including reasons for any gaps in employment, and employment references. Each

person had been subject to a Disclosure and Barring check. The Disclosure and Barring Service helps employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable groups, including children. In two of the files, employment references had been received from the referees' personal email addresses with no evidence of verification of the referees professional capacity. Two references had no dates to confirm when the referee had known or employed the person. We identified no evidence that the information was not legitimate but without robust pre-employment checks, there was a risk the provider may be susceptible to recruiting unsuitable staff.

Integrated governance meetings took place each month. One senior manager told us that these were now better attended than previously. These covered a wide range of areas which included complaints, safeguarding, incidents, restraints, seclusion, rapid tranquilisation, audit feedback, corporate lessons learned amongst other areas. The managers also reviewed training and supervision data within the meetings.

The hospital had introduced monthly data packs. These compiled performance reports for each ward which were circulated to each manager for comment. These covered the same areas as were discussed in the governance meetings. Each data pack had an action plan to address any necessary actions which were to be followed up in the next governance meetings.

There were a number of audits which took place at the hospital. There was a schedule of further audits planned up until March 2019. More staff now took responsibility for audits than was previously the case at our last comprehensive inspection. Some of the newer audits had yet to become fully embedded. Managers undertook spot checks, including when new systems had been implemented to ensure staff were adhering to new practices.

The provider had a corporate lessons learned log. This included notable incidents and events that had occurred at all of the providers hospital which was circulated for discussion at hospital level. This included looking at best practice, what could have been done differently and what changes had been implemented so that lessons could be shared between hospitals.

The hospital had a quality assurance manager who worked across the region and a full time quality and compliance manager, whose roles were to monitor quality and improvement of the hospital. Along with the provider's quality improvement director, they had undertaken an internal compliance inspection of the hospital in March 2017. This assessed the service in line with the same domains used by the care quality commission. The inspection identified areas of improvement required as well as a number of improvements that staff had made. A further inspection was planned in the near future. The quality managers also undertook unannounced visits on the wards and fed-back their findings at that time.

The hospital had a local risk register and managers could submit risks to be included on this via the quality and compliance manager. Managers discussed the risk register within governance meetings. The risk register incorporated the risks we had identified at our last inspection. There was information documented to evidence reviews of the risks and progress that had been made to address these.

Leadership, morale and staff engagement

Since our last comprehensive inspection in July 2016, there had been several changes of personnel at hospital manager and clinical manager level. A new hospital manager was due to commence employment the week following our inspection. Most staff told us even though there had been various changes of senior management, morale was generally good and that the latest changes had led to improvements at the hospital. Some said they were looking forward to stability as changing managers had led to changes in practice which meant several different ways of working.

Two staff, from both adolescent and adult wards, told us about specific instances at work which had affected them where they felt senior management had not been open and clear about the situation. They said they would have appreciated more information about the situations which had led to them feeling unsettled.

Many of the improvements we identified were relatively recent changes in practice and coincided with the start of the current interim hospital manager. The new systems and processes were not yet fully embedded. The manager felt a lot of the shortfalls within the service were attributed to a lack of a substantive staff across the wards and, therefore a lack of consistency of care provision. The manager had set

this as a main area to address. As a result, they spent a lot of time undertaking interviews to try to recruit permanent staff. They had implemented initiatives to try to reduce reliance on agency staff at higher risk times such as nights and recognised that a shift in culture in some areas was needed to achieve this. They understood that changes within the service had and could lead to areas unsettlement within the staff teams. There was strong evidence of the manager actively seeking to address areas of concern that we identified and being proactive to further areas of improvement.

There were opportunities for leadership development. The clinical manager told us about practice development groups where clinical managers met periodically. They said the provider was looking at ways to encourage peer development within this role. Ward managers told us about additional training they were able to access in their roles. The head teacher at the school had recently taken on a new role with increased responsibility to work across the various hospital sites.

The hospital had an initiative to fund support staff to undertake their nurse training. The provider had increased the number of places for staff to apply for this training with an aim to encourage staff development, engagement and retention.

Members of the senior management team we spoke with felt supported by their managers at provider level. They kept in contact by way of conference call and visits to the hospital. Board meetings took place six monthly and the board visited every hospital, including Sheffield, every six months. Members of the senior management team we spoke with were aware there were challenges within the hospital, particularly within the child and adolescent wards. They felt there had been improvements since our last inspections and that these needed to continue and be sustained. They acknowledged that disruption at management level had impacted on morale and some felt a culture change was needed within some areas. There was also recognition that the focus on child and adolescent wards should not be at the detriment of the adult wards.

Staff were able to give feedback via the hospital's annual staff survey. We saw the completed survey and results for 2017. The provider had analysed the results and produced an associated action plan with targets to measure improvements. The areas for action included a reduction in the use of agency staff and improved communication.

Commitment to quality improvement and innovation

In May 2017, Spencer ward had participated in the Royal College of Psychiatrists quality network for forensic mental health services. This is a system where professionals from other forensic mental health services form a team to peer review other similar type services against a standard set of criteria. The report from this review was finalised the week prior to our inspection. Spencer ward had met 94% of the criteria it was assessed against. Shepherd ward did not participate in any accreditation schemes.

Requires improvement

Child and adolescent mental health wards

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

Are child and adolescent mental health wards safe?

Requires improvement

Safe and clean environment

The ward layouts did not allow staff to observe all parts of the ward as the design meant a clear line of sight was not possible to all areas. Staff undertook individual observations of patients at regular intervals to check their location and safety on the ward.

Each ward had a ligature audit last completed in June 2017 with a six monthly review date. This identified potential anchor points and included control measures to try to reduce these. A copy of the audit was kept in the nurses office accessible to staff. A number of ligature cutters were located on each ward and the locations were included in the ligature audits. Staff made new starters on the ward aware of these as part of their security induction.

Haven and Peak View ward did not have designated male or female areas. Each bedroom was ensuite which meant patients did not have to pass through areas of the opposite sex to access bathing and sleeping facilities. Peak view had a male and a female corridor but this was not a formalised arrangement. Communal bathrooms on the wards were available to all patients. The provider had a 'same sex accommodation' policy which said in mixed sex areas of their hospitals, best practice should include a female only lounge area. Both Haven and Peak View had a quiet lounge which staff told us could be used an 'informal' female only area but this was not specified as such. The provider's policy said the views of patients about their preference for such areas should be documented. No patients we spoke with raised concerns about a lack of gender specific areas but we did not see any reference to their preferences in care records.

The provider had a same sex accommodation audit tool incorporated into the policy but only had evidence of this audit completed on Peak View in February 2017 with no completed one for Haven ward. The policy said a comprehensive review should be undertaken in mixed wards. As such, we could not be assured that the provider had assessed their practice and were working in accordance with their policy, national guidance and the Mental Health Act code of practice.

The clinic room on each ward was accessed via the staff office. At our inspection of July 2017 on Haven ward, staff did not always have access to necessary medical supplies kept in the clinic as the nurse in charge was the single person with access to the room. This was in line with the provider's policy. The provider informed us that medical supplies on Haven were to be kept in another office which all staff had access to as a temporary solution. This arrangement was not in place on Peak View.

We checked emergency equipment and found there were adequate supplies of oxygen and defibrillators with two sets of pads. Each ward held adequate stocks of emergency medicines as set out in the hospital's resuscitation policy. The policy required staff to check emergency equipment at least weekly. In July 2017, at our inspection of Haven ward, we saw only three documented checks of the equipment since February 2017. At this inspection, staff on Haven ward had evidenced they now undertook weekly checks of emergency medicines and equipment. Records for Peak View showed staff had undertaken these checks in accordance with policy.

The resuscitation policy said simulation exercises should take place quarterly on each ward. At our July 2017 inspection on Haven ward we found these had not taken place at the required frequency. Since July 2017, four resuscitation simulations had taken place on Haven Ward including one during our inspection. The latest simulation exercise on Peak View was in March 2017 which did not meet the provider's own requirements to undertake these each quarter. The physical health lead advised that further simulations were scheduled and would take place on a rolling basis to meet the requirements of the policy.

There was a seclusion room located on Haven ward that was also used for patients on Peak View if required. The seclusion room had a main room with bed and bathroom separated by a door that could be unlocked by staff externally. An intercom allowed for verbal communication between staff and the patient. There was a window with a blind so patients had access to light and fresh air. A clock was displayed on the wall opposite the seclusion room which could be seen by the patient. There were mirrors fitted to help provide full visibility of patients whilst in seclusion. Staff could adjust the temperature to suit the needs of the patient.

Housekeeping staff cleaned each ward daily with a reduced service at weekends. We saw completed cleaning rotas. These did not include the clinic room and nurse station as night staff took responsibility for these areas as part of their duties. Patient rooms were deep cleaned when they were discharged or as required. A member of the housekeeping team said they had enough time, equipment and supplies to fulfil their role. The team could provide support to other wards, such as covering for absences. We saw the wards were generally clean and tidy although some areas were in need of further attention. For example, the outside area on Peak View had detritus and moss growing in corners and along edges of the yard and the seclusion room windows were smeared on Haven ward.

At our comprehensive inspection of July 2016, we identified an unpleasant malodour in the room used to search patients on the adolescent wards. At this inspection, there was no malodour in the room. A poster on display gave advice to report any offensive odour to the housekeeping team.

Clinic rooms had hand washing facilities and a supply of hand sanitisers was located throughout the hospital for staff, patients and visitors to use. At our comprehensive inspection of July 2016 we were made aware that methicillin-resistant staphylococcus aureus (MRSA) infection was present in some patients and a staff member on Haven ward. Although the provider's policies and procedures outlined good infection control practices, staff had not always followed these to effectively prevent the spread of infection. Since that inspection staff had undertaken additional training in infection control and hand hygiene to further embed their understanding and practice. In addition to this, 84% of staff on Haven ward were current with mandatory infection control training. On Peak View, 69% of staff were current with this training.

Prior to this inspection, there had been a recent case of colonised MRSA on Haven Ward. Colonisation is different to infection and means that the MRSA is carried in the nose, on the skin and possibly in wounds but is causing no harm and producing no symptoms. Staff had nursed the patient in their room and followed the hospital's infection control procedures and advice from an infection control nurse. This included, deep cleaning of the patient's room, bare below the elbow and barrier nursing. This had been effective and had prevented the MRSA from becoming infectious and spreading.

Each ward was subject to an infection control audit in May 2017. This audited areas including clinical practice, hand hygiene, waste management, environment and policies and procedures. Haven ward scored a total of 87% compliance and Peak view had scored 95%. Each audit had an associated action plan with timescales to remedy shortfalls.

At our focussed inspection of Haven ward in July 2017, we identified safety concerns in the environment which were still present. These included damaged furniture, seating areas with the covering pulled off, graffiti on walls and gauges out of plaster work. One set of airlock doors was a known target of repeat incidents of patients breaking through despite the installation of extra magnets to try to prevent this. Since our focussed inspection in July 2017, there had been a further 19 incidents reported of patients breaking through these doors. A new bespoke door was on order to try to prevent these incidents recurring. There was further refurbishment work scheduled on the ward with completion timescales in the upcoming weeks and months. Some redecoration and painting of the ward had

started the week of our inspection. On Peak View, we did not identify any significant maintenance issues. Staff reported any faults and repairs to the hospital maintenance team and said there was usually a timely response.

Monthly health and safety meetings took place at the hospital. Attendees discussed information about accidents, safety incidents, environmental checks, infection control audits and other relevant areas. There was a current fire risk assessment in place and we saw evidence of regular service records and environmental checks of fire equipment, exits and emergency lighting.

Staff carried mobile personal alarms to request assistance if needed. Throughout our inspection we saw that staff used these to get support from their colleagues, such as to help to manage incidents, and staff responded quickly. A staff member on each ward was allocated as the lead person responsible for security checks on each shift and had a set schedule of security checks they were responsible for.

Safe staffing

At the time of our inspection, Haven ward senior team consisted of a ward manager and three clinical team leaders all of whom were registered nurses. The ward manager had commenced employment in June 2017 so was relatively new in post. Two of the clinical team leaders were permanent staff, and one was contracted agency staff. This was an agency staff member who had a long term contract to work at the hospital. The increase of clinical team leaders from two to three was a recent development following our recent responsive inspection on Haven ward. Hospital management had not yet determined if this was to be a permanent arrangement. Feedback from staff was that this had been a positive change and helped create more stability on the ward.

In addition, the staff team requirement to cover all shifts consisted of 11 registered nurses and 31 support workers. There were vacancies for ten nurses and six support workers within this complement. Five of the vacant nurse posts were filled by contracted agency nurses and the remaining five were filled by bank and ad hoc agency staff. Three of these posts were due to be filled by contracted agency staff in September 2017. The vacant support worker posts were covered by bank and agency as required. Three of these vacancies had been recruited to with staff due to start in the next few weeks.

Peak View senior team consisted of a ward manager and two clinical team leaders who were registered nurses. One of the clinical team leaders was a permanent staff member and one post was vacant. In addition, the staff team requirement to cover all shifts consisted of 11 registered nurses and 22 support workers. There were vacancies for seven nurses and three support workers within this complement. Two of the vacant nurse posts were filled by contracted agency nurses and the remaining five were filled by bank and ad hoc agency staff. The vacant support worker posts were covered by bank and agency as required. Two of the posts had been recruited to with staff due to start in the next few weeks.

Ward managers calculated required daily staffing levels using a matrix which corresponded with the number of patients on the ward. Rotas confirmed there was always a mixture of qualified nurses and support staff on each shift. Where additional resources were required, for example due to increased acuity and for patient escorts, ward managers were able to request additional staff support.

A resource assistant at the hospital co-ordinated staff cover for all wards. Wherever possible the hospital tried to use agency staff who were familiar with the ward. The hospital manager told us there was a more robust system in place than previously to ensure that agencies with a poor history were no longer being used.

Management recognised that recruitment and retention of qualified staff was a main issue affecting the hospital. As a result, the provider had looked at ways to incentivise staff to join and remain working at the service. These included monetary bonuses, targeted recruitment and increased preceptorship placements. Preceptorship is a period of structured transition for newly-qualified nurses.

Nursing and support staff we spoke with across both Haven and Peak View said there were usually enough staff on the wards and they did not feel unsafe. Staff were visible on the wards throughout our inspection. Where incidents occurred, we saw there were enough staff to help respond and manage these incidents whilst supporting the rest of the patients.

Staffing rotas showed a higher usage of agency staff at night. This coincided with what patients told us. Patients had varying experiences of being able to have one to one time with staff. Five said they were able to speak with staff but were not comfortable in approaching agency staff who

may not know them well. One patient said it was difficult to find staff to be able to have a one to one session with. The hospital manager was looking at ways of trying to increase the numbers of substantive staff on nights, such as arranging annual leave in a way which did not leave higher reliance on agency staff at these times.

Each ward had a consultant psychiatrist and a specialty doctor was based on Haven ward and provided cover for Peak View. Both consultant psychiatrists were locums. Medical staff told us turnover of consultants had an impact on patients as it affected continuity of care. It also had an impact on staff practice as different consultants had different ways of doing things. There was concern that providing an appropriate level of medical cover, if both Haven and Peak View were full, could be challenging with the amount of patients. Since our last inspection, the provider had made progress to try to increase stability and had recruited permanent consultant psychiatrists for each ward. Peak View's consultant was scheduled to commence employment in August 2017,and has taken up post since the inspection took place. The consultant for Haven ward was due to take up post in November 2017. The hospital was still attempting to recruit substantively into the other vacant medical roles.

The hospital operated a rota of on call doctor cover for evenings and weekends. A hospital manager was also on call out of hours to provide support and advice to staff where required. A nurse was designated as senior nurse on site and on call requests were escalated via this resource.

There was a range of mandatory training staff had to complete with necessary refresher training as required. Overall staff compliance with mandatory training for Haven Ward was 87% and Peak View was 81%. The training matrix for both wards showed a number of key courses which had compliance rates of less than 75%. These included:

- Haven ward: Risk management training 64%, suicide prevention 60% and information governance 64%
- Peak View: Risk management training 64%, suicide prevention 50%, information governance 35% and infection control 58%.

Without completing and being up to date with necessary training, there was a risk that staff may not be equipped with the necessary skills and knowledge to provide safe and appropriate care.

Assessing and managing risk to patients and staff

There was one seclusion room across the adolescent wards which was situated on Haven Ward. In the six month period prior to this inspection there were 39 episodes of seclusion of Haven Ward patients and three instances of seclusion of Peak View patients.

Restraint data for the same six month period showed Haven ward, the psychiatric intensive care unit, had the highest amount of restraint. In this time, there were 707 episodes of restraint on the ward. Within the same time period, there were 128 periods of restraint on Peak View, the general adolescent ward. The number of restraints on Haven ward, had more than doubled for the same duration prior to our last comprehensive inspection and had decreased on Peak View. Staff on Haven ward attributed the increased use of restraint and seclusion to specific patients on the ward who had complex needs and behaviours which had increased the acuity of the ward and the necessity for restraint interventions.

The provider supplied us with prone restraint data for the six months prior to our inspection. Prone restraint is where a person is held in a front down restraint position. This poses an increased risk for the safety of the individual as it can cause compression of the chest and airways which can result in difficulties in breathing. Haven Ward had 11 episodes of prone restraint and Peak View had one. Staff told us prone restraint was only used as a last resort and always for the shortest amount of time possible. The maximum duration of any prone restraint was recorded as 3 minutes with the remainder being recorded as one minute or less. We spoke with the lead trainer at the hospital for managing actual and physical aggression training. They told us staff were taught prone restraint should be avoided wherever possible and that staff followed this principle.

Staff used a risk assessment known as the Salford tool for assessment of risk to assess individual patient risks. At our responsive inspection on Haven ward in July 2017, we found shortfalls in that risk assessments did not always reflect known risks of the patient. Also, risk information was not readily apparent and confusing due to differing levels of information documented in various care plans. At this inspection we noted improvements in patient records in regards to this. Staff had reviewed the risk assessments so these contained clear information as to the current risks. There was evidence of patient involvement in formulating the assessments. Patients on Peak View had risk

assessments in place. Haven ward had implemented a foldable whiteboard in the nurses office which gave key information such as observation levels and risks for each patient on the ward. This was accessible at a glance information available to all staff working on the ward

Patients on both wards had 'staying safe' care plans which included information about their risks, for example self-harm, self-neglect and aggression. They included steps staff should take to help the patient prevent this behaviour and how to help de-escalate and redirect. There was little information about what staff should do to support patients when their behaviour had already escalated or they were already in a crisis. For example, if restraint may be necessary, how this should be undertaken and how to best support the patient's wishes with such interventions. Three patients told us about their experience of restraint and that it made them feel anxious. There was no information about the use of restraint and their preferences within their care records.

At our focussed inspection of July 2017 on Haven ward, staff worked as two separate groups of staff on alternate shifts. One set of staff worked Monday until Thursday and the other set Friday until Sunday. Some staff told us that at times, information from one shift group, such as the history of a newly admitted patient, was not always handed over to the other. On Peak view the same shift system was in place. Some changes had been implemented to try to address this. For example, some staff worked twilight shifts across both shift groups which helped to improve communication. Management had required that substantive staff members work across both days and nights to try to eliminate the practice of alternate shifts groups.

The wards operated blanket restrictions. On Peak View ward, patients were allowed to use their mobile, under staff supervision for a designated amount of time. Patients on Haven ward were not able to have mobile phones. There were no risk assessments in patient records in relation to this. The hospital policy on access to mobile phones said it would be unlikely that blanket mobile phone bans would be in place anywhere except for medium security settings.. At the time of our inspection, work was on-going on Haven ward to look at enabling patient access to mobile phones.

At our inspection of July 2016, patients on both wards were required to open their post in front of staff without any rationale. Since then, the hospital had developed a protocol for opening post which was issued to staff in April 2017. This included the right of patients to open their post unsupervised unless individual risk warranted otherwise. Community meeting minutes included patient discussions about the protocol. Patients told us they could open their mail in private.

There were differences in staff understanding of what constituted restrictive practices. The hospital had recently introduced a role of reducing restrictive practices lead to try to reduce restrictive practices across the hospital and improve consistency of staff knowledge. We spoke with the lead who was supported by the restrictive practice lead at provider level for the North, They very committed to developing their role. They told us about initiatives and further bespoke training they were hoping to undertake in this area. The hospital provided least restrictive training to staff.

On Haven ward, all patients were detained under the provisions of the Mental Health Act. Peak View included a mix of detained and informal patients. Informal patients could have their own fob to access and leave the ward. Staff asked that informal patients make them aware when they wished to leave so staff could assess risks as part of their duty of care.

At our focussed inspection on Haven ward in July 2017, we identified concerns with the implementation of the observation policy. Since then, the provider had made improvements. Management had changed the practice of allocating observations to staff members already undertaking other roles such as response or security. Staff had designed a new observation chart and these were now signed off by the nurse in charge in accordance with policy. None of these changes had been implemented on Peak View although they had the same practices that we had identified concerns with on Haven ward. Senior management told us this was because they wanted to trial and evaluate the new changes prior to implementing them across all wards.

Staff said verbal de-escalation and non contact interventions would always be used prior to restraint. Information in records such as incident reports and daily notes supported this. All staff undertook training in managing actual and potential physical aggression. This consisted of a one day session for non-clinical staff and a four day course for ward based staff. All staff had to have annual refresher training. At the time of our inspection 92%

of on Haven ward had completed their required training and 85% of staff on Peak View. Where individual staff were not up to date with their training, they were not expected to be involved in restraint of patients.

The hospital had a policy for the monitoring of patients following rapid tranquilisation, which was in accordance with national guidance. At our comprehensive inspection of June 2016, we found staff did not consistently complete monitoring of patient's physical health after rapid tranquilisation in line with best practice guidance. At this inspection, on review of records we found observations had been carried out and recorded as set out in the policy.

At our comprehensive inspection of June 2016, seclusion records showed instances of staff keeping patients in seclusion even when they presented as calm. Staff had recorded inappropriate objectives that patients should reflect on their behaviours in order to end seclusion. At this inspection we reviewed 16 seclusion records. There was appropriate rationale for the initiation of seclusion. However, we still found inappropriate reasons documented as part of the objectives to end seclusion. Three records included terminology that the patient should be 'remorseful' or 'reflect on their behaviour' alongside the need for appropriate goals such as reduction in aggression and violence. The Mental Health Act code of practice states that seclusion should not be used as a punishment. The inclusion of this wording indicated that staff were not undertaking a person centred approach when care planning patient goals to end seclusion. However we did not see evidence of patients being kept in seclusion solely for these reasons.

The hospital's quality assurance manager undertook an internal review of the service in March 2017. The review identified other instances than the ones we saw, where staff stated patients in seclusion needed to show remorse of reflect on behaviour. This suggested the findings from the review had not impacted upon staff practice and still needed to be embedded. The quality assurance manager was in the process of reviewing and updating the seclusion and long term segregation policy and associated documentation. We saw a power point presentation that patients and ward staff had helped compile to contribute their views about seclusion.

At our focussed inspection of Haven Ward in July 2017, we found a number of shortfalls with safeguarding procedures. These included a patient without a care plan for a current safeguarding concern and incidents that had not been identified and reported as safeguarding concerns. Several staff were unclear how to report safeguarding concerns outside of the hospital.

At this inspection, the provider had taken action to improve this. Care plans were present for patients with safeguarding concerns. For example, one patient felt they were being picked on by another patient and had a care plan about the support they required for this. Each ward had posters and flow charts on display about who to contact for safeguarding concerns. These included details of external agencies such as the police and local authority. Staff identity badges included Cygnet safeguarding contact details and Care Quality Commission contact information.

The hospital had three named safeguarding leads and three safeguarding co-ordinators. There were two designated safeguarding link staff on each ward. We saw minutes of monthly 'safeguarding training and development meeting minutes'. These included discussions about any safeguarding incidents throughout the hospital so practice could be shared. We saw contact and communication with local authorities in relation to individual safeguarding matters.

Staff undertook regular safeguarding training. On Haven ward, 96% of staff were compliant with safeguarding children training and 92% with safeguarding adults. Peak View ward had 96% of staff trained in both safeguarding children and adults. Staff we spoke with told us they knew how to report any issues.

We checked the arrangements for the safe management of medicines. We reviewed six patient records and spoke with nursing staff responsible for medicines. Medicines were supplied by a pharmacy contractor under a service level agreement. We checked medicines stored in the clinic rooms and medicine refrigerators and found they were stored securely with access restricted to authorised staff. Staff recorded medicines fridge temperatures daily in accordance with national guidance. However, on Peak View staff had not recorded temperatures on three days in July and three days in August 2017. In addition, staff had recorded temperatures which were outside the recommended range on seven occasions in June 2017 and had not recorded any remedial action taken. On Haven

ward, staff had not recorded temperatures on seven days in June 2017. Staff had recorded temperatures which were outside the recommended range on eight occasions in July 2017 and had not recorded any action taken.

Controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse) were stored, managed, and recorded appropriately. We saw evidence of routine balance checks of controlled drugs.

The hospital had a clinical pharmacist who was employed by the pharmacy contractor. The pharmacist visited once weekly and performed a clinical check of all prescription charts. The pharmacist did not routinely attend multidisciplinary meetings or ward rounds due to time constraints. Pharmacist interventions were recorded on an electronic system which could be used to communicate with doctors and provided an audit trail of actions taken

At our comprehensive inspection in June 2016, we observed staff administer medicines to patients via a hatch. This had the potential to compromise privacy where patients may want to discuss their medication and there was no safeguard to ensure patients had taken it. At this inspection we found the service had taken action to improve this arrangement. The size and placement of the clinic rooms meant there were limitations on what structural work could be done to the room. As an alternative staff had put tape on the floor outside of the hatch with foot prints to designate an area solely for the patient receiving their medicines. Patients adhered to this arrangement and were respectful of the designated area. Posters advised patients to ask a staff member if they wanted to speak privately. A second staff member was required to be near the patient to ensure they took their medicines. Managers had undertaken random spot checks of this process across the wards to ensure staff adhered to this.

Track record on safety

The hospital had a policy which included serious incidents and the process for how staff should manage these. This involved the completion of a 24 and 72 hour report of events leading up to the incident. Staff also used root cause analysis in order to investigate and learn from incidents. The findings from these were fed into relevant action plans.

Managers discussed serious incidents as part of their monthly governance meetings. These looked at the numbers of serious incidents for each ward and any learning from these.

We saw evidence of learning following a serious incident which occurred on Haven Ward in June 2017 and was subject of an external review at the time of our inspection. It was also subject to further investigation by the Care Quality Commission. Changes in practice at the hospital following this incident included review and amendments to the observation policy, further training for staff and improvements to systems and documentations.

Reporting incidents and learning from when things go wrong

Staff reported incidents via an electronic reporting system. Staff we spoke with were confident about reporting incidents. At our focussed inspection of Haven ward in July 2017 we found staff had not reported some incidents documented within patient notes on the incident reporting system. Staff undertook monthly triangulation audits; one area within these was to check that incidents documented in patient notes were reported on the incident reporting system.

We observed staff discuss incidents as part of handover, multidisciplinary meetings, care programme approach and professionals meetings. Staff said they received feedback and learning about incidents via email, communication books, reflective practice groups and team meetings. Managers undertook regular checks of incidents reported by staff. They discussed incidents as part of monthly governance meetings and said they shared key learning within their own teams. Staff team meeting minutes we saw did not include any discussion of incidents.

The hospital had a duty of candour policy and staff understood about the need to be open and transparent when mistakes were made. We saw examples of where responses to complaints and contact with patients had acknowledged where staff had made mistakes and given explanations about what had happened.

At our last inspection of Haven ward in July 2017, several parents of patients raised concerns about staff not informing them about incidents. Since then, staff had compiled communication plans with patients which included when and in what circumstances patients agreed to parents or carers being informed about incidents.

Requires improvement

Child and adolescent mental health wards

Debrief following incidents did not routinely take place and records did not show these were consistently offered. Two patients told us staff had offered to discuss incidents with them and others said this was not something that always took place. Staff had opportunity for debriefs and incident discussion in weekly reflective practice sessions. Debriefs were part of the monthly governance meeting agenda. This included reviewing numbers of incidents and numbers of associated staff and patient debriefs. Minutes showed there were a number of incidents documented each month with no debriefs recorded. The latest minutes stated there was a need to review these further on an individual basis.

Are child and adolescent mental health wards effective?

(for example, treatment is effective)

Requires improvement

Assessment of needs and planning of care

We reviewed eight patients' care and treatment records. These included an assessment of the patient's needs upon admission. The provider had a set number of standard care plans available for staff to complete. These were not always completed in all patient records. It was unclear in what circumstances these were required or not. For example, not all patients' records included care plans for staying healthy, life skills and relationships and educational needs but these were present in others. As a result, care records did not always reflect and provide a holistic view of patients' needs. We saw examples of good detailed personalised information within individual care plans which provided information about the patient and their needs.

There was conflicting information present in one patient's staying healthy care plan with regard to the frequency of their physical observations and it was unclear what monitoring the patient required. The same patient also had a specific dietary need mentioned in their referral information but there was no reference to this in their care plans.

We spoke with members of the psychology and occupational therapy team who told us about their involvement with patients. Entries in patient's electronic records also evidenced their involvement However, care records did not include clear information about what therapeutic objectives patients were working towards.

Patients were required to have a physical health screen completed within 24 hours of admission to the hospital. Records showed physical health documentation and assessments were present but some sections were incomplete in three of the records. There was no reason recorded to show why the information had not been completed. Staff undertook on-going monitoring of patients physical observations. A GP attended the hospital on a weekly basis and staff could make referrals where required. Patients at the hospital were registered with the local GP practice as temporary patients.

There was no single complete contemporaneous record for each patient. The hospital used both electronic and paper based systems to record and store patient information as was the situation at our last comprehensive inspection. The provider had introduced extra audits to help ensure staff updated records appropriately. As there were several places where information was kept, this made some information difficult to locate as well as taking extra time to find. It was also not apparent that some interventions were being undertaken. For example, from initial review of patient records it appeared as though staff did not monitor patient's physical health. On further investigation we saw checks were taking place but some information to demonstrate this was happening was held separately by the physical health team using their own system.

Long term and permanent staff knew where to locate information but not all staff, such as agency workers, were familiar with, or had access to, all locations where information was stored. Some records such as multidisciplinary meeting records and care plans were also stored on a local computer drive that required a hospital log on. Hard copy care files contained a lot of paperwork and included out of date records, such as old leave forms, which also had the potential to cause confusion about what information was current.

We found the care plans of one patient located in a different patient's care records and informed a staff member about this. This had the potential for the patient to receive inappropriate care as well as creating a risk of a breach of confidentiality.

Requires improvement

Child and adolescent mental health wards

Best practice in treatment and care

Physical health monitoring was carried out in accordance with national guidance for patients prescribed antipsychotic medicines. The hospital had a physical health team comprising of a lead nurse and two support workers. The team managed blood tests and observations which are regularly required for patients taking antipsychotic medicines. The physical health policy stated patients should be screened for medication side effects using the Glasgow Antipsychotic Scoring System (GASS) tool. We found this tool was not used routinely to monitor patients for side effects arising from their treatment. Where frequent side effects were identified, we found staff had not always reviewed patient's treatment

The hospital used the Modified Early Warning Score (MEWS) which allowed for the regular monitoring and recording of patients' blood pressure, pulse, temperature, conscious state and respiratory rate. This tool is not designed for use in children and this was also reflected in the hospital policy which did not provide any alternative to use. This meant that observations that staff obtained, may not be accurate which could lead to patients receiving inappropriate treatment and healthcare.

The hospital offered psychological therapies recognised by the National Institute for Health and Care Excellence. This included dialectical behavioural therapy and cognitive behavioural therapy.

We observed a psychology group take place on Peak View. The session lasted for 15 minutes out of a scheduled 45 minutes as it took over 30 minutes to motivate the patients to attend. Once the group was underway a task was set but there was limited engagement from patients. The manager said the group was not as motivated as usual.

We spoke with a member of the psychology team who told us that there were differing levels of value attributed to psychology between the wards. There was no process in place for the team to undertake formulation and complex case discussions of patients. There were difficulties on adolescent wards, particularly Haven, when patients were subject to delayed discharges. This could make it problematic in relation to focus on longer term work and goals. As length of stay was longer on adult wards, this allowed for more collaborative consistent working. The psychology department had recently increased staffing levels however this included the use of two locums

Patients had access to education provision delivered by a teaching department located at the hospital. The staff group included head teacher, teachers, teaching assistant and education officers. Within the education area there were classrooms, computer room and rooms for occupational therapy and psychology. Education officers attended care program approach meetings and ward round meetings. The head teacher said there was good information sharing and communication with the wards. Education staff could contribute to care plans. The school had recently been inspected by the office for standards in education (OFSTED) and subsequent to our inspection was rated as good with some areas rated as outstanding.

Staff used a recognised scale known as the Health of the Nation Outcome Scale which is designed to measure the health and social functioning of people with severe mental illness. These were present in patient records but we did not see evidence staff reviewed these in order to measure specific outcomes.

At our last inspection of June 2016, there were a limited amount of clinical audits that took place. It was previously the responsibility of the quality and compliance manager to complete the majority of audits at the hospital. The hospital manager had diversified this to include other staff within the audit process and to make it part of everybody's role. Since our last inspection there was a more comprehensive audit program with a number of further audits scheduled until March 2019. Recurring audits included monthly CCTV audits to observe adherence of patient observations, Mental Health Act audits, clinic room audits, triangulation record audits, seclusion and long term segregation documentation audits among others. Staff undertook focussed audits in order to identify trends and areas for improvement. For example, the occupational therapy team had undertaken an audit in August 2017 to review the differences between uptake of activities across the wards.

Skilled staff to deliver care

The hospital employed a variety of mental health disciplines to provide care and treatment to patients. These included: consultant psychiatrists, psychologists, occupational therapists, social workers, physical health nurse, mental health and learning disability nurses and

support workers. A pharmacist visited the hospital weekly which was a further resource available to staff and patients. Qualified teachers and teaching assistants were in post to facilitate education provision.

The majority of staff we spoke with on the child and adolescent wards told us they received regular supervisions and annual appraisals. Some said that the regularity had only recently become consistent as previously there were long gaps with little or no supervision and appraisals not being undertaken. At the time of our inspection, 84% of Peak View staff and 91% percent of Haven staff had received regular supervisions. Records also showed that 85% of staff on Peak View and 76% of staff on Haven ward had received an appraisal. Staff said they felt supported in their roles and could go to their managers for support.

New staff members completed an induction period prior to commencing work on the wards. The induction program consisted of a variety of mandatory training. New staff were able to complete specialist child and adolescent mental health training. Staff told us they received training to help carry out their roles and could approach their manager to discuss additional training if required.

Some members of staff were self-funding further education and told us the hospital had been accommodating in allowing them time off to study. The hospital was looking at reviewing training needs across the service to ensure these reflected clinical need but this had not yet started. Three staff commented they would find behaviour therapy training for ward staff beneficial to help them engage better with patients.

Managers were able to address staff performance issues via the supervision and appraisal process.

Multi-disciplinary and inter-agency team work

Multidisciplinary ward round meetings took place weekly on each ward with each patient being reviewed on a two weekly cycle. We observed part of the ward rounds on each ward. These were attended by a variety of professionals from the hospital including psychiatrists, psychologist, social worker, nurses, support workers and administration staff. Discussions were documented and were patient centred with everyone present able to contribute. The team discussed each patient's risks and care plans and demonstrated good knowledge of patients. Patients were not present throughout the meeting; they attended following the discussions and the team gave feedback to them individually.

The ward manager on Haven ward had arranged regular meetings to take place between different staff groups on the ward which we saw minutes of. These included a wide range of issues that staff discussed including changes to working practices and expectations. The minutes were made available to staff. We observed a meeting between the senior team on Haven ward which included the ward manager, deputy manager, qualified staff and a senior support worker. Staff discussed issues and put forward solutions to these. Everyone was included in the meeting. One item discussed was allocation of lead roles. The staff identified individual strengths within the team to see who would be most suitable for each task. Peak View staff met monthly however the manager said the staff team had not had a meeting for some weeks since they had returned from temporary management of Haven ward.

Communication between wards was primarily via integrated governance meeting minutes which the ward managers attended. Some staff told us they were not always aware of what was happening in other areas of the hospital outside of where they worked. One example was staff on Peak View not being involved in, or aware of, the changes to working practices on Haven.

Professionals of all disciplines spoke about positive communication and working relationships with both internal colleagues and teams outside of the organisations. This included organisations such as the local authority, local education department and a range of community services. Some allied health professionals within the hospital said they would like to be able to spend more time on the wards and felt this would help improve patient and team relationships further.

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

At our comprehensive inspection of July 2016, on Haven ward we found one patient had been treated under the Mental Health Act without their consent or authorisation by a second opinion appointed doctor. We found further shortfalls in two other records where staff had not followed correct procedures for giving medication in accordance with the Act. These were rectified at the time of the

inspection. At this inspection, the consent to treatment documentation we reviewed showed medicines were prescribed in accordance with the provisions of the Mental Health Act. We reviewed Mental Health Act documentation in patient records and found this to be in order.

Two Mental Health Act administrators worked at the hospital; one for the child and adolescent wards and one for the adult wards. Each could support and provide cover for the other where required. The administrators told us that changes of responsible clinicians, especially on the adolescent wards, could pose challenges with regard continuity of information but there was good communication with the current doctors. Ward managers and staff could contact the administrators for advice and guidance about the Mental Health Act. The provider had a Mental Health Act administrator lead who the administrators could contact for their own support and guidance.

At our comprehensive inspection of June 2016, we found arrangements to monitor adherence of the Mental Health Act were not always effective as audits did not always identify shortfalls . We reviewed the arrangements were in place at this inspection and saw the administrators undertook a number of audits of Mental Health Act documentation. This included audits of drug cards, section 132 rights, section 17 leave forms, tribunal and discharge paperwork amongst other areas. They then sent a weekly report to each ward of their findings which ward staff were expected to address. Administrators followed their part of the process, but there were still instances of ward staff not acting on actions. For example, the reports highlighted the need to ensure expired section 17 leave forms were removed from the nursing files. In the care records we looked at on both Peak View and Haven, the records we looked at still included old section 17 leave forms. Audits on Haven ward from earlier in the year showed repeat instances of missing documentation.

Staff regularly informed detained and informal patients of their rights as required under section 132 and section 131 of the Mental Health Act respectively. Care records showed this occurred on a monthly basis. This had improved since our last comprehensive inspection when records showed long periods of time between this occurring.

Mental Health Act and code of practice training was mandatory training for staff. The administrators provided this training to new staff and annual refresher training to existing staff. Eighty four percent of staff on Haven ward and 88% of staff on Peak View had completed this. Staff we spoke with had a good understanding of the Act and resources such as the code of practice were available. Staff told us they could contact the Mental Health Act administrators for further support if necessary.

Independent Mental Health Advocacy services were available to patients. They were contracted with the hospital to provide a set amount of input each week. There were two advocates who attended the wards, one for males and one for females. Patients we spoke with knew about the advocacy services could access this if they wanted to.

Good practice in applying the Mental Capacity Act

The Mental Capacity Act 2005 is legislation which supports people to make their own decisions wherever possible; and provides a process for decision making where people may be unable to make decisions for themselves. The Mental Capacity Act applies to individuals aged 16 and over. Decision making competency for young people aged under 16 is established under the rules of Gillick Competence. This is used to determine an individuals' ability to consent to his or her own medical treatment, without the need for parental permission or knowledge. No patients were subject to any Deprivation of Liberty safeguard authorisations. These safeguards apply to individuals aged 18 or over.

Staff undertook Mental Capacity Act training as part of their induction and as part of Mental Health Act training. Training in the Mental Capacity Act and Deprivation of liberty safeguards had become mandatory stand alone training requirement for staff since our last inspection. However, only 4% of staff on Haven ward and no staff on Peak View had completed this.

Staff we spoke with had variable knowledge about the Mental Capacity Act and some felt more confident than others about application of the principles. All staff said they would speak to colleagues or their managers if they had any concerns about a person's capacity to consent to something. Staff were aware of resources they could access for further guidance.

Requires improvement

Child and adolescent mental health wards

The hospital had policies and protocols in place to provide guidance to staff for assessing capacity. These included guidance for application of the Mental Capacity Act and capacity, competence and consent policy for children and young people under 18.

There was evidence of staff assessing patients' capacity in relation to specific decisions, including consent to treatment, and patients signing to agree their consent. Assessments related to the principles of Gillick competency, Mental Capacity Act and the associated code of practice. These were present in care records we looked at, however, records were not always consistently completed. One patient's care records included records of capacity for specific decisions such as consent to treatment and input into their treatment plan. The assessing professional had assessed the patient as having capacity. However, the forms did not always include information about the patient's wishes which was an area of the form to be completed and some sections were not fully answered. We saw assessments not fully completed in other records

Care records included evidence of signed consent from patients for decisions such as sharing information with other parties and allowing the hospital to use their photos on records. We saw instances where patients had not given consent and staff respected this.

We saw a good example of a nurse undertaking a capacity assessment for a specific decision in relation to one person. The assessment was comprehensive and showed involvement of the patient and consideration of all principles of the Act.

Capacity assessments for consent to treatment were monitored as part of the monthly Mental Health Act audits that administrators completed.

Are child and adolescent mental health wards caring?

Requires improvement

Kindness, dignity, respect and support

We observed positive and appropriate interactions between staff and patients. When staff spoke with patients, they were kind and respectful. For example, one patient was sat on the floor upset and a staff member sat down next to them to engage them and talk about how they were feeling. The manager of one ward was dancing with a group of patients who were laughing and enjoying the interaction.

Feedback from patients about staff was mixed. Four patients said they did not always feel comfortable when agency staff were on the wards as the staff did not know them or their needs. This had deterred some patients in seeking them out for support. One patient felt staff were not always respectful but did not give examples of why not. Another felt that certain nurses 'picked' on them and did not listen. However, patients also described staff as being supportive and helpful. Three gave information about individual staff members they would go to for support.

Two parents felt staff were not caring and did not always treat the patients with respect. One said staff had not supported their child to maintain a good level of personal hygiene. Three parents spoke positively about staff. One mentioned a number of different professionals on the ward and said they were great. Another gave an example of staff working hard to ensure their child could have a period of leave at a certain time.

Staff we spoke with were knowledgeable about patients and were able to describe their individual needs. They could talk about patient's backgrounds, likes and dislikes and their preferences.

The involvement of people in the care they receive

There was a variance of patient experience when they were first admitted to the wards. One patient and one parent told us they were not given any information about the ward prior to admission. One parent said their child had received paperwork although they themselves had not. One patient said they had been given some information but did not know fully what to expect. Staff told us they did explain information to patients on admission but sometimes this did not take place straightaway if they were too unwell. At the time of our inspection, the service was working on compiling a new welcome pack. The ward managers for Haven and Peak View each said that patients were contributing to the provision of ward specific information designed to form part of the welcome pack.

Patients had differing experiences as to their involvement and participation in care planning. Three told us they had been involved in compiling their care plans with staff and were therefore knowledgeable about them. One of these

patients said their care planning process had been really inclusive and their named nurse had fully involved them in the process. Other patients did not report involvement with two saying they had not participated in their care plans. One patient told us they could have a copy of their care plan and three others said they were not offered this. Care records included information about patients being offered a copy of their care plans and signatures to confirm whether the patient wanted this. These were not always signed in all cases.

Patients did not attend for the entirety of their multidisciplinary ward round meetings. Instead, they had the opportunity beforehand to complete 'my say' forms to raise any issues which staff read out on their behalf and were then invited in at the end of the meeting to get feedback on the outcomes. This meant that as patients were not present during the actual discussions, they may lack understanding as to how decisions had been reached about their care and their rationale for these. Staff contacted family members, where the patient consented, following the meetings to provide feedback. Two parents told us they had not recently received phone calls from staff following ward round meetings and did not know why this was the case.

Patients had access to advocacy support. There were two advocates, one for males and one for females, who attended the wards. We spoke with one of the advocates during our visit who told us they visited weekly and introduced themselves to new patients. The advocate told us about patient concerns they passed on to staff but did not always feel these were handled appropriately. In part, they felt this was due to poor communication and that some staff were not receptive to their input. The advocate also wrote a quarterly report but told us they did not always get feedback from these. At the time of our inspection, a meeting had been scheduled between hospital managers and the advocacy managers to try to address some of the concerns.

Parents and carers gave feedback about their level of involvement in their relative's care. Four highlighted communication as a problem as they found it to lacking or inconsistent. Some felt staff did not keep them suitably updated such as not getting updates after ward rounds. One said staff had not consulted them about a new placement for their child in one case. One parent told us communication had improved over the previous weeks and they received regular updates from staff. Two parents gave feedback about when patients returned to the hospital following periods of leave. One said staff always asked them for feedback on these occasions and the other said staff never asked them and they did not feel their views were valued.

Parents and carers were able to attend multidisciplinary meetings and care programme approach meetings. Two parents told us about care programme approach meetings they had attended in the past but said they had received no information beforehand to prepare them for the meeting and what was to be discussed.

We observed a care programme approach meeting with consent of the patient and their parent present. This was attended by a variety of multidisciplinary professionals from the hospital and an external community support worker. The meeting was well structured and led by the psychiatrist. They regularly checked the patient's understanding and whether they had any concerns with what was being discussed. All attendees were involved and contributed to the meeting. The patient and their parent had opportunity to ask questions and relevant professionals present clearly answered these. Dates for the next meeting were arranged and scheduled around the parent's commitments so they could attend.

Since our last inspection, we saw patients on Haven Ward now had specific communication plans in place. They provided details about what information patients consented to share with their parents and/or carers, such as feedback from ward rounds and notifying parents about incidents. We saw these had been compiled with the involvement of patients.

Each ward had weekly community meetings for patients to attend. These covered a variety of areas relating to the service where patients' were able to give their feedback, raise concerns and discuss issues relevant to them. We saw examples of the hospital seeking patient feedback and inclusion in service level decisions. For example, community meeting minutes showed patient were asked for ideas and suggestions about the refurbishment plans on Haven ward. Patients had been involved in the review of the seclusion and long term segregation policy which was taking place.

Requires improvement

Child and adolescent mental health wards

Are child and adolescent mental health wards responsive to people's needs? (for example, to feedback?)

Requires improvement

Access and discharge

At the time of our inspection, Haven ward had a low occupancy rate as there were only four patients on the ward. The provider had voluntarily suspended admissions following our focussed inspection of the ward in July 2017 where we had identified concerns.

NHS England commissioned beds from the hospital and made referrals to the service. Admission was determined by patient need and patients could come from anywhere in the country if no resources were available in their own geographical area. The hospital did not accept admissions into beds where patients were on leave from the hospital.

Ward managers reviewed referral information and liaised with referrers to obtain further information where required. Ward managers had the authority to accept or reject referrals. They told us they would not accept referrals they felt were unsuitable, did not meet the criteria for the service or may have a detrimental impact on the current patient group.

Managers said where patients were identified as requiring more appropriate placements then this would be actioned. For example, two patients on Peak View had originally been assessed as requiring an acute placement at referral stage. However, due to some of their presentation, the ward manager felt they would be more suitable for a more intensive environment. The manager told us they were making referrals for the patients to be cared for in a more appropriate service. The multidisciplinary team and other relevant parties such as NHS England were involved in such discussions and decisions.

At the time of our inspection, there were four reported delayed discharges of patients on Haven ward. The hospital kept a monthly record of all discharge information. The predominant reason for delays was mainly waits for appropriate placements for patients to move onto which was outside of the hospital's control.

The adolescent ward managers and medical team met weekly with NHS England commissioners to hold a referral, admissions and discharge meeting. The aim of this was to try to improve the access and discharge of patients through the service. We observed one of these meetings and found there was good information sharing between the attendees and a clear structure to the meeting. Discussions took place about bed status and availability nationally. Attendees talked about each patient's individual needs. For example, there was a discussion as to whether a recently admitted patient was an appropriate placement taking into account some behaviours they had since presented with. A plan of action was agreed to hold a professionals meetings about the patient. There was clinical discussion and challenge from attendees and talk of involving other parties such as the local authority and community child and adolescent mental health teams where necessary.

The facilities promote recovery, comfort, dignity and confidentiality

There were various rooms and equipment available within the hospital. The hospital had a physical examination room on site which could be used when GPs visited patients. However, this room was also used as a search room at times which meant there was potential that patients would have to wait to be searched if the room was already in use. There were rooms to undertake individual and group therapy sessions and laundry rooms which patients could use. An extra care area was available for patients on Haven ward. Staff told us this was an area patients could access with their support to help them 'destimulate' if they were over stimulated. There were rooms within the hospital and wards for visitors. Redesign of Haven ward was taking place to make the environment more suitable for the patient group.

Visitor's rooms for visitors of Haven ward patients were located off the ward. Visitors of patients on Peak View were able to go on to the ward when appropriate but young people under 16 were not allowed on the ward. Patients were able to use ward telephones to make phone calls and phone booths were available for patients to make calls in private.

There was an outside space on Haven ward where patients could spend time. The area was not on ground level and was not very spacious and enclosed with wooden panels

and mesh. Peak View had an outside yard area where patients could spend time. If patients were entitled to unescorted leave they could leave the wards and access the hospital grounds.

Patients on Haven ward did not have access to refreshments at all times. There were no snacks or drinks available on display and they had to ask staff in order to get such refreshments. Patients on Peak View did have access to food and drinks. Following our inspection, the manager confirmed that a drinks dispenser was to be installed on Haven ward as part of the refurbishment project.

All patient bedrooms were ensuite. At our comprehensive inspection in June 2016, we found bedrooms did not have doors to the ensuite bathroom. Staff at that time told us that these had been removed to reduce the risk of patients using the doors as an anchor point for ligatures. Peak View had replaced the ensuite doors with a curtain. The patients on Haven ward had no alternative in place of the door which did not afford patients appropriate privacy. At this inspection, we saw bedrooms on Haven ward now had curtains up at the ensuite to afford more privacy. The hospital manager told us about, and we saw plans, of specially designed anti-ligature doors that the hospital hoped to install in ensuites longer term. However, at the time of our inspection, there had been no definitive decision and there were no timescales as to when this may take place.

At the same inspection in 2016 we also found that when staff undertook enhanced observations of patients, patients of the opposite gender could see into their bedrooms when walking along the corridors. As a result, the service had devised a protocol for movement of patients through corridors on the ward. This was designed to help maximise privacy in these circumstances. During our observations, we did not see evidence of any person's privacy being compromised in this manner.

Patients could personalise their rooms with their own belongings. Each patient had a restricted cupboard in their room where their own personal restricted items could be stored. This was accessed by staff who determined what items patients could have from their cupboard dependent upon their level of risk.

Each ward had dedicated occupational therapy input. Occupational therapists and assistants worked on a rota basis to cover weekends We spoke with the head of the occupational therapy department who gave us an overview of the therapies in place for patients. They told us about a 12 week rolling program that had been implemented since January 2017 and had received good feedback. A Monday morning group took place to look at different areas such as goal setting, self esteem, anger management amongst other areas. There was a scheme called recovery through activity which was mixture of theory and practical activities and had been adapted to suit the child and adolescent wards. Activities were designed to be a mixture of ward and community activities.

Patients did not have individualised therapy and activity plans in place. Ward activities were part of a set schedule and patients had the opportunity to participate if they chose to. Activities available included cooking, relaxation, games, baking and animal visits. The hospital had a rabbit located on the grounds which patients could visit. There were also visits from a local service that brought animals on to the wards which patients could interact with. Social outings took place and visits to facilities such as a local wildlife park. Therapeutic programme and vocational activity was a set agenda item within patient community meetings and patients were encouraged to give their views.

During our inspection, we did not observe many activities taking place on the wards. Patients had mixed views about what was on offer. Some patients reported being bored with little to do, especially at weekends, and felt staff were not proactive in facilitating things for them to do. One said a set timetable meant the days were always predictable Another patient said staff did try to promote activities but that constantly changing staff sometimes had an impact upon this happening. The result of a recent occupational therapy audit had identified some actions to try to increase patient uptake. Some staff said an increase in therapy assistants would allow for more individual activities.

Meeting the needs of all people who use the service

The hospital was accessible for people with physical disabilities and who required disabled access. Lifts were present which facilitated access to all wards.

Information leaflets about the hospital and other services were available on display for patients and carers. Alternative formats and languages were available upon

request as required. Information about advocacy was displayed on the wards. We saw that information about how to complain was not displayed on the child and adolescent wards.

Staff had access to interpreters where required to support patients and their families and carers where English was not their first language.

Patients had a choice of foods and the chef told us they were able to provide food to meet any specialist diets or dietary requirements. Staff informed the chef if patients had any dietary needs to ensure their needs were accommodated. The kitchen had been rated the highest five star rating by the food standards agency in March 2017.

A multi-faith room was available in the hospital off the wards which patients could access.

Listening to and learning from concerns and complaints

The general manager was responsible for logging and monitoring records of complaints and ensuring these met necessary timescales. At the time of our inspection there were four open complaints across the hospital under investigation which we saw logged on the inspection tracker.

There was no information on display on the wards advising patients of how to complain and no information to advise detained patients of their right to complain to the Care Quality Commission. Staff told us patients could alert a staff member if they had any complaints and they would provide a form if necessary. However, this may have deterred some patients from raising complaints if they did not feel comfortable approaching a staff member directly and talking about their concern.

Complaints were a regular topic of discussions in patient community meetings as shown in the minutes. Patients we spoke with had mixed experiences when asked about their understanding of complaints. Most were aware of how to make complaints but reported differing satisfaction levels. For example, one patient told us they regularly wrote complaints and sometimes sought assistance from the advocate to do so. Another patient said they made complaints but did not feel listened to by staff in relation to these. One patient said they were unsure about what was involved in the process. Two parents we spoke with told us they were not aware of the complaints procedure at the hospital. Two others told us about previous complaints they had made.

Complaints were not always managed in accordance with policy and to ensure complainants rights were promoted. We looked at the complaint investigation documentation of eight recent complaints at the hospital. The complaint investigation outcome letters provided information about any actions the hospital had implemented as a result of the complaint; and an apology where it was acknowledged the hospital was at fault.

However, in six out of the eight letters, there was no information about the complainant's right to appeal, either higher up in the organisation or to the ombudsman if they were not satisfied with the outcome. The hospital's complaint policy stated,' Cygnet complainants in NHS funded services are entitled to refer their complaint to the Health or Local Government Ombudsman'. The hospital manager also confirmed that outcome letters should include reference about the complainant's right to appeal. Without such information present, complainants may not have been aware of their entitlements for further review of their complaints.

Details of complaints were included in each monthly ward data pack that were circulated to ward managers. Integrated governance meeting minutes showed they were also discussed within this forum, highlighting any noticeable themes and trends. Ward level staff meeting minutes did not show any on-going discussion between staff about complaints or any learning which had taken place as a result of these.

Are child and adolescent mental health wards well-led?

Requires improvement

Vision and values

Cygnet Hospital had a set of organisational values staff were expected to work in accordance with. These were: helpful, responsible, respectful honest and empathetic. Staff we spoke with were aware of the organisations values and these were displayed around the hospital.

All staff we spoke with knew who the senior managers were. However not all staff had yet met them and some said they had not seen them on the wards. The new incoming hospital manager was not yet in post at the time of our inspection.

Good governance

The current training figures showed a number of courses where staff were not up to date with their mandatory training. The hospital had recently changed the system for recording staff training which had previously been outsourced to an external company. This now took place in house and had been implemented so the hospital could better identify when and what staff training was due.

Each ward had systems in place to monitor staff supervision and appraisals information.

There was a system in operation to ensure that wards had sufficient numbers of staff and to identify where extra resources were required. Managers reported that this worked well. A resource assistant had oversight for sourcing additional staff where these were required and was the main link with the staffing agencies the hospital used.

We reviewed the personnel files of four staff members who had recently commenced employment. These included information such as job descriptions, fitness for employment, interview notes including reasons for any gaps in employment, and employment references. Each person had been subject to a Disclosure and Barring check. The Disclosure and Barring Service helps employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable groups, including children. In two of the files, employment references had been received from the referees' personal email addresses with no evidence of verification of the referee's professional capacity. Two references had no dates to confirm when the referee had known or employed the person. We identified no evidence that the information was not legitimate but without robust pre-employment checks, there was a risk the provider may be susceptible to recruiting unsuitable staff.

Integrated governance meetings took place each month. One senior manager told us that these were now better attended than previously. These covered a wide range of areas which included complaints, safeguarding, incidents, restraints, seclusion, rapid tranquilisation, audit feedback, corporate lessons learned amongst other areas. The managers also reviewed training and supervision data within the meetings.

The hospital had introduced monthly data packs. These compiled performance reports for each ward which were circulated to each manager for comment. These covered the same areas as were discussed in the governance meetings. Each data pack had an action plan to address any necessary actions which were to be followed up in the next governance meetings.

There were a number of audits which took place at the hospital. There was a schedule of further audits planned up until March 2019. More staff now took responsibility for audits than was previously the case at our last comprehensive inspection. Some of the newer audits had yet to become fully embedded. Managers undertook spot checks, including when new systems had been implemented to ensure staff were adhering to new practices.

The provider had a corporate lessons learned log. This included notable incidents and events that had occurred at all of the provider's hospitals which was circulated for discussion at hospital level. This included looking at best practice, what could have been done differently and what changes had been implemented so that lessons could be shared between hospitals.

The hospital had a quality assurance manager who worked across the region and a full time quality and compliance manager, whose roles were to monitor quality and improvement of the hospital. Along with the provider's quality improvement director, they had undertaken an internal compliance inspection of the hospital in March 2017. This assessed the service in line with the same domains used by the care quality commission. The inspection identified areas of improvement required as well as a number of improvements that staff had made. A further inspection was planned in the near future. The quality managers also undertook unannounced visits on the wards and fed-back their findings at that time.

The provider employed a child and adolescent mental health specialist clinician to provide support to the hospitals with child and adolescent wards. They had

attended the hospital to undertake unannounced visits of the adolescent wards including at night. The findings of these were fed-back to managers so they could address any concerns as required.

The hospital had a local risk register and managers could submit risks to be included on this via the quality and compliance manager. Managers discussed the risk register within governance meetings. The risk register incorporated the risks we had identified at our last inspection. There was information documented to evidence reviews of the risks and progress that had been made to address these.

Leadership, morale and staff engagement

Since our last comprehensive inspection in July 2016, there had been several changes of personnel at hospital manager and clinical manager level. A new hospital manager was due to commence employment the week following our inspection. Most staff told us even though there had been various changes of senior management, morale was generally good and that the latest changes had led to improvements at the hospital. Some said they were looking forward to stability as changing managers had led to changes in practice which meant several different ways of working.

Two staff, from both adolescent and adult wards, told us about specific instances at work which had affected them where they felt senior management had not been open and clear about the situation. They said they would have appreciated more information about the situations which had led to them feeling unsettled.

Many of the improvements we identified were relatively recent changes in practice and coincided with the start of the current interim hospital manager. The new systems and processes were not yet fully embedded. The manager felt a lot of the shortfalls within the service were attributed to a lack of a substantive staff across the wards and, therefore a lack of consistency of care provision. The manager had set this as a main area to address. As a result, they spent a lot of time undertaking interviews to try to recruit permanent staff. They had implemented initiatives to try to reduce reliance on agency staff at higher risk times such as nights and recognised that a shift in culture in some areas was needed to achieve this. They understood that changes within the service had and could lead to areas unsettlement within the staff teams. There was strong evidence of the manager actively seeking to address areas of concern that we identified and being proactive to further areas of improvement.

There were opportunities for leadership development. The clinical manager told us about practice development groups where clinical managers met periodically. They said the provider was looking at ways to encourage peer development within this role. Ward managers told us about additional training they were able to access in their roles. The head teacher at the school had recently taken on a new role with increased responsibility to work across the various hospital sites.

The hospital had an initiative to fund support staff to undertake their nurse training. The provider had increased the number of places for staff to apply for this training with an aim to encourage staff development, engagement and retention.

Members of the senior management team we spoke with felt supported by their managers at provider level. They kept in contact by way of conference calls and visits to the hospital. Board meetings took place six monthly and the board visited every hospital, including Sheffield, every six months. Members of the senior management team we spoke with were aware there were challenges within the hospital, particularly within the child and adolescent wards. They felt there had been improvements since our last inspections and that these needed to continue and be sustained. They acknowledged that disruption at management level had impacted on morale and some felt a culture change was needed within some areas. There was also recognition that the focus on child and adolescent wards should not be at the detriment of the adult wards.

Staff were able to give feedback via the hospital's annual staff survey. We saw the completed survey and results for 2017. The provider had analysed the results and produced an associated action plan with targets to measure improvements. The areas for action included a reduction in the use of agency staff and improved communication.

Commitment to quality improvement and innovation

In May 2017, both Haven and Peak View had participated in the Royal College of Psychiatrists quality network for inpatient child and adolescent mental health services. This is a system where professionals from other inpatient child and adolescent mental health services form a team to peer

Requires improvement

Child and adolescent mental health wards

review other similar type services against a standard set of criteria. At the time of our inspection, the reports of these reviews were at draft stage. These showed Haven ward had met 96%, and Peak View 98%, of the criteria they were assessed against.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that the hospital operates in accordance with their policy for same sex accommodation and have regard to applicable guidance and legislation in this area.
- The provider must ensure that staff complete necessary mandatory and refresher training as necessary to help ensure the safe running of the service.
- The provider must ensure that where staff use interventions such as restraint and seclusion, these are carried out in accordance with the patient's preferences wherever possible. Information must be present for staff with regards to this where necessary and debriefs must be integral to this process
- Plans to end such interventions as seclusion must be person centred, individual to each patient's clinical needs and not punitive..
- The provider must ensure that they can provide accurate and contemporaneous records for patients that are fit for purpose and include all necessary information about decisions staff take in relation to a patient's care and treatment.
- The provider must ensure that patients have full opportunity, wherever possible, to be partners in, and influence their own care. This must include input and involvement in the compilation and review of their own care plans and involve on-going input where necessary and appropriate from relatives and carers.
- The provider must have an effective and accessible system for identifying, receiving, recording, handling and responding to complaints by service users. This must include a information about appeal rights where the complainant may be dissatisfied with the outcome.

Action the provider SHOULD take to improve

- The provider should ensure staff work in accordance with the policy for responding to emergencies.
- The provider should review the systems in place for staff to identify, report and record when medicines fridge temperatures fall outside of the recommended range and what action they take,
- The provider should continue their work towards embedding reducing restrictive practices across the hospital.
- The provider should ensure that staff use outcome scales and monitoring tools as intended and that they are suitable for the patient group.
- The provider should ensure that ward staff act upon issues identified in Mental Health Act audits in a timely manner.
- The provider should review recruitment procedures to ensure that these are suitably robust with regard to verification of employment information and applicants' suitability.
- The provider should ensure that there is stability of management personnel and that improvements in working practices are sustained, embedded and shared where relevant.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care **How the regulation was not met:** The care and treatment of patients was not always appropriate, did not always meet their needs and reflect their preferences. All patients did not feel involved in the care planning process and decisions affecting them. Staff did not demonstrate a person centred approach for the use of restraint and seclusion and seek patient's views in relation to this. There was a lack of information on adolescent wards about patient's individual preferences. It was not clear what therapeutic objectives patients were working towards. Patients did not always have care plans in place for all areas of their needs on both adolescent and adult wards. This was a breach of regulation 9 (1)(2)(3)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints **How the regulation was not met:** The provider did not establish and operate effectively an accessible system for identifying, receiving, recording, handling and responding to complaints by service users and other persons in relation to the carrying on of the regulated activity.

This section is primarily information for the provider

Requirement notices

There was a lack of information available for people about how to complain, including to the Care Quality Commission. Concluded complaints did not always offer a right of appeal to the complainant.

This was a breach of regulation 16 (2)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **How the regulation was not met:** Systems in place to assess, monitor and improve the safety and quality of the service were not effective**.** The provider did not operate in accordance with all applicable policies. Systems and processes had not identified this and had not fully identified and addressed shortfalls in other areas of the service. There were still areas of overall low compliance with mandatory training within the hospital . There was no single contemporaneous record for each patient. Patient information was stored in several different locations. Some patient documentation was not fully completed. This was a breach of regulation 17(1)(2)(a) (b) (c)