Cygnet Surrey Limited

Cygnet Lodge Woking

Inspection report

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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

Overall rating for this location	Requires Improvement
Are services safe?	Inadequate
Are services effective?	Requires Improvement
Are services caring?	Requires Improvement
Are services responsive to people's needs?	Requires Improvement
Are services well-led?	Requires Improvement

Summary of findings

Overall summary

Cygnet Lodge Woking is a 31 bed service providing acute and high dependency rehabilitation services for men with complex mental health needs.

Our rating of this location went down. We rated it as requires improvement because:

- The acuity of the patients on the long stay rehabilitation wards was higher than expected for this type of service. Staff felt unsafe to be on the ward due to the acuity of the patients and spent a significant amount of time in the nursing office.
- Care plans on Marlowe and Milligan wards were generic and generally did not include personalised information on how to care for each patient. Care records for patients with an autism or Asperger's diagnosis rarely included their diagnosis and lacked information on how to support them with their care. Patients' involvement in care planning and risk assessment was limited.
- The temperature in the clinic rooms on all wards was too high. This was appropriately escalated on George Willard ward, however prompt action was not taken when this was raised on Marlowe and Milligan wards.
- Patients on Marlowe and Milligan wards felt the activities offered did not meet their needs, and the recorded activity and engagement was not appropriate for a rehabilitation ward. Activities recorded on the ward did not correlate with those on the timetable.
- Physical health observations on Marlowe and Milligan wards were conducted in the lounge where patients' privacy and dignity could not be maintained.
- Blood glucose monitoring machines were not being consistently calibrated on Marlowe and Milligan wards.
- Staff on Marlowe ward did not ensure that medicines for patients to take away with them were given in appropriate packaging with correct instructions for use.
- We found gaps in the governance of the long stay rehabilitation wards. The senior leadership team did not have sufficient oversight of the activity provision on the wards.

However:

- Staff on all wards treated patients with kindness and respect. Staff actively sought patient feedback on the quality of care provided. They ensured that patients had easy access to independent advocates.
- Staff followed good practice with regards to safeguarding.
- Staff assessed and managed risk well and were skilled in de-escalation. There was therefore low use of restrictive interventions throughout the hospital.
- Staff provided a range of treatment and care for patients based on national guidance and best practice. Staff supported patients with their physical health and encouraged them to live healthier lives. Staff used recognised rating scales to assess and record severity and outcomes. They also participated in clinical audit, benchmarking and quality improvement initiatives.
- Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care. They had effective working relationships with staff from services providing care following a patient's discharge.
- Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice and discharged these well. Staff supported patients to make decisions on their care for themselves. They understood the provider's policy on the Mental Capacity Act 2005 and assessed and recorded capacity clearly for patients who might have impaired mental capacity.

Summary of findings

- The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Acute wards for adults of working age and psychiatric intensive care units	Good 	This was the first time we rated this service. We rated it as good because: • The service provided safe care. The ward environments were safe and clean. The wards had enough nurses and doctors. Staff assessed and managed risk well. They minimised the use of restrictive practices, managed medicines safely and followed good practice with respect to safeguarding. • Staff developed holistic, recovery-oriented care plans informed by a comprehensive assessment. They provided a range of treatments suitable to the needs of the patients and in line with national guidance about best practice. Staff engaged in clinical audit to evaluate the quality of care they provided. • The ward teams included or had access to the full range of specialists required to meet the needs of patients on the wards. Managers ensured that these staff received training, supervision and appraisal. The ward staff worked well together as a multidisciplinary team and with those outside the ward who would have a role in providing aftercare. • Staff understood and discharged their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005. • Staff treated patients with compassion and kindness, respected their privacy and dignity, and understood the individual needs of patients. They actively involved patients in care decisions. • The service managed beds well so that a bed was always available locally to a person who would benefit from admission and patients were discharged promptly once their condition warranted this. • The service was well led and the governance processes ensured that ward procedures ran smoothly.

Summary of findings

However:

- Staff did not always document whether patients had been offered a copy of their care plan.
- We found some instances where risk assessments had not been updated following incidents.
- Staff did not always document capacity to consent to treatment within patient records.
- The temperature in the clinic room was over 30 degrees celsius on the morning of our inspection.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

Our rating of this service went down. We rated it as requires improvement because:

- At the time of the inspection it was recognised that the acuity of the patients was higher than expected for this type of service. Staff felt unsafe to be on the ward due to the acuity of the patients and spent a significant amount of time in the nursing office.
- Care plans were generic and generally did not include personalised information on how to care for each patient. Care records for patients with an autism or Asperger's diagnosis rarely included their diagnosis and lacked information on how to support them with their care. Patients' involvement in care planning and risk assessment was limited and did not always reflect the patient voice.
- The ward areas were not clean and some rooms required maintenance. The temperature in the clinic rooms and fridge temperatures were recorded on several days as being out of the recommended range. This was raised by members of the inspection team on the first day of the inspection but appropriate actions to ensure medicines were being stored correctly were not taken until the third day of the inspection.
- Patients were not actively engaged in therapeutic activities and the recorded activity and engagement was not appropriate for a rehabilitation ward. Activities recorded on the ward did not correlate with those on the timetable.

Summary of findings

- Physical health observations were conducted in the lounge where patients' privacy and dignity could not be maintained.
- Blood glucose monitoring machines were not being consistently calibrated. Without proper calibration the service cannot be assured the readings taken on these machines are accurate and that the treatment being offered to patients is appropriate.
- Where patients were administered a 'when required' (PRN) medicine to manage agitation and aggression the daily records did not often reflect why this had been offered or whether it had had the desired outcome. We could not be assured that medicines for the management of agitation and aggression were being used appropriately.
- Where people were prescribed creams and emollients that contained paraffin there were no fire risk assessments in place for any of the patients reviewed.
- The correct procedure for leave medicines (TTOs) was not being followed on Marlowe unit. We witnessed a member of staff taking a pot of dispensed tablets and placing them in an envelope to administer to a patient away from the ward. There were no instructions or precautions given with these tablets. It was not clear how the service could assure itself what had been administered or that it had been done correctly.
- We found gaps in the governance of the hospital. There was little discussion in the clinical governance meeting around actions taken to remedy issues highlighted. The monitoring of therapeutic activities did not tally with the narrative of activities in patients' care records. The hospital did not hold information regarding unfilled shifts and at the time of the inspection, they could not provide the number of bank staff used. There was no oversight on how these issues may affect patient care.

However:

Summary of findings

- Staff were generally kind and respectful. Staff actively sought patient feedback on the quality of care provided. They ensured that patients had easy access to independent advocates.
- Positive behaviour support (PBS) plans were of good quality and written from a patient perspective. Patients were clearly involved in creating their PBS plans and identified their own triggers and how staff should respond when these are present.
- Staff assessed and managed risks to patients and themselves well. Staff followed best practice in de-escalating and managing challenging behaviour. As a result, they used restraint only after attempts at de-escalation had failed.
- The service used systems and processes to safely prescribe, administer, record and store medicines. Staff regularly reviewed the effects of medications on each patient's mental and physical health.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.
- The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service.
- Staff provided a range of treatment and care for patients based on national guidance and best practice. Staff supported patients with their physical health and encouraged them to live healthier lives. Staff used recognised rating scales to assess and record severity and outcomes. They also participated in clinical audit, benchmarking and quality improvement initiatives.
- Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care. They had effective working relationships with staff from services providing care following a patient's discharge.

Summary of findings

- Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice and discharged these well. Staff supported patients to make decisions on their care for themselves. They understood the provider's policy on the Mental Capacity Act 2005 and assessed and recorded capacity clearly for patients who might have impaired mental capacity.

Summary of findings

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Summary of this inspection

Background to Cygnet Lodge Woking

Cygnet Lodge Woking is a 31 bed service providing acute and high dependency rehabilitation services for men with complex mental health needs.

The service is purpose-built and located in a residential area close to its sister site, Cygnet Hospital Woking. The service has 31 beds split across three wards. George Willard is an acute ward with 11 beds, Marlowe ward is a high dependency rehabilitation unit with 12 beds and Milligan ward has eight beds which consist of six pre-discharge beds and two self-contained flatlets.

Patients were able to move to Marlowe ward from George Willard ward when they were deemed appropriate for the service. Marlowe ward was a recovery focused service that supported community access when patients were moving towards the least restrictive care option or the community.

Milligan House is an annexe to Cygnet Lodge Woking and contains six pre-discharge beds with an additional two self-contained flatlets. Milligan House allows Cygnet Lodge Woking to provide a three-tier care pathway for service users as they reach a level of increased stability.

The service is registered to provide the following regulated activities:

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

• Diagnostic and Screening Procedures

• Treatment of disease, disorder and injury.

There was a registered manager at the service. The senior staff at Cygnet Lodge Woking, including the registered manager, were also responsible for Cygnet Hospital Woking, a hospital which has four wards and provides care for adult men and women.

The service was previously inspected in March 2020 and was rated as good overall and good in all domains. At that time the service only provided rehabilitation services. The acute ward, George Willard ward, opened in July 2021. This was the first inspection of the service since the acute ward had opened.

What people who use the service say

Patients on the acute ward told us they felt safe on the ward and well supported by staff. They told us that staff treated them with kindness, dignity and respect. They told us that they enjoyed participating in activities with staff on and off the ward, for example playing pool or going to the park to play football.

Patients on the long stay rehabilitation wards had a less positive experience.

Three patients told us they did not feel safe on the ward. Patients had witnessed staff being assaulted and had to support a staff member after an assault. One patient told us that they were fearful of aggression and blackmail from other patients.

Summary of this inspection

Two patients told us that staff do not engage with them and they are not supported to cook, clean or go off the ward unescorted. Patients told us that there is nothing going on and there are no activities to do. One patient told us that staff are always busy and in the nursing office.

One patient told us they felt their health has deteriorated since admission.

One patient told us that visits are not facilitated and had not seen their friends since their admission. They would not know how to make this happen.

One patient told us that the service was more like a secure ward than a rehabilitation ward as everything is locked.

One patient told us that they are still awaiting a repair to their bedroom.

One patient told us that the service does not provide any way for patients to access a hairdresser/barber.

A carer we spoke with said they attend a monthly carers' group, and they find it interesting and supportive. They said that their relative is rarely taken outside due to staff being scared of the patient. They felt that their relative's personal hygiene needs were not being attended to by staff.

A carer told us that they are involved in their relative's care plan and find the medical team very approachable. However, felt that they sometimes do not act on promises. They felt that their relative may be denied opportunities such as home leave, due to a shortage of staff.

A carer we spoke with stated that they would like the service to talk to relatives more and have a more structured approach when it comes to sharing updates.

How we carried out this inspection

The inspection team was made up of an inspection manager, three CQC inspectors, a CQC pharmacy specialist, an expert by experience and two specialist advisors with nursing backgrounds.

During the inspection visit, the team:

- Spoke with the registered manager for the service
- Spoke with 19 other staff members, including a ward manager, ward doctors, an assistant psychologist, an occupational therapist, nurses, support workers, an activities co-ordinator and clinical team leaders
- Spoke with eight patients and one carer
- Reviewed care records for 12 patients
- Reviewed physical health charts for 11 patients
- Visited all three wards to look at the quality of the environment and observe how staff were caring for patients
- Carried out a specific check of medicines and clinic rooms on all wards
- Observed ward rounds, a handover meeting, a flash meeting, a governance meeting and a community meeting
- Reviewed a range of policies, procedures and documentation relating to the running of the service.

You can find information about how we carry out our inspections on our website: https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

Summary of this inspection

Areas for improvement

Action the service MUST take is necessary to comply with its legal obligations. Action a service SHOULD take is because it was not doing something required by a regulation but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the service MUST take to improve:

Long stay rehabilitation core service:

- The service must ensure that the activities on Marlowe and Milligan wards t are suitable for a long stay rehabilitation service and meet the needs of the patient group. [Regulation 9 (1) Person-centred care].
- The service must ensure that patients are aware of and encouraged to attend community oriented care, education and vocational opportunities. [Regulation 9 (1) Person-centred care].
- The service must ensure that the patients are involved in developing their care plans. Care plans must describe how staff support patients in the early stages of crisis in line with their wishes. [Regulation 9 (3) (d) Person-centred care].
- The service must ensure that patients with an autism/Asperger's diagnosis have care plans that support their care and treatment. [Regulation 9 (3) (d) Person-centred care].
- The service must ensure that patient identifiable information is not accessible or available for patients to read/see. [Regulation 10 (2) (a) Dignity and respect].
- The service must ensure that physical observations are conducted in a way that protects the patient's privacy and dignity. [Regulation 10 (2) (1) Dignity and respect].
- The service must ensure that the senior management team have appropriate oversight of the provision of activities being delivered on both Milligan and Marlowe wards. [Regulation 17 (1) Good governance].
- The provider must ensure that medicines supplies are stored within the recommended temperature limits on Marlow and Milligan wards. [Regulation 12 (2) (g) Safe care and treatment].
- The provider must ensure that medicines to be administered off the wards are given with the correct instructions and in appropriate packaging. [Regulation 12 (2) (g) Safe care and treatment].
- The provider must ensure that the medical equipment for measuring blood glucose levels is calibrated at the frequency required for this equipment. [Regulation 12 (2) (e) Safe care and treatment].

Action the service SHOULD take to improve:

Acute core service:

- The service should ensure that it is documented whether patients have been offered a copy of their care plans [Regulation 17 (2) (c) Good governance].
- The service should ensure that all patients' risk assessments and management plans are updated following any incidents [Regulation 12 (2) (a) Safe care and treatment].
- The service should ensure that capacity to consent to treatment is routinely documented [Regulation 17 (2) (c) Good governance].
- The provider should ensure that the clinic room temperature is maintained within a range that ensures the safe storage of medicines [Regulation 12 (2) (g) Safe care and treatment].

Long stay rehabilitation core service:

- The provider should ensure appropriate fire risk assessments are in place for those people using paraffin-based skin products [Regulation 12 (2) (a) Safe care and treatment].

Summary of this inspection

- The provider should ensure that when 'as required' medicines (PRN) are administered for the management of agitation and aggression the reason for use and patients' responses are recorded [Regulation 12 (2) (g) Safe care and treatment].

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Acute wards for adults of working age and psychiatric intensive care units	Good	Good	Good	Good	Good	Good
Long stay or rehabilitation mental health wards for working age adults	Inadequate	Requires Improvement	Requires Improvement	Requires Improvement	Requires Improvement	Requires Improvement
Overall	Inadequate	Requires Improvement	Requires Improvement	Requires Improvement	Requires Improvement	Requires Improvement

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

Good

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

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

Good

This was the first time we had rated this service. We rated safe as good.

Safe and clean care environments

The ward was safe, clean, well equipped, well furnished, well maintained and fit for purpose.

Safety of the ward layout

Staff completed and regularly updated thorough risk assessments of all ward areas and removed or reduced any risks they identified. There was an identified security lead assigned on each shift who was responsible for completing various safety checks.

Staff could observe patients in all parts of the wards. Mirrors and closed circuit television (CCTV) were used to mitigate any blind spots.

The ward accepted male patients only so there was no mixed sex accommodation.

Staff knew about any potential ligature anchor points and mitigated the risks to keep patients safe. Staff carried out an annual ligature audit. Where any ligature risks had been identified they had documented mitigation plans in place. A copy of the audit and a ligature heat map were available in the nursing office.

Staff had easy access to alarms and patients had easy access to nurse call systems. Staff carried a portable alarm and there were six alarm points throughout the ward which showed the location assistance was needed when they were pulled. The alarms were tested weekly. Patients had call buttons in their bedrooms. Both staff and patients told us they felt safe on the ward.

Maintenance, cleanliness and infection control

Ward areas were clean, well maintained, well furnished and fit for purpose. The ward was bright and spacious. It was nicely decorated and had a calm atmosphere.

Staff made sure cleaning records were up-to-date and the premises were clean.

Staff followed infection control policy, including handwashing.

Seclusion room

There were no seclusion facilities on the ward. The ward did not admit patients who were at significant risk of violence and aggression or who were likely to require a bed on a psychiatric intensive care unit (PICU).

Clinic room and equipment

Clinic rooms were fully equipped, with accessible resuscitation equipment and emergency drugs that staff checked regularly.

Staff checked, maintained, and cleaned equipment.

Safe staffing

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

Nursing staff

The service had enough nursing and support staff to keep patients safe. Managers had been able to fill all the shifts on the ward since it opened.

The service had low vacancy rates. Two staff had recently resigned and so managers were in the process of trying to recruit to their posts.

The service had low rates of agency staff usage. There were two agency staff who were on long-term contracts.

Managers limited their use of agency staff and requested staff familiar with the service. Between 1 October 2021 and 31 December 2021 245 shifts had been filled by agency staff.

Managers made sure all bank and agency staff had a full induction and understood the service before starting their shift. The agency staff working on the ward were long-term. They completed the same mandatory training courses as the permanent staff, either in-house or via their agency.

The service had low turnover rates and managers supported staff who needed time off for ill health.

Levels of sickness were low. The sickness rate in the three months prior to the inspection was less than two percent.

Managers accurately calculated and reviewed the number and grade of nurses and healthcare assistants for each shift. The staffing establishment for the ward was two nurses and three support workers per shift. Some staff told us that they would rather have four support workers during the day and two at night, as there were more tasks to do during the day, such as facilitating leave for patients.

The ward manager could adjust staffing levels according to the needs of the patients.

Patients had regular one to one sessions with their named nurse. Staff audited this weekly. We reviewed the results from recent audits and saw that all patients had had weekly one to one sessions with their named nurse.

Patients rarely had their escorted leave or activities cancelled.

The service had enough staff on each shift to carry out any physical interventions safely.

Staff shared key information to keep patients safe when handing over their care to others. We observed a handover meeting during our inspection and found the information shared was comprehensive.

Medical staff

The service had enough daytime and night time medical cover and a doctor available to go to the ward quickly in an emergency.

Managers could call locums when they needed additional medical cover. The ward doctor was a locum.

Managers made sure all locum staff had a full induction and understood the service before starting their shift.

Mandatory training

Staff completed and kept up-to-date with their mandatory training. Compliance with the majority of mandatory training courses was 100%. The only course which fell below this was personality disorder training, which 81.3% of staff had completed.

The mandatory training programme was comprehensive and met the needs of patients and staff.

Managers monitored mandatory training and alerted staff when they needed to update their training.

Assessing and managing risk to patients and staff

Staff assessed and managed risks to patients and themselves well and followed best practice in anticipating, de-escalating and managing challenging behaviour. Staff used restraint only after attempts at de-escalation had failed.

Assessment of patient risk

Staff completed risk assessments for each patient on admission, using a recognised tool, and reviewed this regularly, including after any incident. The psychology team took the lead on risk assessments. The provider's policy was that risk assessments should be updated fortnightly, but this was usually done in weekly ward rounds. Staff told us that risk assessments were updated following any incidents, however when we reviewed care records we saw that this was not always the case. For example, one patient had been involved in five incidents and their risk assessment had only been updated following three of these. However, staff had a good understanding of the risks and management plans for each patient.

Management of patient risk

Staff knew about any risks to each patient and acted to prevent or reduce risks.

Staff identified and responded to any changes in risks to, or posed by, patients.

Staff could observe patients in all areas of the ward. Staff used mirrors and CCTV to cover areas with blind spots. Staff could view the CCTV footage in the nursing office.

Staff followed policies and procedures when they needed to search patients or their bedrooms to keep them safe from harm. Patients were searched depending on risk. Staff had received training in how to conduct searches from the security lead.

Staff carried out random urine drug screening tests when patients returned from unescorted leave. Patients were made aware of this on admission and consented to this.

Staff took part in monthly scenario-based training drills where possible emergency situations were role played and staff were required to respond. Staff received feedback following these drills.

Use of restrictive interventions

Levels of restrictive interventions were low. Staff reviewed any blanket rules with patients quarterly.

Staff made every attempt to avoid using restraint by using de-escalation techniques and restrained patients only when these failed and when necessary to keep the patient or others safe. Staff had used restraint on seven occasions between 1 December 2021 and 28 February 2022. We observed staff skilfully de-escalating and negotiating with a patient during our inspection.

Staff followed NICE guidance when using rapid tranquilisation. Staff had used rapid tranquilisation twice in the last three months. The provider had a policy in place to monitor patients following rapid tranquilisation. Staff audited compliance with the policy.

Safeguarding

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

Staff received training on how to recognise and report abuse, appropriate for their role.

Staff kept up-to-date with their safeguarding training. Compliance with safeguarding training was 100%.

Staff knew how to recognise people at risk of or suffering harm and worked with other agencies to protect them.

Staff knew how to make a safeguarding referral and who to inform if they had concerns.

Staff access to essential information

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

Patient notes were comprehensive and all staff could access them easily.

Records were stored securely on password protected systems. The majority of records were electronic, however hard copies of physical health monitoring charts were stored in the nursing office.

Medicines management

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

Staff followed systems and processes to prescribe and administer medicines safely. Staff used a paper-based system for prescribing and recording administration of medicines.

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

Good

Medicines were obtained from an external pharmacy contractor who dispensed and delivered to the service the next working day. The service kept a stock of commonly used medicines. Outside of regular working hours staff could send prescriptions to the local community pharmacy to obtain supplies.

A clinical pharmacist visited the service once a week to check prescription charts and support the prescribers. Regular audit work was conducted by the pharmacist and actions were followed up by the ward team.

Access to medicine storage areas was appropriately restricted.

Medicines were usually stored appropriately so that they would remain safe and effective for use. However, when temperatures were out of range, we did not always see appropriate action being taken by staff to safeguard medicines. The temperature in the clinic room was out of the recommended range at the time of the inspection. This was raised by members of the inspection team on the first day of the inspection but appropriate actions to ensure medicines were being stored correctly were not taken until the third day of the inspection. We had to prompt staff to escalate concerns when temperatures exceeded 30 degrees Celsius.

Staff had access to medicines disposal facilities.

Staff had pictures of consenting patients with the medicines administration charts to assist in identifying them.

Staff reviewed each patient's medicines regularly and provided advice to patients and carers about their medicines.

Staff reviewed patient's medicines during ward rounds.

Patients and carers could access a pharmacist if they wanted to discuss their medicines in more detail.

Staff took appropriate action to safeguard patient's safety and monitor the effect of their medicines on them.

Where patients were not engaging with proposed treatment regimens we saw clinical staff worked with them to negotiate and find appropriate alternative solutions that ensured their mental and physical wellbeing whilst addressing their personal wishes.

Staff stored and managed all medicines and prescribing documents safely.

Patient's medicine administration charts were stored in the clinic room which only authorised staff had access to.

Within the medicines administration charts there were copies of the Mental Health Act certificates as well as monitoring forms for various medicine treatments and records of physical health monitoring.

All consent to treatment documentation was in place and being adhered to. Where a patient required additional treatment for a mental health condition that was not included on the T2 or T3 a section 62 urgent treatment form was completed.

Staff followed current national practice to check patients had the correct medicines.

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

Good

Staff reviewed patients' medicines and clinical records when they were admitted to ensure they had the correct medicines.

Any medicines which were no longer suitable or needed were disposed of appropriately with the prior consent of the patient.

Staff told us they would get permission from the patient to contact their GP and any other specialists to gather accurate information about a patient's current medicines.

The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely.

Nursing staff would receive patient safety alerts and we saw a folder which evidenced that these were reviewed and actioned as necessary. The independent pharmacy contractor also ensured these safety alerts were being actioned appropriately.

Medicines incidents were logged on an electronic reporting system. Staff told us that learning from any local incident or those from the wider provider group would be shared with them to improve safe practice and learning.

Decision making processes were in place to ensure people's behaviour was not controlled by excessive and inappropriate use of medicines.

Prevention Management of Violence and Aggression (PMVA) training was mandatory for all staff who worked with patients.

The organisation's medicines policy encourages the exploration of non-pharmacological interventions before using medicines. When medicines are used for managing violence and aggression, oral medicines are to be explored before injections.

Records showed the use of oral and intra-muscular rapid tranquilisation was rare on the ward. Staff were able to explain the de-escalation attempts that would be made prior to the use of rapid tranquilisation. They also understood the need for monitoring of a patient's physical health post dose and how this should be recorded.

Staff reviewed the effects of each patient's medicines on their physical health according to NICE guidance.

The service employed a lead physical health nurse who ensured that patients had the required blood tests and investigations in line with requirements. The physical health lead nurse trained staff to become physical health champions for each ward.

Physical health monitoring was conducted regularly on the wards. Machines were checked and calibrated regularly to ensure they were giving accurate readings and providing the right information to make clinical decisions.

Track record on safety

The service had a good track record on safety.

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

Good

Reporting incidents and learning from when things go wrong

The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately.

Staff knew what incidents to report and how to report them. Staff had reported 21 incidents in February, eight in March and at the time of the inspection there had been five so far in April.

Staff raised concerns and reported incidents and near misses in line with provider policy.

The ward had no never events.

Managers debriefed and supported staff after incidents.

Staff received feedback from investigation of incidents. We reviewed team meeting minutes and saw that incidents and lessons learned were discussed.

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

Good

This was the first time we had rated this service. We rated effective as good.

Assessment of needs and planning of care

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

Staff completed a comprehensive mental health assessment of each patient either on admission or soon after.

Patients had their physical health assessed soon after admission and regularly reviewed during their time on the ward.

Staff developed a comprehensive care plan for each patient that met their mental and physical health needs.

Staff regularly reviewed and updated care plans when patients' needs changed.

Care plans were personalised, holistic and recovery-orientated, however could have included more information relating to patients' strengths.

Best practice in treatment and care

Staff provided a range of treatment and care for patients based on national guidance and best practice. They ensured that patients had good access to physical healthcare and supported them to live healthier lives. Staff participated in clinical audit.

Staff provided a range of care and treatment suitable for the patients in the service.

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

Good

Staff delivered care in line with best practice and national guidance. The assistant psychologist offered two groups a week on the ward as well as one to one interventions with patients. The groups were mindfulness and dialectical behavioural therapy (DBT) skills, and the one to one interventions were also focused around DBT skills and psychoeducation. The provider informed us following the inspection that they engaged in the Music 2 Empower programme which is a national initiative aimed to harness the power of music therapy and showcased talents of patients.

Staff identified patients' physical health needs and recorded them in their care plans.

Staff made sure patients had access to physical health care, including specialists as required. Patients had access to a physical health nurse who worked at the hospital.

Staff helped patients live healthier lives by supporting them to take part in programmes or giving advice. Healthy eating posters were displayed on the ward and a healthy eating group took place once a week. Patients were supported to exercise, for example, they could access the hospital gym, go on bike rides, and play football. The provider informed us they took part in the Smoke Aware Initiative, a least restrictive intervention aimed at reducing tobacco dependency within inpatient services.

A therapy dog visited the wards once a week offering comfort and affection to people who were dealing with physical and emotional problems.

Staff took part in clinical audits. Regular audits included self-medication, rapid tranquilisation, health records, hand hygiene, blanket rules, information governance, Mental Capacity Act and physical health. We reviewed team meeting minutes and saw that outcomes from audits were discussed. Managers used results from audits to make improvements.

Skilled staff to deliver care

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

The service had access to a full range of specialists to meet the needs of the patients on the ward.

Managers ensured staff had the right skills, qualifications and experience to meet the needs of the patients in their care, including bank and agency staff.

Managers gave each new member of staff a full induction to the service before they started work.

Managers supported staff through regular, constructive appraisals of their work. All staff had received an appraisal within the last year.

Managers supported staff through regular, constructive clinical supervision of their work. Staff received individual supervision once a month. They also received group supervision and had monthly reflective practice with a psychologist.

Managers made sure staff attended regular team meetings or gave information from those they could not attend.

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

Good

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Staff told us they felt supported to further their knowledge, for example, support workers had been trained in how to take blood and blood sugar readings.

Multi-disciplinary and interagency team work

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

Staff held weekly multidisciplinary meetings to discuss patients and improve their care.

Staff made sure they shared clear information about patients and any changes in their care, including during handover meetings.

Ward teams had effective working relationships with other teams in the organisation.

Ward teams had effective working relationships with external teams and organisations. Staff told us they had a good working relationship with local community mental health teams.

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

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

Staff received and kept up-to-date with training on the Mental Health Act and the Mental Health Act Code of Practice. Compliance with Mental Health Act training was 100%.

Staff had access to support and advice on implementing the Mental Health Act and its Code of Practice.

Staff knew who their Mental Health Act administrators were and when to ask them for support.

The service had clear, accessible, relevant and up-to-date policies and procedures that reflected all relevant legislation and the Mental Health Act Code of Practice. Staff also had easy-read versions of the Code of Practice to give to patients.

Patients had easy access to information about independent mental health advocacy.

Staff explained to each patient their rights under the Mental Health Act in a way that they could understand, repeated as necessary and recorded it clearly in the patient's notes each time.

Staff made sure patients could take section 17 leave (permission to leave the hospital) when this was agreed with the Responsible Clinician.

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

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

Good

Informal patients knew that they could leave the ward freely and the service displayed posters to tell them this. We also observed a community meeting where staff reminded patients that some of the patients on the ward were informal, and so they could leave the ward as they wished.

Good practice in applying the Mental Capacity Act

Staff supported patients to make decisions on their care for themselves. They understood the principles of the Mental Capacity Act 2005 but did not always clearly record whether patient's capacity to consent to treatment had been assessed.

Staff received and kept up-to-date with training in the Mental Capacity Act and had a good understanding of at least the five principles. Compliance with Mental Capacity Act training was 100%.

There were no deprivation of liberty safeguards applications made since the ward opened.

Staff knew where to get accurate advice on the Mental Capacity Act and deprivation of liberty safeguards.

Staff did not always record capacity to consent clearly. Two of the seven care records we reviewed did not contain assessments of capacity to consent to treatment.

The service monitored how well it followed the Mental Capacity Act and acted when they needed to make changes to improve.

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

Good

This was the first time we rated this service. We rated caring as good.

Kindness, privacy, dignity, respect, compassion and support

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

Staff were discreet, respectful, and responsive when caring for patients. We observed staff interacting with patients in a kind and respectful manner during our inspection. We also observed staff speaking about patients respectfully during meetings.

Staff gave patients help, emotional support and advice when they needed it. Patients told us that staff always made time for them.

Staff supported patients to understand and manage their own care, treatment or condition.

Staff directed patients to other services and supported them to access those services if they needed help.

Patients said staff treated them well and behaved kindly.

Staff understood and respected the individual needs of each patient.

Staff felt that they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards patients.

Staff followed policy to keep patient information confidential.

Involvement in care

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

Involvement of patients

Staff introduced patients to the ward as part of their admission. Staff gave patients a welcome pack containing key information they needed to know on arrival. They also showed patients around the ward and introduced them to other patients and staff.

Staff involved patients and patient views were included within care plans, however it was not always documented whether patients had been offered a copy of their care plan. Patients were asked to complete a form prior to their weekly ward round which included details of how their week had been, details of any goals and how the team could help them work towards these, whether they wanted family to attend, what they had found helpful and whether they had any questions they wanted to ask.

Staff made sure patients understood their care and treatment.

Staff involved patients in decisions about the service, when appropriate. The service held a weekly community meeting which provided opportunity for staff to consult patients on decisions about the service. We attended a community meeting during our inspection and all 11 patients on the ward attended this along with ward staff and members of the senior leadership team.

Patients could give feedback on the service and their treatment and staff supported them to do this. Following the inspection, the provider informed us that there was an Expert by Experience lead who regularly visited the wards and supported management decisions around the service including overseeing and capturing feedback from patients. The provider also told us they had a People's Council which aimed to ensure that the voices of patients and carers were heard at every level of the organisation.

Staff made sure patients could access advocacy services. Staff reminded patients of this in the community meeting we observed.

Involvement of families and carers

Staff informed and involved families and carers appropriately.

Staff supported, informed and involved families or carers. Where patients consented, staff invited carers to attend ward rounds.

Staff gave carers information on how to find the carers assessment. Staff told us they referred carers to the local authority if they wished to have a carers assessment.

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

Good

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

Good

This was the first time we rated this service. We rated responsive as good.

Access and discharge

Staff managed beds well. A bed was available when a patient needed one. Patients were not moved between wards. Patients did not have to stay in hospital when they were well enough to leave.

Bed management

Managers regularly reviewed length of stay for patients to ensure they did not stay longer than they needed to. Managers closely monitored length of stay and the organisation that commissioned the beds on the ward had oversight of this. The average length of time a patient stayed on the ward was 36 days.

Managers and staff worked to make sure they did not discharge patients before they were ready.

Patients were moved between wards only when there were clear clinical reasons or it was in the best interests of the patient. For example, since the ward opened there had been three instances where patients had become too unwell to stay on the ward and been transferred to a psychiatric intensive care unit (PICU).

Discharge and transfers of care

Managers monitored the number of patients whose discharge was delayed. None of the patients were experiencing delayed discharge at the time of the inspection.

Patients did not have to stay in hospital when they were well enough to leave.

Staff carefully planned patients' discharge and worked with care managers and co-ordinators to make sure this went well. Staff began discharge planning from admission and this was reviewed at every ward round.

Facilities that promote comfort, dignity and privacy

The design, layout, and furnishings of the ward supported patients' treatment, privacy and dignity. Each patient had their own bedroom with an en-suite bathroom and could keep their personal belongings safe. There were quiet areas for privacy. The food was of good quality and patients could make hot drinks and snacks at any time.

Each patient had their own bedroom, which they could personalise.

Patients had a secure place to store personal possessions. Patients had lockable storage in their bedrooms as well as lockers in the lounge area of the ward where they could safely store personal belongings. However, one patient we spoke with told us they did not have a key for the storage in their bedroom. Staff told us they would resolve this.

Staff used a full range of rooms and equipment to support treatment and care. There was no treatment room on the ward, however staff told us that physical observations were taken privately in the activity room.

The service had quiet areas and a room where patients could meet with visitors in private. There were three quiet spaces for patients to use on the ward and a visitors room was available off the ward.

Patients could make phone calls in private. Patients had access to their mobile telephones, providing they agreed not to use the recording functionality. There was also a phone booth available in the communal area of the ward. Patients could close the door to ensure privacy.

The service had an outside space that patients could access easily. Patients had access to a well-maintained garden with benches and a picnic table. The door to the garden was open during the day and locked at night for security reasons, however patients could request access at night if they wished.

Patients could make their own hot drinks and snacks and were not dependent on staff. There was a tap in the lounge area which offered hot water at a temperature of 60 degrees. Patients could also request access to the kitchen which had a kettle and facilities for patients to access snacks. Fruit was available in the lounge area.

The service offered a variety of good quality food and could cater for specific dietary needs. Patients gave positive feedback about the food in the community meeting we attended.

Patients' engagement with the wider community

Staff supported patients with activities outside the service.

Staff helped patients to stay in contact with families and carers.

Staff encouraged patients to develop and maintain relationships both in the service and the wider community.

Meeting the needs of all people who use the service

The service met the needs of all patients. Staff helped patients with communication, advocacy and cultural and spiritual support.

The service could support and make adjustments for disabled people and those with communication needs or other specific needs. The ward was located on the ground floor of the building and had a disabled toilet in the lounge area. Managers told us that disabled beds could be obtained if needed.

Staff made sure patients could access information on treatment, local services, their rights and how to complain. This information was displayed on notice boards throughout the ward.

Managers made sure staff and patients could get help from interpreters or signers when needed. We saw evidence that an interpreter had recently been used.

The service provided a variety of food to meet the dietary and cultural needs of individual patients.

Patients had access to spiritual, religious and cultural support. A patient told us they had been supported to attend church.

Listening to and learning from concerns and complaints

There had been no complaints about the ward since it opened. Information about how to make a complaint was displayed on the ward.

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

Good

There had been no complaints about the ward since it opened.

Patients knew how to complain or raise concerns. Staff reminded patients how to raise complaints in the community meeting we attended.

The service clearly displayed information about how to raise a concern in patient areas.

Staff understood the policy on complaints and knew how to handle them.

The service used compliments to learn, celebrate success and improve the quality of care. Staff had logged 37 compliments since the ward opened.

Are Acute wards for adults of working age and psychiatric intensive care units well-led?

Good

This was the first time we rated this service. We rated well-led as good.

Leadership

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

The ward was managed by an experienced ward manager who was supported by clinical team leaders. Patients and staff told us that managers were always present and approachable should they need them. The management team had very good oversight of the service.

Vision and strategy

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

The organisation's values were integrity, trust, empower, respect and care. Staff we spoke with had a good understanding of these and we observed them demonstrating the values during our inspection. The values were considered during objective setting when staff received their annual appraisal.

Culture

Staff felt respected, supported and valued. They said the organisation promoted equality and diversity in daily work and provided opportunities for development and career progression. They could raise any concerns without fear.

Staff told us that there was a positive culture on the ward, that it was a great place to work, and that they felt trusted to do their jobs. They told us that they were able to raise any concerns or suggestions as necessary and that they felt listened to, respected and valued.

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

Good

The service offered opportunities for career progression. For example, there was a senior support worker role available and staff were encouraged to learn new skills, for example nurses had trained support workers how to take bloods and blood sugar readings.

Governance

Our findings from the other key questions demonstrated that governance processes operated effectively at ward level and that performance and risk were managed well.

Managers and commissioners utilised key performance indicators to monitor performance.

Managers attended monthly clinical governance meetings to discuss safety, training and education, clinical effectiveness, patient and carer experience, leadership and lessons learnt. Key information and actions were shared with ward staff during their monthly meetings.

Management of risk, issues and performance

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

Staff had access to all of the relevant information needed to be able to carry out their roles effectively.

Managers had access to the information needed to maintain good oversight of the service.

The hospital had a local risk register in place. Risks were rated either red, amber or green with documented mitigation plans for each identified risk.

Information management

Staff collected and analysed data about outcomes and performance.

Managers collected data about outcomes and performance which was shared with commissioners monthly.

Engagement

Managers engaged actively with other local health and social care providers to ensure that an integrated health and care system was commissioned and provided to meet the needs of the local population.

Staff worked very closely with the commissioners of the service. There was close monitoring of the service, including a daily flash meeting. We observed this meeting during our inspection and staff discussed the number of patients, discharges, details of weekend leave, any pertinent risks and any care co-ordinator concerns.

A staff survey was in the process of being conducted at the time of the inspection.

Learning, continuous improvement and innovation

The ward did not participate in the Accreditation for Inpatient Mental Health Services (AIMS) programme, which is a quality improvement initiative managed by the Royal College of Psychiatrists.

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

Good

After the inspection the provider informed us that the services had a mental health first aider, who offered people a welcoming space to express themselves and talk. Other initiatives included Trauma Risk Management (TRiM) which involved supporting people who have been through a traumatic experience and also and Sustaining Resilience at Work (StRaW) a peer support programme aimed to help detect and prevent occupational mental health issues and boost an organisation's psychological resilience.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

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

Are Long stay or rehabilitation mental health wards for working age adults safe?

Inadequate

Our rating of safe went down. We rated it as inadequate.

Safe and clean care environments

The ward areas were not clean and some rooms required maintenance. All wards were safe, well equipped and well furnished.

Safety of the ward layout

Staff completed and regularly updated thorough risk assessments of all wards areas and removed or reduced any risks they identified. Ligature assessments were up to date and provided ways in which risks were reduced on the ward. Staff knew about any potential ligature anchor points and mitigated the risks to keep patients safe.

The layout of Milligan ward was cramped and narrow. The corridors were narrow and the stairs were steep. The ward had little communal space, as the lounge and kitchen were in the same room as staff used for an office. As a result, laptops were left unattended in the communal areas and patient documents were not being stored securely. Patient identifiable information was also visible through the nurses office window on Milligan ward.

Staff had easy access to alarms and patients had easy access to nurse call systems.

Maintenance, cleanliness and infection control

Ward areas were well furnished and fit for purpose. However, on the first day of our inspection we observed that all ward areas were dirty and untidy. The occupational therapy kitchen on Milligan ward had dirty cupboards and out of date food/oil in drawers. Staff confirmed that they thought the ward areas were dirty. We told the ward manager and the following day we observed that the ward areas were much cleaner. We felt assured that action had been taken to remedy this issue. The service shared three domestic staff with their sister site, Cygnet Hospital Woking.

Some of the ward required maintenance to ensure the safety of patients. We observed that one patient could access the pipework underneath their sink and had a peeling door. The patient had a bathroom mirror which had been drawn on with permanent marker by a previous patient. The provider took action to rectify this issue on the second day of the inspection.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

We observed patient laundry left in the communal lounge on Milligan ward and trip hazards as a result of staff charging their laptops.

The showers across the wards leaked out of the cubicles and soaked into the carpet of the bedroom. Patients told us that the showers do not work well. The provider reported they had taken action to fix this problem soon after the inspection.

The wards had a maintenance log to record the repairs that were needed. The provider had processes in place to monitor maintenance actions and ensure they were rectified in a timely way.

Staff followed infection control policy, including handwashing.

Clinic room and equipment

Medicines were usually stored appropriately so that they would remain safe and effective for use. However, when temperatures were out of range, we did not always see appropriate action being taken by staff to safeguard medicines. Staff had not taken any action to ensure medicines were suitable for use or arranged alternate storage at the time of the inspection. The provider took action after the inspection to ensure that medicines were stored in a safe temperature regulated room until the air conditioning was fixed.

Staff had access to emergency equipment, and we saw that this equipment was checked daily. Staff maintained and cleaned equipment.

Staff did not ensure equipment was calibrated. At the previous inspection in 2020, we told the provider they should ensure that all medical equipment is calibrated. We found that this was still an issue. Where patients had their blood glucose levels monitored to manage diabetes, the machines being used were not always calibrated. This meant there was a risk that staff made clinical decisions based on inaccurate information.

Safe staffing

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

Nursing staff

Managers calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants for each shift according to a high dependency rehabilitation model. At the time of the inspection it was recognised that the acuity of the patients was higher than expected for this type of service. All ward staff we spoke with told us that the acuity of the patient group was an issue and staff felt they were not suitable for a rehabilitation service. Managers were aware and had increased their support worker ratio by one in order to support Marlowe ward. However, three of the staff we spoke with felt unsafe working on the ward because the service relied heavily on agency staff who were less familiar with patients, and the acuity of patients at the time was high, meaning that they required more intensive, tailored support to meet their needs

The service had low vacancy rates. At the time of the inspection, the rehabilitation wards had one healthcare worker vacancy and one registered nurse vacancy. They had recently recruited two registered nurses who were going through pre-employment and two healthcare workers.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

Data provided by the service showed that between 1 January 2022 and 31 March 2022, 62 shifts on Milligan ward and 247 shifts on Marlowe were covered by agency staff for sickness, absence or vacancies on Marlowe and Milligan wards. The service tried to use regular agency staff to ensure continuity of care. When the ward did not have enough staff to maintain safe staffing limits, staff from other wards would be asked to support the ward. We were told that this happened rarely. Managers supported staff who needed time off for ill health. Levels of sickness were low.

The turnover rate for Cygnet Lodge Woking was 30.7% across the previous 12 months. This included information from George Willard ward, an acute service. Staff told us that it was hard to maintain a team and to recruit to posts.

Staff told us that patients had regular one to one sessions with their named nurse. However, the documentation did not reflect this. We looked at the record for 16 patients and only seven patients had received a recent one to one with their named nurse. However, one patient had not had a one to one recorded since January and five patients had not received a one to one since February.

Staff felt that patients had more leave than they could facilitate due to most patients having escorted leave. Staff told us that patients felt frustrated and hostile towards staff as a result.

Staff shared key information to keep patients safe when handing over their care to others.

Medical staff

The service had enough daytime and night time medical cover and a doctor available to go to the ward quickly in an emergency. The ward had a consultant psychiatrist three days a week and a fulltime associate specialist doctor. The doctor and consultant provided out of hours duty cover to respond to emergencies.

Managers made sure all locum staff had a full induction and understood the service before starting their shift.

Mandatory training

Staff had completed and kept up-to-date with their mandatory training. At the time of the inspection some training fell below the provider's target of 90% compliance. Training that did not meet their internal compliance levels were: Medication competency for nursing services 0%, ligature rescue training 58.8%, dysphagia training 88.9%, PMVA (initial) 88.2%, PMVA personal safety 83.3%, physiological observations for adult services 0%, START training 28.6%, The low levels of compliance were due to new staff being added to the database and new training programmes being delivered. In most cases, a small number of staff not completing a training made a significant impact on the compliance data.

The mandatory training programme was comprehensive and met the needs of patients and staff. Training included safeguarding, prevention and management of violence and aggression, infection control, the Mental Health Act, basic life support and automated external defibrillator training. Nurses had completed immediate life support training. Some staff felt more autism training could be offered beyond an e-learning requirement, in order to meet the needs of some patients on the ward.

Managers monitored mandatory training and alerted staff when they needed to update their training.

Assessing and managing risk to patients and staff

Staff assessed and managed risks to patients and themselves well. Staff followed best practice in de-escalating and managing challenging behaviour. As a result, they used restraint only after attempts at de-escalation had failed. However, staff were scared to be on the ward due to the acuity of the patients and spent a significant amount of time in the nursing office.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

Assessment of patient risk

Staff completed risk assessments for each patient on admission / arrival, using a recognised tool, and reviewed this regularly, including after any incident. Staff used a short-term assessment of risk and treatability (START) risk assessment. The comprehensive assessment considered a range of risks including social skills, relationships, occupation, relational, self-care, mental state, substance misuse, external triggers, social support, violence, self-harm, suicide, unauthorised leave, attitudes and medicines. This was present in all patients care records. The tool was not being completed in an effective way that described patient risks. For example, under signature risk signs it stated "increase in hostility and physical aggression". The information did not include personal or specific triggers for patients. However, Positive Behaviour Support plans were detailed with this information but had not been used in collaboration with the risk assessment tool.

Management of patient risk

Staff knew about any risks to each patient. However, staff told us that they were scared to be on the ward due to the acuity of the patients. On the first day of the inspection, Marlowe ward was visibly unsettled and noisy. We observed most staff spending time in the nursing office even when patients were increasing in agitation towards each other. One staff member told us that some staff feel intimidated by patients and will stay in the office as a result, leaving those remaining on the ward feeling unsafe.

Staff identified and responded to any changes in risks to, or posed by, patients. Managers held daily flash meetings to discuss a range of information which included staffing figures, increased observations and incidents, in order to determine whether staffing levels were safe and to escalate any known risks. We observed managers discussing incidents that took place on the wards. This included whether the relevant authorities had been involved and what the next steps were to manage the risk. However, one patient's leave had been cancelled and the only record of this was on the white board in the nursing office on Marlowe ward. This had not been recorded in the patient's section 17 form or in the folder.

In the event of an emergency or when more staff are needed to manage an incident, staff could call a response team from across both sites to help.

Staff followed procedures to minimise risks where they could not easily observe patients. The ward has closed circuit television (CCTV) which was reviewed when incidents occurred. Staff followed the provider's observation policy.

Staff followed policies and procedures when they needed to search patients or their bedrooms to keep them safe from harm. The wards had recently experienced illicit substances and lighters being bought onto the ward. As a result, management facilitated sniffer dog searches and random searches in order to keep patients safe. However, one patient had leave requirements to be breathalysed on return from unescorted leave. We could see no evidence of the patient being breathalysed on return from leave.

Use of restrictive interventions

Levels of restrictive interventions across both wards were low. Staff participated in the provider's restrictive interventions reduction programme, which met best practice standards.

Staff made every attempt to avoid using restraint by using de-escalation techniques and restrained patients only when these failed and when necessary to keep the patient or others safe. Prevention Management of Violence and Aggression

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

(PMVA) training was mandatory for all staff who worked with patients. The organisation's medicines policy encourages the exploration of non-pharmacological interventions before using medicines. When medicines were used for managing violence and aggression, oral medicines were explored before injections. Marlowe and Milligan wards had low levels of restraint between January and March 2022. They had a total of three episodes of restraint.

Staff followed NICE guidance when using rapid tranquilisation (RT). Records showed the use of intra-muscular rapid tranquilisation was rare on the ward. The wards had reported zero uses of rapid tranquilisation in between January and March 2022. Staff were able to explain the de-escalation attempts that would be made prior to the use of RT. They understood the need for monitoring of a patient's physical health post dose and how this should be recorded.

Safeguarding

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

Staff received training on how to recognise and report abuse, appropriate for their role. Staff kept up-to-date with their safeguarding training. At the time of the inspection, 94% of staff had completed their safeguarding individuals at risk e-learning training and 100% of staff had completed safeguarding adults at risk intermediate training.

Staff could give clear examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. Staff knew how to recognise adults at risk of or suffering harm and worked with other agencies to protect them. Staff knew how to make a safeguarding referral and who to inform if they had concerns. The hospital shares a social work team and safeguarding lead with their sister site, Cygnet Hospital Woking. Managers took part in serious case reviews and made changes based on the outcomes.

Staff access to essential information

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

Records were stored securely and staff could access patient notes easily. The service used a combination of electronic and paper records. Key documents including positive behaviour plans, care plans and risk assessments were stored on a shared drive to allow staff quick access. Staff recorded progress notes on a specific electronic record system.

Medicines management

The service used systems and processes to safely prescribe, administer, record and store medicines. However, these were not always being followed. Staff regularly reviewed the effects of medicines on each patient's mental and physical health.

Staff used a paper-based system for prescribing and recording administration of medicines. They used an electronic system to document patient's care plans, risk assessments and progress notes. Medicines were obtained from an external pharmacy contractor who dispensed and delivered to the service the next working day. The service kept a stock of commonly used medicines. Outside of regular working hours staff could send prescriptions to the local community pharmacy to obtain supplies. A clinical pharmacist visited the service once a week to check prescription charts and support the prescribers. They also conducted regular audit work. Access to medicine storage areas was appropriately restricted.

Staff had access to medicines disposal facilities.

Staff had pictures of consenting patients with the drug charts to assist in identifying them. Where there was a section on the cover sheet for 'notes on taking medicines' these were very often left blank with no person-centred information included. One example stated 'compliance' with no explanation of what this meant or how to support staff to give medicines effectively to that patient.

The correct procedure for leave medicines (TTOs) was not being followed on Marlowe unit. In the morning whilst observing in the office, we witnessed a member of staff holding a pot of tablets that had been dispensed by the nurse. The staff member was talking to a colleague explaining that these were for a leave but had no way to carry to tablets safely. These were placed in an envelope to be taken off the ward. The medicines were not given with instructions or provided in appropriate packaging to ensure that they were kept safe in transit. The provider subsequently investigated this incident and lessons were learned which were shared with staff and commissioners.

Staff reviewed patients' medicines regularly and provided specific advice to patients and carers about their medicines. Staff reviewed patients' medicines during the ward round. Patients and carers could access a pharmacist if they wanted to discuss their medicines in more detail. Staff took appropriate action to safeguard patients' safety and monitor the effect of their medicines on them. However, there were no fire risk assessments in place for those patients prescribed paraffin-based skin products. There was a high risk of patients being exposed to naked flame on the wards due to recent concerns with patients bringing in lighters and smoking on the ward.

Staff stored and managed medicines and prescribing documents in line with the provider's policy. Patient's MAR (medicine administration record) charts were stored in the clinic room which only authorised staff had access to. Within the MAR charts there were copies of the Mental Health Act certificates as well as monitoring forms for various medicine treatments and records of physical health monitoring. All consent to treatment documentation was in place and being adhered to. Where a patient required additional treatment for a mental health condition that was not included on the T2 or T3 a section 62 urgent treatment form was completed.

Staff followed current national practice to check patients had the correct medicines. Staff reviewed patients' medicines and clinical records when they were admitted, to ensure they had the correct medicines. Any medicines which were no longer suitable or needed were disposed of appropriately with the prior consent of the patient.

The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely. Nursing staff would receive patient safety alerts and we saw a folder which evidenced that these were reviewed and actioned as necessary. The independent pharmacy contractor also ensured these safety alerts were being actioned appropriately. Medicines incidents were logged into an electronic reporting system. Staff told us that learning from any local incidents or those from the wider provider group would be shared with them to improve safe practice and learning.

Processes were in place to ensure people's behaviour was not controlled by excessive and inappropriate use of medicines. PRN medicines for the management of agitation and aggression were used frequently on Marlowe ward and often at the maximum available dose. We did not see records made of the reason for administration or the patients' response to the medicine. We could not be assured that the medicines were being used appropriately to meet patient needs.

Staff reviewed the effects of each patient's medication on their physical health according to NICE guidance. The service employed a lead physical health nurse who ensured that patients had the required blood tests and investigations in line with requirements.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

Track record on safety

Between 1 January 2022 and 12 April 2022, the Care Quality Commission has been notified of 41 incidents across both Milligan and Marlowe wards. These include patients going absent without leave (AWOL), patient on patient assaults, patient on staff assaults, criminal damage and inappropriate use of social media.

Reporting incidents and learning from when things go wrong

The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service.

Staff knew what incidents to report and how to report them. Staff and patients had seen an increase in the amount of racially motivated abuse. Staff reported serious incidents clearly and in line with provider policy.

Staff understood the duty of candour. They were open and transparent, and gave patients and families a full explanation if and when things went wrong.

We reviewed 11 incidents. In general, these were well recorded and reviewed in an appropriate timeframe. However, we found that two incidents were not reflected in the patients' care plans with regards to leave and how staff would support them with leave in the future.

Managers debriefed and supported staff after any serious incident. Staff told us that after a recent serious incident, the hospital director attended the ward to support staff.

Staff received feedback from investigation of incidents, both internal and external to the service. All staff received a weekly learning from incidents bulletin, that shared incidents from across both hospital sites, as well as other Cygnet locations. Staff met to discuss the feedback and look at improvements to patient care. Learning from incidents were shared at clinical governance meetings and shared with ward-based staff at team meetings. An example of changes made as part of learning was that staff should always use a key strap while on shift to ensure the security of ward keys.

Are Long stay or rehabilitation mental health wards for working age adults effective?

Requires Improvement

Our rating of effective went down. We rated it as requires improvement.

Assessment of needs and planning of care

Staff assessed the physical and mental health of all patients on admission. They developed individual care plans which were reviewed regularly through multidisciplinary discussion and updated as needed. However, care plans were generic and generally did not include personalised information on how to care for each patient. Care records for patients with an autism or Asperger's diagnosis rarely included their diagnosis and lacked information on how to support them with their care.

Staff completed a comprehensive mental health assessment of each patient either on admission or soon after. Psychology staff assessed patients within 48 hours of admission so that they could access groups and one to one sessions.

In general, patient care plans were not recovery focused or holistic. In the five care records we reviewed, care plans were generic and generally did not include personalised information on how to care for each patient. Of the five care records we reviewed, two patients had a diagnosis of autism or Asperger's. This information was not evident throughout the care records and did not have associated care plans to support these patients' needs. The provider told us they had put these plans in place for these patients after the inspection. Patient risk assessments were generic and did not contain information on how to successfully de-escalate patients and patient preferences. Although, patients had thorough positive behaviour support plans that were written from the patient voice around their triggers, associated behaviours and how to successfully respond to their increased agitation. This information was not within the care plans or risk assessments and was kept in a different area of the computer system.

Managers had oversight of care planning and a recent audit showed that Milligan and Marlowe wards were 60% compliant. There was no discussion of how this would be improved. However, a monthly care plan review meeting was being planned for both wards.

Best practice in treatment and care

Patients were not actively engaged in therapeutic activities and the recorded activity and engagement was not appropriate for a rehabilitation ward. Activities recorded on the ward did not correlate with those on the timetable. However, staff provided a range of treatment and care for patients based on national guidance and best practice. Staff supported patients with their physical health and encouraged them to live healthier lives. Staff used recognised rating scales to assess and record severity and outcomes. They also participated in clinical audit, benchmarking and quality improvement initiatives.

Although the ward had a comprehensive activity timetable which covered seven days a week and evenings; we observed on the first day of the inspection that activities recorded on the ward did not correlate with those on the timetable. Staff and patients told us that they do not go by the activity timetable but go by the activities on the whiteboard.

Despite activities being available to patients, the patients we spoke with told us they felt bored on the ward and that the activity schedule did not meet their needs. The recorded activity and engagement was not appropriate for a rehabilitation ward, such as cigarette breaks or personal care. We observed activities being attempted on the ward, these included music appreciation, a nature walk and a substance misuse group. Two of these groups did not take place as patients were unwilling to attend and the other group took place because a cigarette break could be facilitated at the same time. Staff told us that they find it difficult to engage patients in the therapeutic programme and activities. The activities timetable was appropriate for the patients within a rehabilitation setting, however, many of the patients admitted at the time of the inspection could not take part in these activities due to their acuity. Staff told us that they find it difficult to facilitate life skill activities due to most patients being on escorted leave, resulting in patients not being upskilled to support their discharge.

There was little evidence in care records that patients were attending groups or being supported with life skill activities suitable for a rehabilitation service. Examples of activities recorded in care records and handover notes were as follows: fresh air for cigarette break, self-directed activity in bedrooms, watching TV, time in communal lounge and a shower. One patient we spoke with stated that they wanted to cook food they enjoyed but that this was not facilitated by staff. The provider informed us following the inspection that they engaged in the Music 2 Empower programme which is a national initiative aimed to harness the power of music therapy and showcased talents of patients.

The service employed a range of therapeutic staff to facilitate activities across the hospital such as assistant psychologists, occupational therapists, and a gym instructor. The occupational therapist had only recently been

employed and was in the process of reviewing the activities on offer and seeking patient views. Two activity co-ordinators were due to start work in the next week. The service had recently seen the departure of the ward psychologist, however a lead psychologist was temporarily covering both Cygnet Lodge Woking and Cygnet Hospital Woking.

Staff identified patients' physical health needs and recorded them in their care plans. The hospital employed a physical health lead nurse, who also worked at the sister site, Cygnet Hospital Woking. The physical health lead nurse trained up physical health champions for each ward. There were some patients with complex physical health needs that were being managed on the wards. Staff ensured they were monitoring weight and vital observations in line with patient risk. Staff made sure patients had access to physical health care, including specialists as required. We saw evidence in care records that patients with significant physical health issues were supported in a multidisciplinary way to meet their needs. Patients were given a physical health review on admission and annually. All patient records we looked at showed regular ongoing monitoring of physical health care.

Staff met patients' dietary needs, and assessed those needing specialist care for nutrition and hydration.

Staff helped patients live healthier lives by supporting them to take part in programmes or giving advice. The service offered a full range of primary health care interventions including health promotions such as smoking cessation, and physical health screening and had a database in place to track and monitor progress. The gym instructor encouraged patients to use the on-site gym. The provider informed us they took part in the Smoke Aware Initiative, a least restrictive intervention aimed at reducing tobacco dependency within inpatient services.

A therapy dog visited the wards once a week offering comfort and affection to people who were dealing with physical and emotional problems.

Staff used recognised rating scales to assess and record the severity of patients' conditions and care and treatment outcomes. For example, the Health of the Nation Outcome Scales, Model of Human Occupation Scale, Short Term Assessment of Risk and Treatability and the Historical Clinical Risk Management 20. However, of the five care records we looked at, no care plans had been evaluated for their effectiveness.

Staff took part in clinical audits, benchmarking and quality improvement initiatives. Support workers conducted a monthly care plan audit and the manager had plans to implement monthly spot checks by the clinical team leads. Managers used results from audits to make improvements.

Skilled staff to deliver care

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

The service had a full range of specialists to meet the needs of the patients on the ward and could refer out to other specialists when needed.

Managers ensured staff had the right skills, qualifications and experience to meet the needs of the patients in their care, including bank and agency staff. Staff were up to date with their mandatory training.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

Managers gave each new member of staff a full induction to the service before they started work. All staff completed an induction when they began their employment. Bank staff completed the same induction and training as permanent staff. Agency staff were inducted into the service at the beginning of their shift. The service requested agency staff who were familiar with the service and the patient group.

Managers supported staff through regular, constructive appraisals of their work. Managers supported staff through regular, constructive clinical and managerial supervision of their work.

Managers made sure staff attended regular team meetings or gave information from those they could not attend. The team meeting agenda was comprehensive and had space for staff to openly feedback about the service. The consultant had started regular senior clinical team meetings once a month to discuss service improvements and how to engage patients in their care and treatment.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge.

Managers recognised poor performance, could identify the reasons and dealt with these.

Multi-disciplinary and interagency team work

Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care. They had effective working relationships with staff from services providing care following a patient's discharge.

Staff held regular multidisciplinary meetings to discuss patients and improve their care. Staff told us that the multidisciplinary team conducted fortnightly reviews of patients are and held monthly care programme approach (CPA) reviews. Patients are routinely invited to attend reviews and if they decline, the nurse will seek feedback from the patient and share this at the meeting.

Staff made sure they shared clear information about patients and any changes in their care, including during handover meetings. However, we did note that one patient who had recently been detained was still recorded as informal on the handover records.

Ward teams had effective working relationships with other teams in the organisation.

Ward teams had effective working relationships with external teams and organisations. External organisations and teams were routinely invited to CPA discussions and the service were actively seeking professionals meetings to ensure that patients were moved onto more appropriate placements that met their needs.

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

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

Staff received and kept up-to-date with training on the Mental Health Act and the Mental Health Act Code of Practice and could describe the Code of Practice guiding principles. At the time of the inspection 94.4% of staff had completed Mental Health Act awareness training.

Staff had access to support and advice on implementing the Mental Health Act and its Code of Practice. Staff knew who their Mental Health Act administrators were and when to ask them for support.

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

We could not see any information on the wards that showed the contact information for the mental health advocate. The provider was in the process changing its advocacy agency at the time of the inspection and leaders took action to ensure posters were displayed after the inspection. The advocate attended the ward every Tuesday morning and this was included on the activity timetable.

Staff made sure patients could take section 17 leave (permission to leave the hospital) when this was agreed with the Responsible Clinician. However, staff told us they find it difficult to facilitate all the leave due to most patients having to be escorted by staff. A carer told us that their relative is rarely taken outside and believes this is because staff are scared of the patient.

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

Managers and staff made sure the service applied the Mental Health Act correctly by completing audits and discussing the findings.

Good practice in applying the Mental Capacity Act

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

Staff received and kept up-to-date with training in the Mental Capacity Act and had a good understanding of at least the five principles. At the time of the inspection, 94.4% of staff had completed Mental Capacity Act/Deprivation of liberty safeguards in principle and practice training. Staff also completed a combined training of the Mental Health Act, Mental Capacity Act and deprivation of liberty safeguards, which 100% of staff had completed.

There was a clear policy on Mental Capacity Act and deprivation of liberty safeguards, which staff could describe and knew how to access. Staff knew where to get accurate advice on the Mental Capacity Act and deprivation of liberty safeguards.

Staff assessed and recorded capacity to consent clearly each time a patient needed to make an important decision. All consent to treatment documentation was in place with medication charts and being adhered to. Where a patient required additional treatment for a mental health condition that was not included on the T2 or T3 a section 62 urgent treatment form was completed. However, capacity assessments were not stored with care plans and there were no capacity assessments for decisions that were not related to medication.

The service monitored how well it followed the Mental Capacity Act and acted when they needed to make changes to improve.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

Are Long stay or rehabilitation mental health wards for working age adults caring?

Requires Improvement

Our rating of caring went down. We rated it as requires improvement.

Kindness, privacy, dignity, respect, compassion and support

Physical health observations were conducted in the lounge where patients' privacy and dignity could not be maintained. Patients told us that staff were reluctant to engage with them. Staff generally treated patients with compassion and kindness.

Staff were not always discreet when caring for patients. We observed physical health monitoring of all patients being conducted in the communal lounge. We felt this did not maintain the dignity and privacy of patients' personal information. We are concerned that this would have an impact of patients feeling able to communicate any physical health concerns they have during this time.

In general, we observed staff treating patients with kindness, dignity and respect. However, on several occasions we found staff were dismissive of patient's views and requests.

The relative we spoke with stated that staff do not care for their relative's personal hygiene. Two patients told us that staff do not engage with them and they are not supported to cook, clean or go off the ward unescorted. Patients told us that there is nothing going on and there are no activities to do.

Staff said they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards patients. Staff followed policy to keep patient information confidential.

Involvement in care

Patients' involvement in care planning and risk assessment was limited and did not always reflect the patient voice. However, staff actively sought their feedback on the quality of care provided. They ensured that patients had easy access to independent advocates.

Involvement of patients

Staff introduced patients to the ward and the services as part of their admission.

Patients had limited involvement in their care planning and there was limited evidence that care plans and risk assessments had been shared with patients. We reviewed five care records across two wards. We found that four care plans contained all the same information and were not personalised. They did not reflect the patient voice and were not written from the patient perspective. For example, statements such as "patient to be supported to shower twice a week" and "patient to be supported to do laundry" were used. However, there was no information on how to achieve these goals. On the other hand we viewed two specific activity care plans that were written in the first person and had clear input from the patients regarding these activities. The positive behavioural support (PBS) plans also demonstrated patient involvement.

Patients could give feedback on the service and their treatment and staff supported them to do this. Both wards held a joint community meeting chaired by the patients. The records showed that these were irregular and did not happen weekly as staff told us. However, in the records we reviewed, we could see that patients could feedback about the

service and make recommendations about the treatment and activities on offer. Some examples for changes made are an Xbox and a new TV for the second lounge. Patients also expressed interest in other groups that could be on offer. Following the inspection, the provider informed us that there was an Expert by Experience lead who regularly visited the wards and supported management decisions around the service including overseeing and capturing feedback from patients. The provider also told us they had a People's Council which aimed to ensure that the voices of patients and carers were heard at every level of the organisation.

The mental health advocate attended the ward weekly. Milligan ward did not have information present on the ward on how to contact the mental health advocate.

Involvement of families and carers

Staff informed and involved families and carers appropriately.

There was a room off the ward that could be used for visiting families. One patient told us that they had not had visitors since their admission and did not know how to go about facilitating this.

Staff supported, informed and involved families or carers. Staff told us that families were routinely invited to monthly ward rounds and care programme approach meetings for their relatives. The relative we spoke with told us they were actively involved in the planning of their relative's care. However, we found little evidence (two out of five care records) of family and relative involvement in the development of patient care plans. In one care plan, we found no family involvement even though the patient had stated that they were important to them.

Staff told us that families and carers were invited to a monthly carers' group. One relative we spoke with told us that they found this interesting and supportive. The occupational therapist had plans to increase engagement such as summer BBQ's.

Are Long stay or rehabilitation mental health wards for working age adults responsive?

Requires Improvement

Our rating of responsive went down. We rated it as requires improvement.

Access and discharge

Staff had recently implemented a new multidisciplinary approach to assess new referrals. Staff were in the process of working with other services to move patients out of hospital to more appropriate services. Patients did not have to stay in hospital when they were well enough to leave.

Senior leaders recognised that the acuity of the patient group was high at the time of the inspection. This meant that patients required more intensive support than would normally be expected in this type of service. Referrals were made through a central Cygnet system and reviewed by an independent Cygnet nurse reviewer. The service had recently created a multi-disciplinary meeting to review referrals that the nurse reviewer deemed appropriate. This gave opportunity for the team to ask questions about the patient in order to assess whether they were appropriate for the service. The team felt confident that they could decline referrals for patients whose needs they could not meet. At the time of the inspection, it was too early to tell whether the new approach had made an impact on the acuity of the service and whether the practice was embedded in the service.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

The service had exclusion criteria for the service. The service used generic inclusion / exclusion criteria for the service line but had no criteria for their individual site. Decisions were down to the multidisciplinary team. Managers said the service had received more referrals for patients with a higher level of acuity and complexity.

At the time of the inspection three patients had been admitted for a period of three years. The average expected length of stay was one and a half to two years. Managers were actively seeking alternative placements for those who were not appropriate for the service and needed a higher level of care and for those who were ready for discharge.

The service accepted referrals from across the country. At the time of inspection, most patients admitted to the service were out-of-area placements.

Discharge and transfers of care

Managers monitored the number of patients whose discharge was delayed, knew which wards had the most delays, and took action to reduce them. At the time of inspection, four patients on Marlowe and Milligan ward were experiencing delayed discharge. Two of these patients were due to be discharged in the upcoming days/weeks. There were active plans in place to support the other two patients in finding alternative placements.

Staff worked with care managers and coordinators to make sure discharge went well. However, only one care record of the five we looked at, had a discharge plan in place.

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

The service followed national standards for transfer.

Facilities that promote comfort, dignity and privacy

Each patient had their own bedroom with an en-suite bathroom and could keep their personal belongings safe. There were quiet areas for privacy. The food was of good quality and patients could make hot drinks at anytime. Patients needed staff to be able to access the kitchen.

Each patient had their own bedroom, which they could personalise. Patients had a secure place to store personal possessions. All patients had keys to their bedrooms.

Staff used a full range of rooms and equipment to support treatment and care. Patients had access to a range of daily activities including, mindfulness, creative arts, breakfast club, self-catering group, karaoke, movie night and the gym. Records showed staff efforts to encourage engagement in activities, however, uptake from patients was low. Patients told us that they were bored and had very little to do. Staff had introduced incentives for patients to attend activities, which included a group outing when patients had attended two groups within a week.

The service had quiet areas and a room where patients could meet with visitors in private.

Patients could make phone calls in private. All patients had access to their own mobile phones. Patients were expected to adhere to the mobile phone policy which they had agreed to.

Patients on Marlowe ward needed staff to support them to access the outside space as the ward was based on the first floor of the building.

Patients could smoke at set times throughout the day, as they needed to be supported by staff to access the garden space. Staff said they tried to encourage patients to reduce or stop smoking, although it was a challenge.

Patients could make their own hot drinks and snacks and were not dependent on staff. However, the kitchen door was locked at all times, due to recent incidents. Patients on Milligan ward were given a £15 allowance a week to buy food in order to cater for themselves. This was supported by occupational therapy. Patients on Marlowe ward were expected to use their own money to buy food if they wanted to cook for themselves.

The service offered a variety of good quality food.

Patients' engagement with the wider community

At the previous inspection in 2020, we told the provider they should ensure that patients are aware of and encouraged to attend community oriented care, education and vocational opportunities. We found that this was still an issue as there was little evidence of patients accessing opportunities for education and work. We were informed by the provider that vocational activities were being looked into by the occupational therapist with consultation from patients in community meetings and on a 1:1 basis.

Meeting the needs of all people who use the service

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

The service could support and make adjustments for disabled people and those with communication needs or other specific needs.

Staff made sure patients could access information on treatment, local services and their rights.

The service had information leaflets available in languages spoken by the patients and local community. Managers made sure staff and patients could get help from interpreters or signers when needed. At the time of the inspection, the ward had no patients who needed this.

The service provided a variety of food to meet the dietary and cultural needs of individual patients. All food adhered to Halal standards and the kitchen staff were happy to facilitate patient preferences. Kitchen staff were able to support patients participating in religious festivals such as Ramadan.

Patients had access to spiritual, religious and cultural support. Patients could access a multifaith room located on the top floor of the building with staff support. The room was shared with the acute ward located at the same site.

Listening to and learning from concerns and complaints

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team and wider service.

Patients, relatives and carers knew how to complain or raise concerns. Milligan and Marlowe ward had received three complaints in March 2022 from one patient. The theme of complaint was staff attitude. However, Milligan ward did not have information on the ward that detailed how to complain about the service.

Staff understood the policy on complaints and knew how to handle them.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

Managers investigated complaints and identified themes.

Staff protected patients who raised concerns or complaints from discrimination and harassment.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint.

Managers shared feedback from complaints with staff and learning was used to improve the service.

The service used compliments to learn, celebrate success and improve the quality of care.

Are Long stay or rehabilitation mental health wards for working age adults well-led?

Requires Improvement

Our rating of well-led went down. We rated it as requires improvement.

Leadership

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

Staff told us the ward manager, medical director and hospital manager were all very approachable. The ward manager had not been in post long and felt supported by his direct line managers and the acute ward manager.

Although the ward manager is not based on the wards, staff told us that the ward manager is supportive and is available when needed. Senior managers had plans to strengthen the support offered to the ward manager. However, this was not yet in place.

Vision and strategy

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

Staff felt that they were not supporting patients who needed to be on a rehabilitation pathway. They told us that the patient acuity was difficult to manage and patients were hard to engage in activity. There were mixed views from staff as to whether they were delivering a rehabilitation model. We were informed by senior managers that the rehabilitation wards were under review for the model of care and the suitability of patients on the ward. Recently, an internal and an external review were conducted with the aim to make changes to the rehabilitation model. The outcome of these reports had not yet been established. The hospital director told us that they were reluctant to make any changes to the service until they had the outcome of the reports.

Culture

In general, staff felt respected and valued. They said the organisation promoted equality and diversity in daily work and provided opportunities for development and career progression. They could raise any concerns without fear.

Staff told us that the team morale was low. When speaking with staff, there appeared to be a divide between agency staff and permanent staff. Staff said they felt more comfortable and supported on shifts with permanent staff. The ward manager was aware of this and had been making attempts for the staff team to work more cohesively together.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

Governance

Information for escalation from handover meetings was cascaded to the daily flash meetings where staff discussed staffing, skill mix and safeguarding. There were fortnightly multidisciplinary meetings to review patients' treatment.

Clinical governance meetings took place monthly and covered a wide range of information, including incidents, restrictive practice, use of restraint, use of rapid tranquilisation, enhanced observations, therapeutic hours, medicines management, complaints, compliments, supervision, appraisals and training. On observation of the clinical governance meeting for April 2022, we found there to be little discussion around actions taken to remedy issues highlighted. For example actions noted from an audit conducted by Ashton's pharmacy did not involve discussion around how these were going to be remedied or improved.

Monitoring of therapeutic activities within a clinical governance meeting showed Marlowe at 92% compliant and Milligan ward at 86% compliant with 25 hours a week of therapeutic activity per patient. This was not evident in care records which recorded activities that did not support a rehabilitation model such as cigarette breaks and personal care.

The hospital did not hold information regarding unfilled shifts and at the time of the inspection, they could not provide the number of bank staff used. There was no oversight of how these issues may affect patient care.

When staff were not meeting compliance targets, the compliance manager would follow up with the ward manager and ask for action to be taken.

Management of risk, issues and performance

Teams had access to the information they needed to provide safe and effective care and used that information to good effect. Ward managers could escalate concerns so that senior managers were aware. Senior managers decided if an issue needed to be added to the risk register. On review of the risk register, concerns we identified, such as acuity of the patient group and delivering to a rehabilitation model were not included.

The wards had recently introduced a multidisciplinary meeting to discuss any new referrals deemed appropriate to be admitted to the rehabilitation wards. Staff felt supported to decline inappropriate referrals and seek further information regarding patients, if needed, to make an informed decision about admission. It was too early to state whether this had become embedded practice or have an impact on the acuity of patients on the ward.

The hospital conducted an internal review of their rehabilitation patients to determine whether their medicines were appropriate.

Information management

Staff collected analysed data about outcomes and performance and engaged actively in local and national quality improvement activities.

Staff used an online training system that identified outstanding training for staff when they logged on. Staff received emails one, two or three months prior to training expiring and if training was outstanding.

Staff used a combination of electronic and paper records. Staff had their own individual computer log in to access patient records to ensure confidentiality. Staff uploaded documents such as positive behaviour plans, care plans and risks assessments onto patient records.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

Staff had access to an online incident reporting tool which prompted staff to consider if notifications to external bodies was appropriate.

Learning, continuous improvement and innovation

The hospital was actively recruiting international nurses to fill vacancies across Cygnet Lodge Woking and their sister site. We were told that this had been successful and two new qualified nurses had been recruited on Milligan and Marlowe wards.

The service held a quarterly improvement meeting to monitor the internal quality improvement team's actions for the service.

The hospital was in the early stages of introducing a quality improvement initiative regarding the amount of patient AWOL's on the rehabilitation wards. It was too early in the process to see any changes that had been made as a result and the impact of these.

After the inspection the provider informed us that the services had a mental health first aider, who offered people a welcoming space to express themselves and talk. Other initiatives included Trauma Risk Management (TRiM) which involved supporting people who have been through a traumatic experience and also and Sustaining Resilience at Work (StRaW) a peer support programme aimed to help detect and prevent occupational mental health issues and boost an organisation's psychological resilience.

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 10 HSCA (RA) Regulations 2014 Dignity and respect • The provider did not ensure that patient identifiable information was not accessible or available for patients to read/see on Marlowe and Milligan wards. • The provider did not ensure that physical observations were conducted in a way that protected the patient's privacy and dignity on Marlowe and Milligan wards.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury Diagnostic and screening procedures	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care • The provider did not ensure that the patients on Marlowe and Milligan wards were actively engaged in therapeutic activities that were suitable for a long stay rehabilitation service and met the needs of the patient group. • The provider did not ensure that patients on Marlowe and Milligan wards were aware of and encouraged to attend community oriented care, education and vocational opportunities. • The provider did not ensure that the patient voice was heard throughout their care plans and risk assessments on Marlowe and Milligan wards. • The provider did not ensure that patients with an autism/Asperger's diagnosis had care plans which supported their care and treatment.

Regulated activity	Regulation

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance • The senior management team did not have appropriate oversight of the provision of activities being delivered on both Milligan and Marlowe wards.
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment • The provider did not ensure that action was taken to safeguard medicines supplies when the temperature of medicines storage areas fell outside of the recommended limits on Marlowe and Milligan wards. • The provider did not ensure that medicines to be administered off Marlowe ward were given with the correct instructions and in appropriate packaging. • The provider did not ensure that the medical equipment for measuring blood glucose levels on Marlowe and Milligan wards was calibrated at the frequency required for this equipment.