Cygnet Behavioural Health Limited

Cygnet St. Williams

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	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Good

Summary of findings

Overall summary

Our rating of this location stayed the same. We rated it as good because:

- The service provided safe care. The hospital 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 personalised, holistic, recovery-oriented care plans informed by a comprehensive assessment. They provided care and treatments suitable to the needs of the patients and in line with national guidance about best practice.
- The hospital team included or had access to a range of specialists required to meet the needs of patients in the hospital. The staff worked well together as a multidisciplinary team and with those outside the hospital who would have a role in organising 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 and families and carers in care decisions. The service received consistently positive feedback from patients.
- Staff planned and managed discharge well and liaised well with services that would provide aftercare. As a result, discharge was rarely delayed.
- The service was well led, and the governance processes ensured that ward procedures ran smoothly.

However:

- Not all staff had up to date appraisals in place in line with the providers policy
- The manager did not have oversight of whether nurse to patient 1:1 time was completed on a weekly basis.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Services for people with acquired brain injury	Good 	As detailed in the summary section above.

Summary of findings

Contents

Summary of this inspection

Background to Cygnet St. Williams

Cygnet St Williams is a 12 bed neuropsychiatry service offering care and treatment to men over the age of 18 years affected by acquired brain injuries.

The service has been registered with the Care Quality Commission since 18 February 2019 to provide the following regulated activities:

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

• Treatment of disease, disorder and or injury.

The service has a registered manager and controlled drugs accountable officer.

There had been one previous inspection of this service, carried out on 5 & 6 February 2020. The inspection found the provider to be meeting all of the standards inspected in the domains of effective, caring, responsive and well led however in the safe domain the service required improvement.

What People who use the service say

We spoke with five patients during our inspection and reviewed feedback from eight patients from a survey in January 2022.

Patients who used the service gave overwhelmingly positive comments. They said the staff treated them with kindness, respect and dignity and they felt safe.

We spoke with four relatives who were positive about the service and commented that patients were safe living there. They reported staff knew and supported their relatives well, involved them in the relatives' care and kept in touch with the family on a regular basis even when they lived a long way away.

How we carried out this inspection

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

• Is it safe?

• Is it effective?

• Is it caring?

• Is it responsive to people's needs?

• Is it well-led?

Summary of this inspection

Before the inspection visit, we reviewed information that we held about the location including information discussed at provider engagement meetings.

During the inspection visit, the inspection team:

- visited the hospital, looked at the quality of the ward environment and observed how staff were caring for patients
- spoke with five patients who were using the service
- spoke with four family members of patients
- spoke with the registered manager and operations director
- spoke with twelve other staff members; including doctors, nurses, occupational therapist, psychologist, speech and language therapist, health care support workers, activity coordinators and administrative staff
- received feedback about the service from the Commissioners
- spoke with an independent advocate
- attended and observed a handover meeting and a multidisciplinary meeting
- looked at four care and treatment records of patients
- carried out a specific check of the medication management
- looked at a range of policies, procedures and other documents 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

Areas for improvement

Action the service SHOULD take to improve:

- The service should ensure staff log informal complaints from patients or carers to help highlight trends for improvement.
- The service should ensure staff appraisals are completed in a timely manner in line with the providers policy.
- The service should review the use of the three assisted bedrooms on the ground floor as they do not promote independent patient care.
- The service should ensure the patients 'you said we did board' is displayed in patient communal areas to inform patients of progress from issues raised in community meetings or surveys.
- The service should further consider the methods staff used to record patient care information to ensure they remain contemporaneous, are completed in full and are easy for staff to follow.
- Prescribers should ensure the name of the drug prescribed is handwritten clearly for other staff to read.

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Services for people with acquired brain injury	Good	Good	Good	Good	Good	Good
Overall	Good	Good	Good	Good	Good	Good

Good

Services for people with acquired brain injury

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

Are Services for people with acquired brain injury safe?

Good

Our rating of safe improved. We rated it as good.

Safe and clean care environments

All wards were 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.

The design and layout of the hospital meant that staff could not easily observe patients in all parts of the wards. The nurse's station was located centrally in the main corridor and we saw curved mirrors had been placed in corridors to remove blind spots. The staff used regular observation, individual risk assessments, management plans and a qualified nurse in the ward areas to reduce risks.

There were potential ligature anchor points in the service. Staff knew about these and mitigated the risks to keep patients safe. The hospital had a ligature risk audit which included ligature risk heat maps for all rooms and a ligature risk assessment by room, which were readily available for staff.

Staff had easy access to alarms and patients had easy access to nurse call systems. Visitors to the unit were provided with alarms and instructed how to use them.

Maintenance, cleanliness and infection control

Ward areas were clean, well maintained, well-furnished and fit for purpose.

Staff made sure cleaning records were up-to-date and the premises were clean. Cleaning rotas were kept up to date and had been signed daily to demonstrate cleaning had been completed including patient bedrooms.

Staff followed infection control policy, including handwashing. There were appropriate COVID-19 guidelines in operation at the service. Hand sanitisers were available for patients, staff and visitors to use.

Good

Services for people with acquired brain injury

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. The hospital had two shifts a day, which covered 24 hours, seven days a week. The nurse establishment at the time of inspection was two registered nurses with five support workers during the day shift, and one registered nurse and five support workers at night. The service had no nursing vacancies but six health care support worker vacancies at the time of our inspection for which they were in the process of recruiting.

The service had low rates of bank nurse usage. However, the use of bank and agency health care assistants was higher due to the vacancy rate. The manager used a specific agency and requested staff familiar with the service. Managers made sure all bank and agency staff had a full induction and understood the service before starting their shift.

The service had a 38 % turnover rate totalling ten staff in the last 12 months which covered a range of staff roles. This included three bank staff who had not taken up shifts in a three-month period. Two members of staff had since returned to the service. Exit interviews were conducted for the majority of staff who left the service.

Managers supported staff who needed time off for ill health. Staff sickness in the last 12 months was 5.5%.

Managers accurately calculated and reviewed the number and grade of nurses, and healthcare support workers for each shift. 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, these sessions were recorded in the patient notes. However, the manager had no recent oversight as to whether these were completed weekly as required.

Patients rarely had their escorted leave or activities cancelled, even when the service was short staffed.

The service had enough staff on each shift to carry out any physical interventions safely. All staff were trained in managing violence and aggression.

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 service did not use locum doctors as there was adequate cover.

Mandatory training

The service provided mandatory training in key skills to all staff and made sure everyone completed it.

Good

Services for people with acquired brain injury

Staff had completed and kept up to date with their mandatory training. The mandatory training programme was comprehensive and met the needs of patients and staff. Mandatory training included topics such as safety intervention, Mental Health Act, Mental Capacity Act, Deprivation of Liberty Safeguards, intermediate life support, basic life support, epilepsy, infection prevention control, supporting autistic people, epilepsy, equality and diversity, and food safety.

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. They achieved the right balance between maintaining safety and providing the least restrictive environment possible in order to facilitate patients' recovery. Staff followed best practice in anticipating, de-escalating and managing challenging behaviour. As a result, they used restraint only after attempts at de-escalation had failed. The ward staff participated in the provider's restrictive interventions reduction programme.

Assessment of patient risk

Staff completed risk assessments for each patient on admission, using a recognised tool, and reviewed this regularly, including after any incident.

The service used the Short-Term Assessment of Risk and Treatability (START). We reviewed four records relating to the care and treatment of patients. We found in all records staff had completed a risk assessment for each patient and those assessments had been regularly reviewed and updated.

Management of patient risk

Staff knew about any risks to each patient and acted to prevent or reduce risks. Care plans contained guidance and interventions for managing those risks.

Staff identified and responded to any changes in risks to, or posed by, patients. Staff attended daily handover meetings, and weekly ward rounds where any risk presented by a patient were discussed and actioned via the multidisciplinary team approach led by the doctor. This approach had led to more robust interventions which had minimised risk of incidents re-occurring such as peer to peer assaults and physical aggression.

Staff followed the providers policies and procedures when they needed to search patients or their bedrooms to keep them safe from harm.

Use of restrictive interventions

Levels of restrictive interventions were at a low or medium level.

This was an improvement on the previous inspection as we found blanket restrictions were now individually assessed and regularly reviewed.

Staff participated in the provider's restrictive interventions reduction programme, which met best practice standards. Staff understood the Mental Capacity Act definition of restraint and worked within it.

There were 38 instances of restraint for three months prior to the inspection. We fully reviewed two restraint records which involved the use of arm holds. Staff made every attempt to avoid using restraint by using de-escalation and diversion techniques and restrained patients only when these failed and when necessary to keep the patient or others safe.

Seclusion and rapid tranquilisation was not used at Cygnet St Williams.

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 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 and children at risk of or suffering harm and worked with other agencies to protect them. The service had effective communication with the local authority and were able to query safeguarding issues with them. Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff had made safeguarding referrals and were able to give examples of these.

Staff followed clear procedures to keep children visiting the ward safe.

Staff access to essential information

Staff had access to clinical information, but it was not easy for them to maintain high quality clinical records – whether paper-based or electronic.

Patient notes were comprehensive, but were a mix of electronic and paper records, stored in different locations. All patients also had a summary record of key information for the patients care which included individual risks and staff knew where these were kept. Whilst the four records we reviewed were complete and contemporaneous we were concerned there was a risk that key information could be missed due to information being kept in different locations. This made it onerous for staff to locate key information. The system was also difficult to navigate initially which could also be an issue for new or agency qualified nursing staff should they be used in the future.

When patients transferred to a new team, there were no delays in staff accessing their records.

Records were stored securely.

Medicines management

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 followed systems and processes to prescribe and administer medicines safely. A pharmacist visited the ward on a weekly basis to audit the prescribing and offer advice.

Staff reviewed each patient's medicines regularly and provided advice to patients and carers about their medicines. Staff reviewed the effects of each patient's medicines on their physical health in line with to National Institute for Health and Care excellence guidance.

We examined the medicines records of all nine patients and found that decision-making processes were followed to ensure that people's behaviour was not controlled by excessive and inappropriate use of medicines.

Staff completed medicines records accurately and kept them up to date. However, in some records we reviewed the name of some medication handwritten on the form was a little unclear.

Staff stored and managed all medicines and prescribing documents safely. The clinic room had recently been relocated to a larger room to facilitate greater storage of medication, a quieter location and additional space for the nurse and patient.

Staff followed national practice to check patients had the correct medicines when they were admitted, or they moved between services.

Staff learned from safety alerts and incidents to improve practice.

Track record on safety

The service had a good track record on safety.

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. When things went wrong, staff apologised and gave patients honest information and suitable support.

Staff knew what incidents to report and how to report them. As part of their mandatory training, staff received guidance on incident management. Staff reported serious incidents clearly and in line with the providers policy. All the staff we spoke with felt confident to recognise and report incidents.

The service had no never events on the ward.

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. The hospital had not had any incidents that met the duty of candour threshold in the last 12 months.

Managers debriefed and supported staff after any serious incident. The staff we spoke with confirmed they felt fully supported after any incident with a patient. Support from the psychologist was available for staff that required it.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations.

Staff received feedback from the investigation of incidents, both internal and external to the service. Lessons learned was a standard agenda item for staff meetings and we saw this covered learning from internal incidents and incidents from other services managed by the provider. Managers also shared learning with their staff about never events that happened elsewhere.

Staff met to discuss the feedback and look at improvements to patient care. Incidents from the previous 24 hours were discussed at daily handover meetings as a standard agenda item and at the weekly ward rounds with the multidisciplinary team. They were also reviewed weekly by the manager and senior nurse.

Good

Services for people with acquired brain injury

There was evidence that changes had been made as a result of feedback. For example, managing patient to patient incidents by looking at the risky periods and locations such as outside breaks and mealtimes and distracting or diverting to avoid conflict points. A further example was assessing a patient's mood before mealtimes to determine the type of tableware appropriate for the patient on each occasion to avoid more serious incidents.

Are Services for people with acquired brain injury effective?

Good

Our rating of effective stayed the same. We rated it 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, and were personalised, holistic and recovery oriented.

We examined, in detail, four care records of current patients and found each patient had a full and comprehensive assessment.

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 which met their mental and physical health needs. Staff regularly reviewed and updated care plans when patients' needs changed.

Best practice in treatment and care

Staff provided a range of treatment and care for patients based on national guidance and best practice. This included access to psychological therapies, support for self-care and the development of everyday living skills and meaningful occupation. 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 provided a range of care and treatment suitable for the patients in the service. Patients had access to psychological therapies, occupational therapies, speech and language therapy and physiotherapy as well as pharmacological therapies.

Staff delivered care in line with best practice and national guidance. The provider had an experienced neuropsychiatric lead overseeing and developing the hospital's approach. There was a service model in place, incorporating guidance from recognised bodies, for example, the British Society of Rehabilitation Medicine and National Institute for Health and Care excellence.

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. A registered general nurse was part of the hospital

nursing team and was taking up a physical health lead role. There was a service level agreement with the local GP surgery, so all patients were registered locally and a GP attended the hospital weekly to attend to physical health needs of patients. Patients also had access to a dentist, podiatrist, a chiropodist and optician. Patients had weekly physical health checks and more frequent as required.

Staff met patients' dietary needs and assessed those needing specialist care for nutrition and hydration. A dietician visited the hospital one day a week and had input into patients' care plans as needed. The speech and language therapist was part of the multidisciplinary team and provided support with dysphagia - problems swallowing certain foods or liquids, difficulties with communication and swallowing disorders. Staff used a nationally recognised framework to prepare food and drink for patients with swallowing difficulties.

Staff helped patients live healthier lives by supporting them to take part in programmes or giving advice. This included specific eating plans from the dietician through to healthy menus devised by the full-time chef or staff assisting the patients with shop and cook sessions as an activity. The multidisciplinary team also worked with activity coordinators to develop a coordinated approach to rehabilitation and exercise. Information about healthy eating and other programmes was also available for patients in the activity rooms and communal areas of the hospital.

Staff took part in clinical audits, benchmarking and quality improvement initiatives. These were completed regularly by the multidisciplinary team who monitored improvements in patient functioning. For example, the speech and language therapist used outcome measures including, Specific Measurable Achievable Relevant Time bound targets, Goal Attainment Scaling, National Service Framework for long term conditions and accessible information standards. The occupational therapist used standardised outcome measures such as the Functional Independence Measure and Functional Assessment Measure and Model of Human Occupational Screening. Outcomes were reported to the clinical board and heads of service and shared with the clinical governance team.

Staff used technology to support patients, this included a laptop, hand-held electronic devices, a handheld telephone and access to an electronic games console. The equipment helped to facilitate video calls with patient's friends and family, online shopping and online games.

Managers used results from audits to make improvements. Staff took part in clinical audits for example patient records, Mental Health Act and Deprivation of Liberty Safeguards documentation, incidents and cleaning. We saw actions were addressed and the results from a further audit compared to show an improvement.

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 a full range of specialists to meet the needs of the patients on the ward. This included a neuropsychiatrist, a psychologist, an occupational therapist, a speech and language therapist a physiotherapist and a dietician. An assistant psychologist was also due to start work having already volunteered at the hospital, whilst training. The provider employed activity coordinators who worked with the therapy team and patients. Patients also had access to a GP.

Good

Services for people with acquired brain injury

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. The service employed seven qualified nurses with a mix of general, mental health and learning disability qualifications to support the patient group.

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. This included an annual appraisal and regular clinical and management supervision. At the time of our inspection management and clinical supervision compliance was 91%. The appraisal rate was 62% largely due to staffing pressures due to COVID-19. Managers were aware of the appraisal issue and working to resolve the position. All the staff we spoke with confirmed they had access to appropriate supervision and appraisal.

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

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Staff also had the opportunity to access a variety of support from the psychologist such as drop-in sessions, resilience training and mindfulness and relaxation to support their work.

Managers made sure staff received any specialist training for their role this included a neuropsychiatry workbook for all new staff including agency at the start of working on the ward. There was also other specialist training provided such as dysphagia, using feeding tubes, catheter training and working with people with a learning disability.

Managers recognised poor performance, could identify the reasons and dealt with these. They had access to a supportive corporate human resources department that could provide the necessary knowledge and guidance.

Multi-disciplinary and interagency teamwork

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 and engaged with them early on in the patient's admission to plan discharge.

Staff held regular multidisciplinary meetings to discuss patients and improve their care. We observed a multidisciplinary meeting and saw how staff from different disciplines worked together in a patient focussed way. Each member of the multidisciplinary team had input into patients' treatment and care plans.

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

Ward teams had effective working relationships with other teams in the organisation. The provider had other hospitals including those working with patients with acquired brain injuries. Where appropriate, staff from this location shared knowledge, good practice and learning to develop services and the quality of care.

Ward teams had effective working relationships with external teams and organisations.

Good

Services for people with acquired brain injury

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 and could describe the Code of Practice guiding principles. At the time of inspection staff compliance for the Mental Health Act training was 100%.

Staff had access to support and advice on implementing the Mental Health Act and its Code of Practice. The hospital employed a part-time Mental Health Act administrator and staff knew they could ask 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.

Patients had easy access to information about independent mental health advocacy and patients who lacked capacity were automatically referred to the service. We saw the advocate engaging well with patients during our inspection whilst on their weekly visit to the hospital.

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 and/or with the Ministry of Justice. Staff facilitated patients to take leave and often supported them with excursions in the hospital minibus. The patients we spoke with told us there was never any problem with them taking leave.

Staff requested an opinion from a second opinion appointed doctor when they needed to.

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

Informal patients knew that they could leave the ward freely and the service displayed posters to tell them this.

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 providers 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 inspection staff compliance for the Mental Capacity Act/ Department of Liberty Safeguards training was 100%.

Good

Services for people with acquired brain injury

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. There were six Deprivation of Liberty Safeguards applications made in the last 12 months. These applications were overseen by managers to ensure they were completed correctly,

Staff gave patients all possible support to make specific decisions for themselves before deciding a patient did not have the capacity to do so. Staff supported patients to communicate their wishes through the use of pictures, talking mats and non-verbal communication such as a facial expression or body movement. Staff were very aware of methods of communication for all patients, which were well documented in patient notes. Staff used this when assessing capacity with patients.

Staff assessed and recorded capacity to consent clearly each time a patient needed to make an important decision. We saw examples of detailed capacity assessments in patient's care records. Where staff could not identify a patient's nearest relative, they involved an independent mental capacity advocate. This is someone who can support and represent the patient in the decision-making process and ensure the Mental Capacity Act is being followed.

When staff assessed patients as not having capacity, they made decisions in the best interest of patients and considered the patient's wishes, feelings, culture and history. We saw evidence of best interest meetings in care records which involved family members or where appropriate advocates, and these were well documented.

Staff made applications for a Deprivation of Liberty Safeguards order only when necessary and monitored the progress of these applications.

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

Are Services for people with acquired brain injury caring?

Good

Our rating of caring stayed the same. We rated it 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.

We spoke with five patients throughout the inspection and they were very positive about the staff and the care they received.

Staff were discreet, respectful, and responsive when caring for patients. They gave patients help, emotional support and advice when they needed it. We observed and heard positive interactions between patients and staff. There were always staff in communal areas to support patients.

Good

Services for people with acquired brain injury

Staff supported patients to understand and manage their own care treatment or condition. The diagram for the model of care was well displayed in communal areas and some patients could identify where they were currently on the illustrated pathway for recovery. 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. The full staff team worked across disciplines to get to know and understand patients and where appropriate their families, to help understand the patients personal, cultural and social needs.

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 and the services as part of their admission. Patients received an easy to read welcome brochure to help them navigate around the ward.

Staff involved patients and gave them access to their care planning and risk assessments. Not all patients wanted this but there was evidence in care records that staff had offered them the opportunity to be involved in their care and this was regularly reviewed. Staff made sure patients understood their care and treatment and found ways to communicate with patients who had communication difficulties. Staff supported patients to make decisions on their care and patients were invited to multidisciplinary meetings where their care was reviewed.

Patients could give feedback on the service and their treatment and staff supported them to do this. There had been a patient survey in January which all patients completed themselves or with the help of staff. Patients were also encouraged to attend a weekly community meeting. Community group minutes showed both staff and patients attended. We saw eight sets of community meeting minutes which often referred to food, menus choices and activities.

The ward did not have a 'You said, we did' board, to record actions from issues raised at patient meetings. However, we were told this was a temporary measure whilst other information was displayed in its place.

Staff made sure patients could access advocacy services. The advocate visited the ward every week and all patients were offered the opportunity to meet with them.

Involvement of families and carers

Staff informed and involved families and carers appropriately.

Staff supported, informed and involved families or carers. We spoke with four carers of patients who were highly complementary about the service and staff. They felt involved in their family member's care and had regular

communication with the team. One carer commented that they had not been notified of a change in their relatives' observation until it was in place. Families and carers were invited to attend or contribute to multidisciplinary team review meetings where appropriate and provided with notes of the meeting. Families commented that they could ring or visit any time and were made to feel welcome, one carer stated that staff had 'made them feel part of the family'.

The carers we spoke with described the staff as 'amazing', 'going the extra mile' and 'that they really want the best for each patient'. A couple of carers commented that since their relative moved to the hospital, knowing that they are well looked after gave them peace of mind, and they were no longer anxious about them. Another carer said that they had seen significant improvement in the two years their relative had been at the hospital.

Staff helped families to give feedback on the service their relative received. Some families had provided positive feedback to staff verbally and by email and one responded recently to the carers survey.

Are Services for people with acquired brain injury responsive?

Good

Our rating of responsive stayed the same. We rated it as good.

Access and discharge

Staff planned and managed patient discharge well. They worked well with services providing aftercare and managed patients' move out of hospital. As a result, patients did not have to stay in hospital when they were well enough to leave.

Managers regularly reviewed length of stay for patients to ensure they did not stay longer than they needed to. The expected length of stay for patients was six months to two years. Staff worked to make sure they did not discharge patients before they were ready. When patients were discharged it was planned and well-coordinated with the new placement of the patient. Staff did not move or discharge patients at night or very early in the morning.

There were nine patients in the hospital at the time of our inspection. Most patients were from other areas of the country because the hospital provided specialist treatment that was not available everywhere. When patients went on leave there was always a bed available when they returned.

Since opening, no patients had required access to a psychiatric intensive care bed, however if needed there was a ward locally.

Discharge and transfers of care

Discharge plans were discussed with patients on admission and regularly discussed in their care review meetings. Managers monitored the number of patients whose discharge was delayed, and took action to reduce them. The service had only one delayed discharge recently and staff were working with the local community team to resolve this.

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 coordinators to make sure this went well. Patients had discharge plans and discharge meetings took place with the involvement of relevant professionals.

Good

Services for people with acquired brain injury

The service followed national standards for transfer.

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 dependent on individual risk assessments. When clinically appropriate, staff supported patients to self-cater.

Each patient had their own bedroom, which they could personalise. This included a secure place to store personal possessions.

Staff used a full range of rooms and equipment to support treatment and care. Patients had access to a gym, an activity room, two lounges, a dining room and an activities of daily living kitchen. Some patients prepared their own meals using the specially designed kitchen, sometimes as part of a shop and cook activity with staff.

The service had outside space patients could access easily. This comprised of one large garden and a second smaller one accessed from different areas of the ward.

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

Patients could make phone calls in private. Some patients had access to their own mobile phones, and the ward had a cordless phone patients could use in their rooms if they wanted.

Patients could make their own hot drinks and snacks however, their kitchen was kept locked, and patients had to ask for it to be opened whenever they wanted to make a drink. Patients assessed as being well enough and safe to have the responsibility to access the kitchen independently were given a fob.

The service offered a variety of good quality food. Patients discussed menus and food choices and requests in community meetings, and we saw requests were frequently met. The patients we spoke with told us they enjoyed the food and it was of a high standard.

Patients' engagement with the wider community

Staff supported patients with activities outside the service, such as work, education and family relationships.

When appropriate, staff made sure patients had access to opportunities for education and work, but some patients required a period of stabilisation before engaging in these activities.

Staff helped patients to stay in contact with families and carers. Patients had access to facilities so they could have virtual meetings with their loved ones and carers were encouraged to visit patients as often as they wanted.

Staff encouraged patients to develop and maintain relationships both in the service and the wider community. One patient was supported to go to the local church each Sunday and patients also had access to two local gyms. The hospital had a minibus which facilitated patient's local appointments as well as trips out for example to the parks, cinema, shopping and a local football match. The service was also on a bus route which patients used, particularly to do shopping.

Good

Services for people with acquired brain injury

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. The hospital was accessible for patients with mobility needs including a lift for patients to the first-floor rooms. There were assisted bathroom facilities and an occupational therapist supported patients to obtain any additional equipment they needed. In total there were five assisted bedrooms, however the three on the ground floor were more restricted in space and therefore less suitable for more independent living. We saw patients use one of the larger two assisted bedrooms upstairs as they became more independent.

Staff made sure patients could access information on treatment, local services, their rights and how to complain. There were communication boards for patients that contained information on their rights, advocacy and local activities. They also contained information explaining the patient journey through from admission to discharge. There was easy-read information available and patients were regularly reminded about their rights. Patients told us they knew how to complain if they needed to.

The service did not have information leaflets available in languages spoken by the patients and local community, but managers made sure staff and patients could get help from interpreters or signers when needed.

The service provided a variety of food to meet the dietary and cultural needs of individual patients. This included halal meat, vegetarian options, diabetic diets and modified diets.

Patients had access to spiritual, religious and cultural support. One visitor room was also used as a multifaith room and there was a local church close by.

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. We confirmed this when we spoke to carers. Most patients raised their concerns with the hospital manager or staff working with them.

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

Managers investigated complaints and identified themes where possible. There was one formal complaint which was resolved and one informal complaint in the last 12 months. The manager said that this was because patients would report issues to the staff who would try to resolve the issue straight away to minimise any distress. Patients also had access to the advocacy service weekly. We reviewed the last three advocacy quarterly reports which identified no complaints from patients.

Staff understood the policy on complaints and knew how to handle them. They protected patients who raised concerns or complaints from discrimination and harassment because they welcomed the feedback to help improve care.

Good

Services for people with acquired brain injury

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 through staff meetings and handovers. We saw learning was used to improve the service from complaints, for example night staff changed their outside break area away from patient bedroom areas to minimise noise for patients.

The service also used compliments to learn, celebrate success and improve the quality of care. There were 14 compliments recorded in the last 12 months.

Are Services for people with acquired brain injury well-led?

Good

Our rating of well-led stayed the same. We rated it 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.

Managers had a good understanding of the service which followed a model for neuro rehabilitation care based on national good practice guidance. They had the right skills, knowledge and experience to run the service providing good-quality, individualised, sustainable care. Staff told us that senior managers and the ward manager were visible, and they knew who they were. Staff and patients at the hospital were consistently complimentary about the registered manager.

Managers and staff confirmed development opportunities for career progression were available and were encouraged to take these up.

Vision and strategy

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

We saw staff worked to the visions and values of the service and that these were discussed in staff supervisions, staff meetings, debriefs, in house training and lessons learnt discussions. They were also available for all staff on the intranet. We heard how staff worked together with the leadership team to ensure they delivered high quality care.

The service used values-based recruitment processes. Staff induction included information and guidance about the provider's vision and values.

Culture

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

Staff felt respected, supported and valued. They were motivated, friendly and focused on the needs of each individual patient receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. We saw several examples of additional training staff were involved in. The service had an open culture where patients, their families and staff could raise concerns without fear. We saw the manager operated an open-door policy for staff, patients and families.

Staff told us they enjoyed working as part of a team and were very proud of the patient's improvements over time as a result of the care they received at Cygnet St Williams.

The provider had a 'Random acts of kindness award scheme' for staff to nominate other staff members. If successful, staff received an e-thank you card and gift voucher. In the last 18 months eight staff members at the service had received awards.

The hospital had appropriate whistleblowing policies in place and staff received training and guidance about this.

Governance

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

Leaders operated effective governance processes, throughout the service. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

We saw systems and processes were embedded in the hospital to ensure there was effective oversight of areas including undertaking audits, incident reviews and shared learning. Findings were reviewed and monitor by senior managers in the service and the regional quality manager to support the monitoring of performance.

The service provided staff at every level with development opportunities and staff were supported to access specialist training relevant to their role.

Shifts at the time of inspection were filled with the right numbers and skills to meet the needs of patient's needs. There were no registered nurse vacancies however, there were six health care support worker vacancies. There was an active recruitment drive to appoint to these vacancies.

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.

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and implemented actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

Managers and senior managers had easy access to key performance data for the service in the form of three weekly dashboards namely operational, clinical and quality which were discussed and reviewed with any necessary actions taken. The data included key information such as incidents, training, supervision, restraint, falls, complaints and staffing.

Good

Services for people with acquired brain injury

Effective multidisciplinary meetings across the service helped to reduce patient risks and keep patients and staff safe. Staff notified and shared information with external organisations. Staff were open and transparent and explained to patients and families when something went wrong. We saw staff had good rapport with patients.

Managers told us they had access to the risk register at ward level.

There were plans in place to manage any emergency that arose for the hospital. The service had plans for emergencies, for example, adverse weather or other incidents that could affect the running of the service.

Information management

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

The service collected reliable data and analysed it. Staff had access to equipment and information technology needed to do their work. Staff could find the data they needed, in accessible formats, to understand performance, make decisions and improvements.

Managers had access to information to support them with their leadership of the hospital. This included information on performance of the service, staffing and patient care. Information was in an accessible presentation and was completed in a timely manner.

Data or notifications were consistently submitted to external organisations as required.

Staff undertook training in patient confidentiality and information governance.

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.

Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

In November 2021 the service received an 'Excellence in Care award' from the local authority in recognition of the additional care extended to a patient and his relatives, located out of area.

The experience of patients was actively sought by staff. Patients could give feedback through community and other meetings as well as through the advocacy service or directly with staff.

Carers were invited to provide feedback in ways that reflected their individual needs such as surveys, phone calls, visits and emails.

The service managers kept in regular contact with the patient's commissioners of their care inviting them to monthly multi-disciplinary meetings and advising them of any changes in care or risks.

The service had good communication with the local adult safeguarding team.

Good

Services for people with acquired brain injury

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

Managers had made several improvements since the last inspection which addressed the concerns that were found. This included a conclusive response for staff morale with staff being respected, supported and valued, completing an assisted bathroom suitable for patients requiring assistance and further ensuring an individualised approach to patients care therefore removing blanket restrictions previously in place.

Managers worked together effectively to improve the service, for example the new model of neurorehabilitation and recovery of care.

The consultant neuropsychiatrist held regular teaching sessions for the multi-disciplinary members to further knowledge and encourage debate and challenge around a patients care when considering care and treatment plans. Topics included delusion and other erroneous ideas, hypoxic ischemic brain injury, vestibular system and sensory system.

The psychologist was the lead for research and development, working in the role one day a week. The role included being chair of the provider's research and development team who scrutinise all research studies to ensure they have ethical permissions and monitor them throughout the ongoing research.

In terms of neuro specific work, the psychologist had completed a piece of research offering mindfulness and relaxation sessions for staff working in St Williams and also supervising two other pieces of research. Firstly, research looking at carers perceptions of having a loved one with an acquired brain injury admitted to a neurorehabilitation unit and secondly research looking at patient peer relationships within a neurorehabilitation unit.

Nationally the provider participated in a variety of national audits and benchmarking initiatives. These include the Prescribing Observatory for Mental Health national audit, National Group Benchmarking-Prescription chart audit, NHS Benchmarking data including for neuro services.