Cygnet Surrey Limited

# Cygnet Lodge Woking

**Inspection report**

Barton Close
Knaphill
Woking
GU21 2FD
Tel: 01483485999
www.cygnethealth.co.uk

Date of inspection visit: 1st February 2023
Date of publication: 03/04/2023

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? | Requires Improvement |
| 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

Our rating of this service stayed the same. We rated it as requires improvement because:

- The ligature risk assessment for Marlowe ward did not accurately reflect the identified ligature risks of the bedroom environment. For example, although the bedrooms were suitably rated as high risk, there were identified ligature risks that were shown as low risk. The mitigation provided in the assessment for one of these risks was also not accurate with what was in place at the time. We fed this back during the inspection and have seen evidence that the provider addressed this for the bedrooms, as well as reassessing and developing new ligature forms for other areas of the ward, though these should be reviewed regularly to ensure they remain accurate.
- At the time of the inspection, the service did not have a maintenance log in place to record repairs that were needed, or that had been requested. This meant that they could not monitor and ensure that maintenance actions already reported were rectified in a timely way. We found maintenance issues on Marlowe ward including a broken fridge that was still being used, and a broken door handle, both of which had been reported but not addressed. Since inspection, the service has sent evidence of a new log which will monitor the progress of maintenance issues.
- Some staff raised concerns around the safety of staffing numbers on Milligan ward when it was expected that one support worker would be on the ward with four patients. Although, there had not been any reported incidents as a result of this lone working and staff confirmed that there was support from staff on Marlowe ward if an incident was to occur or if cover was needed for breaks. Management assured staff that they would review and increase the staffing numbers, yet this had not been done. Leaders told us that staffing was based on the ward acuity and the resources needed to escort community patients.
- Not all managers were visible within the service. Some staff told us that the ward manager was not always visible on the wards although the senior nurses and deputy manager were supportive and available when needed. The consultant psychiatrist was also not visible on the wards to both staff and patients other than during ward rounds, and some staff felt that a greater presence on the wards would have a positive impact for both patients and staff.
- Although the service had positive behaviour support (PBS) plans in place which identified triggers and described how to work with individuals diagnosed with autism, this information was not clear throughout the care plans. Given the use of agency staff on the wards who may not be familiar with these individuals, this could impact the care and appropriate risk management of these patients. Following initial feedback, the senior leaders and wider directors reviewed this and developed a more suitable template to ensure that this information is captured fully within the care plans.
- We saw discharge planning discussed as part of the ward round, although we only saw discharge plans outlined in one of the seven care records we reviewed and there was clearly still a need for this to be embedded fully. Leaders acknowledged that these needed to be captured in care plans.

However:

- The ward environments were clean and well furnished. Staff assessed risk well. They analysed and minimised the use of restrictive practices through clinical governance, they managed medicines safely and followed good practice with respect to safeguarding.
- Staff provided a range of activities and treatments suitable to the needs of the patients and in line with national guidance about best practice. Patients told us that they engaged in regular activities including quiz nights, community skills, shopping/ cooking and breakfast groups, as well as therapy sessions, including both occupational therapy and psychology. Staff engaged in clinical audits to evaluate the quality of care they provided.
- We saw good practice around physical health monitoring including clozapine and stool monitoring.

# Summary of findings

- The ward teams 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.
- We saw that each patient had their care team details on the front of their bedroom door, so they knew which staff were caring for them. Ward rounds were inclusive and patient feedback was respected.
- Staff understood and discharged their roles and responsibilities with the use of the Mental Health Act 1983 and the Mental Capacity Act 2005 safely.
- Patients reported that staff treated them with kindness and respect. Patients we spoke with felt safe and told us that they had access to nursing and care staff when they needed. They actively involved patients, families and carers in care decisions.
- The service worked to a recognised model of mental health rehabilitation. It was well led, and the governance processes ensured that ward procedures ran smoothly.

# Summary of findings

## Our judgements about each of the main services

| Service | Rating | Summary of each main service |
|---|---|---|
| **Long stay or rehabilitation mental health wards for working age adults** | Requires Improvement  | Our rating of this service stayed the same. We rated it as requires improvement because:<br>• The ligature risk assessment for Marlowe ward did not accurately reflect the identified ligature risks of the bedroom environment. For example, although the bedrooms were suitably rated as high risk, there were identified ligature risks that were shown as low risk. The mitigation provided in the assessment for one of these risks was also not accurate with what was in place at the time. We fed this back during the inspection and have seen evidence that the provider addressed this for the bedrooms, as well as reassessing and developing new ligature forms for other areas of the ward, though these should be reviewed regularly to ensure they remain accurate.<br>• At the time of the inspection, the service did not have a maintenance log in place to record repairs that were needed, or that had been requested. This meant that they could not monitor and ensure that maintenance actions already reported were rectified in a timely way. We found maintenance issues on Marlowe ward including a broken fridge that was still being used, and a broken door handle, both of which had been reported but not addressed. Since inspection, the service has sent evidence of a new log which will monitor the progress of maintenance issues.<br>• Some staff raised concerns around the safety of staffing numbers on Milligan ward when it was expected that one support worker would be on the ward with four patients. Although, there had not been any reported incidents as a result of this lone working and staff confirmed that there was support from staff on Marlowe ward if an incident was to occur or if cover was needed for breaks. Management assured staff that they would review and increase the |

# Summary of findings

staffing numbers, yet this had not been done. Leaders told us that staffing was based on the ward acuity and the resources needed to escort community patients.

- Not all managers were visible within the service. Some staff told us that the ward manager was not always visible on the wards although the senior nurses and deputy manager were supportive and available when needed. The consultant psychiatrist was also not visible on the wards to both staff and patients other than during ward rounds, and some staff felt that a greater presence on the wards would have a positive impact for both patients and staff.
- Although the service had positive behaviour support (PBS) plans in place which identified triggers and described how to work with individuals diagnosed with autism, this information was not clear throughout the care plans. Given the use of agency staff on the wards who may not be familiar with these individuals, this could impact the care and appropriate risk management of these patients. Following initial feedback, the senior leaders and wider directors reviewed this and developed a more suitable template to ensure that this information is captured fully within the care plans.
- We saw discharge planning discussed as part of the ward round, although we only saw discharge plans outlined in one of the seven care records we reviewed and there was clearly still a need for this to be embedded fully. Leaders acknowledged that these needed to be captured in care plans.

However:

- The ward environments were clean and well furnished. Staff assessed risk well. They analysed and minimised the use of restrictive practices through clinical governance, they managed medicines safely and followed good practice with respect to safeguarding.
- Staff provided a range of activities and treatments suitable to the needs of the

# Summary of findings

patients and in line with national guidance about best practice. Patients told us that they engaged in regular activities including quiz nights, community skills, shopping/ cooking and breakfast groups, as well as therapy sessions, including both occupational therapy and psychology. Staff engaged in clinical audits to evaluate the quality of care they provided.

- We saw good practice around physical health monitoring including clozapine and stool monitoring.
- The ward teams 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.
- We saw that each patient had their care team details on the front of their bedroom door, so they knew which staff were caring for them. Ward rounds were inclusive and patient feedback was respected.
- Staff understood and discharged their roles and responsibilities with the use of the Mental Health Act 1983 and the Mental Capacity Act 2005 safely.
- Patients reported that staff treated them with kindness and respect. Patients we spoke with felt safe and told us that they had access to nursing and care staff when they needed. They actively involved patients, families and carers in care decisions.
- The service worked to a recognised model of mental health rehabilitation. It was well led, and the governance processes ensured that ward procedures ran smoothly.

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

**Good**

# Summary of findings

## Contents


### Summary of this inspection

Page

Background to Cygnet Lodge Woking 8

Information about Cygnet Lodge Woking 10

### Our findings from this inspection

Overview of ratings 12

Our findings by main service 13

# 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 adult 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. The high dependency rehabilitation unit is split over two wards and consists of Marlowe ward with 12 beds and Milligan House has eight beds which consist of six pre-discharge beds and 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 outline their high dependency rehabilitation service as a recovery focused service that delivers high quality care balancing risk management with therapeutic optimism and encourages men to break cycles of relapse and build upon skills needed to move towards the least restrictive care option or return to the community. The National Institute for Health and Care Excellence (NICE) defines high dependency rehabilitation units as "Inpatient rehabilitation units for people with complex psychosis whose symptoms have not yet been stabilised and whose associated risks and challenging behaviours remain problematic. These units aim to maximise benefits of medicine, address physical health comorbidities, reduce challenging behaviours, re-engage families and facilitate access to the community." The primary diagnoses of the patients referred to the high dependency rehabilitation unit was a mental health condition with may include complex co-morbities, substance misuse, treatment resistance and behaviours that challenge. The provider described how most of their patients came to them following multiple placement breakdowns, failed treatment programmes or as a step down from secure settings.

Cygnet Lodge Woking 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

The hospital manager has been registered with the Care Quality Commission (CQC) as the registered manager for the location since March 2022. The registered manager, along with the registered provider, is legally responsible and accountable for compliance with the requirements of the Health and Social Care Act 2008 and associated regulations.

We carried out this focused inspection of the high dependency rehabilitation unit because at our last inspection in 2022 we rated them Inadequate in Safe and told the provider that they must take action to improve the following:

• The service must ensure that the activities on Marlowe and Milligan wards are suitable for a long stay rehabilitation service and meet the needs of the patient group.

• The service must ensure that patients are aware of and encouraged to attend community-oriented care, education and vocational opportunities.

• 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.

• The service must ensure that patients with an autism/Asperger's diagnosis have care plans that support their care and treatment.

# Summary of this inspection

• The service must ensure that patient identifiable information is not accessible or available for patients to read/see.

• The service must ensure that physical observations are conducted in a way that protects the patient's privacy and dignity.

• 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.

• The provider must ensure that medicines supplies are stored within the recommended temperature limits on Marlowe and Milligan wards.

• The provider must ensure that medicines to be administered off the wards are given with the correct instructions and in appropriate packaging.

• The provider must ensure that the medical equipment for measuring blood glucose levels is calibrated at the frequency required for this equipment.

Following the 2022 inspection the hospital responded to the concerns and provided the CQC with an action plan to address them. We monitored the progress of the action plan and held frequent engagement meetings with them. We undertook this focused inspection of this service to check they had followed their action plan and to confirm they now met the required standards. Based on the findings at this inspection, we saw that the provider had made improvements to address all of the required standards and we did not identify any outstanding breaches.

This report covers our findings in relation to the key questions: Safe and Well led which have been inspected and re-rated. We also inspected how the provider had specifically addressed the previous concerns under Effective, although not all parts of this key question were inspected and as such, not able to be re-rated. For the key questions of Caring and Reponsive which were not inspected, we used the ratings awarded at the last inspection to calculate the overall rating. The overall rating for the service has remained as requires improvement, however the rating for the key question of Safe has improved.

**What people who use the service say**

At the time of the inspection there were 15 patients on the high dependency rehabilitation unit, out of a total capacity of 20. We spoke with two patients who both gave us positive feedback on their experience of the service. Most patients were out on leave during our visit.

Both patients we spoke with told us that they felt safe, with one who explained that this had been the safest place that they had been and the other told us that this had been the best ward that they had been on. They told us that they were engaged in regular activities including quiz nights, community skills, and shopping/ cooking and breakfast groups, as well as therapy sessions, including both occupational therapy and psychology. One told us that they would like more sport based activities to engage with. They told us that they could have one to ones with staff when they wanted them, and that staff were nice and kind towards them and treated them with respect. One told us that staff worked hard and listened to them when they raised concerns. Both patients were aware of how to make a complaint. They told us that they were involved in their care planning and had seen a copy and signed their care plans. Both patients told us that the service was clean and that the ward was cleaned daily. They also told us that they loved the food.

# Summary of this inspection

## How we carried out this inspection

**What we did:**

The team that inspected the service comprised of four CQC mental health inspectors. Before the inspection visit, we reviewed information that we held about the hospital.

During the inspection visit, we completed the following activity:

- visited both wards and observed how patients were being cared for by staff
- spoke with two patients
- spoke with 12 members of staff including the hospital manager, clinical manager and deputy hospital manager, the ward manager, the deputy ward manager, a physical healthcare nurse, a clinical psychologist, an occupational therapist, a senior social worker, and support staff.
- observed the hospital daily flash meeting and ward round on Milligan ward
- reviewed seven care plans and risk assessments across both wards
- reviewed 14 prescription charts across both wards
- inspected the clinic rooms on both wards
- reviewed incident records
- reviewed a range of documentation and policies relating to the running of the wards.

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 MUST take is necessary to comply with its legal obligations. Action a trust 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**:

- The service must ensure audits of ligature risk assessments identify the appropriate risk rating and that the mitigations in place are accurate. (Regulation 12: Safe care and treatment)
- The service must review the staffing matrix on Milligan ward to ensure its appropriateness for the safety of staff and patients. (Regulation 12: Safe care and treatment)
- The service must ensure appropriate oversight of the recording and documentation of individualised discharge plans within patient's care records. (Regulation 17: Good governance)

**Action the service SHOULD take to improve:**

- The service should ensure visibility of managers and multidisciplinary (MDT) leaders on the wards to improve communication and approachability for staff and patients.
- The service should ensure better oversight by local leaders of incidents, complaints and the risk register.
- The service should audit care plans to ensure that information is clearly outlined around the specific care and treatment of patients with autism.

# Summary of this inspection

- The service should consider formalising the local arrangement with commissioners to return inappropriate admissions to their referring providers and include this into their service line operating framework.
- The service should consider adding dates to the “You said, we did” boards so that it is clear how current the responses are.

# Our findings

## Overview of ratings

Our ratings for this location are:

| | Safe | Effective | Caring | Responsive | Well-led | Overall |
|---|---|---|---|---|---|---|
| Long stay or rehabilitation mental health wards for working age adults | Requires Improvement | Insufficient evidence to rate | Not inspected | Not inspected | Requires Improvement | Requires Improvement |
| Acute wards for adults of working age and psychiatric intensive care units | Good | Good | Good | Good | Good | Good |
| Overall | Requires Improvement | Requires Improvement | Requires Improvement | Requires Improvement | Requires Improvement | Requires Improvement |

# Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

| | |
|---|---|
| Safe | Requires Improvement |
| Effective | Insufficient evidence to rate |
| Well-led | Requires Improvement |

## Is the service safe?

Requires Improvement

Our rating of safe improved. We rated it as requires improvement.

### Safe and clean care environments

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

### Safety of the ward layout

Staff completed risk assessments of all wards areas and mitigated most of the risks they identified. However, we checked the ligature audits against what risks were present in the different areas of the wards and whilst most risks were identified and mitigated, we did find inconsistencies with the ligature audit risk assessments for the patient bedrooms. The ligature risk assessment for Marlowe ward did not accurately reflect the identified ligature risks of the bedroom environment. For example, although the bedrooms were suitably rated as high risk, there were identified ligature risks that were shown as low risk. The mitigation provided in the assessment for one of these risks was also not accurate with what was in place at the time. As such, there were ligature risks which were not reflected appropriately within the audit. We fed this back at the time of the inspection and have seen evidence that the ligature risk audit has since been updated for the bedroom to address the inconsistencies, as well as reassessment and new ligature forms that have been put in place for other areas of the ward. Leaders told us that refresher ligature training has also been provided to the senior ward team.

Due to the layout of the building staff could not always observe patients in all parts of the wards. For example, the layout on Milligan ward was quite cramped and did not allow staff to observe patients in all parts of the wards. Although, the patients on both Marlowe and Milligan wards were all assessed as low risk of self-harm and/or suicidality, with those on Milligan ward assessed as the most stable in their rehabilitation. Managers told us that in the event of the risk increasing, appropriate enhanced observations would be put in place.

Staff had easy access to alarms and patients had easy access to nurse call systems. Managers told us these were checked every six months. Some staff told us that they felt safe on the wards, although others told us that they did not feel safe working on Milligan ward alone.

### Maintenance, cleanliness and infection control

# Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

Ward areas were clean, well-furnished and fit for purpose. Patients and staff told us that the wards were cleaned daily and cleaning records were up-to-date. In addition, on a weekly basis they carried out a "all hands-on deck" whereby all staff and patients worked together to clean the communal ward spaces and the patients bedrooms. Cleaning schedules were in place and up to date.

However, the wards were not always well maintained. Some of the communal bathroom suites were looking worn and tired. On the day of the inspection, there was a broken door handle on the door of the second lounge which was used as a relaxation room/ or for activities. We also saw a faulty fridge on Marlowe ward besides the drink making facilities. This showed a temperature of 28c and had an open carton of milk inside which staff told us was because a patient had placed it back there. It also had an out of date Portable Appliance Testing (PAT) sticker for September 2022. PAT testing is the term used to describe the examination of electrical appliances and equipment to ensure they are safe to use. Managers informed us that the fridge was out of use although this would not have been obvious to anyone on the ward due to being switched on and having no signage. This was shown by the patient who placed the milk carton back inside. The provider took action to rectify this issue by removing the fridge. Managers also showed evidence of reporting a fault with the fridge via email in January and told us that they had also reported the faulty door handle which they were going to escalate on that day.

Leaders told us that they had a hospital wide system where green forms were completed and sent to the maintenance teams to action and once actioned, these were signed off. However, when asked, managers on the ward did not have a maintenance log in place to record issues that had been reported or to monitor and ensure that maintenance actions already reported were rectified in a timely way. Since inspection, the service has sent evidence of a new log which will monitor the progress of maintenance issues.

Staff followed infection control policy, including handwashing. There were infection control notice boards within the main ward areas and infection control concerns were discussed as part of the senior management team flash meeting.

### Clinic room and equipment

Clinic rooms were fully equipped, with accessible resuscitation equipment and emergency drugs that staff checked regularly. Whilst the clinic room on Milligan ward was particularly small, it had the appropriate stock and equipment which were all within safe parameters. Previously we were concerned about the temperature recordings within the clinic rooms however on this inspection, temperature checks evidenced that medicines were stored within the manufactures recommended range in both clinic rooms, and an audit was in place and used regularly to check this.

Staff checked, maintained, and cleaned equipment. Records were kept of all clinical devices that were cleaned and this was audited daily.

Previously we were also concerned about the infrequent calibration of blood glucose medical equipment. We found that blood glucose monitoring forms were completed, and the machines were calibrated weekly for all patients.

During the last inspection, we identified concerns around physical observations of patients and how these were not protective of their privacy or dignity. We observed that on Marlowe ward these were being carried out in the separate quiet room with the door closed. On Milligan ward, a screen was available for staff to use to maintain the privacy and dignity.

### Safe staffing

# Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

**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 the number and grade of nurses, nursing assistants and healthcare assistants for each shift. The service had a staffing matrix which they used to indicate the numbers of each grade required for a shift dependent upon patient numbers. The ward manager told us that they could adjust staffing levels according to the needs of the patients.

Recent staffing figures for the month prior to our visit showed the service was not always working with the numbers of both qualified and unqualified staff assessed as required for the number of patients they had on the wards. However, managers adjusted the mix of skills to ensure that there were enough staff. Managers told us that staff worked across both wards. Some staff told us that staffing was often left short on Marlowe ward due to patients going on escorted leave. For Milligan ward, on most occasions when there were lower support worker numbers, there were higher numbers of qualified nursing staff.

Some staff that we spoke with did not feel that the staffing numbers on Milligan ward were enough when it was expected that one support worker would be on the ward with four patients. Although, there had not been any reported incidents as a result of this lone working and staff confirmed that there was support from staff on Marlowe ward if an incident was to occur or if cover was needed for breaks. Management had assured staff that they would review and increase the staffing numbers, yet this had not been done. Leaders told us that staffing based on the ward acuity and the resources needed to escort community patients.

Both Marlowe and Milligan wards used bank and agency support workers daily. Although, the service had low use of bank and agency nurses. Within the last month, Marlowe ward had a total of five bank and agency qualified nursing shifts and Milligan ward had a total of four bank and agency qualified nursing shifts.

Some staff told us that it was difficult working with agency staff as they did not have the rapport with patients, which sometimes made it difficult to support them. Managers told us that they limited their use of bank and agency staff and requested staff familiar with the service. Managers showed the electronic system used to fill shifts and monitor any unfilled shifts. If the shifts are not filled by overtime or bank staff, then it goes to agency. However, if a member of permanent staff or bank staff subsequently decided to take on the shift, then they would have priority over an agency staff member.

The service had low and reducing vacancy rates. There were currently two vacancies for qualified nurses, with one international nurse due to start in March. There were also four vacancies for support workers, although two were in the process of onboarding which left two remaining vacancies.

Managers made sure all bank and agency staff had a full induction and understood the service before starting their shift. The service also had handovers at the start of both day and night shifts to ensure that necessary information about patients was shared. Managers created a staff induction booklet which was thorough and provided all new starters to the ward with necessary information for working on the ward including handover times, environment, equipment, documentation, important points of contact, and security.

The turnover rate for the last 12 months for Cygnet Lodge Woking was 33%. This figure included information from George Willard ward, an acute service. It was at 29% including those staff who had left permanent positions to join the staffing bank.

# Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

Data given to us by the provider showed that levels of sickness were low at 2.26%.

Patients rarely had their escorted leave or activities cancelled, even when the service was short staffed. The two patients we spoke with told us that they could engage with regular activities and vocational opportunities. One patient told us that staff were available when they needed and that there would always be at least one member of staff that could take them on escorted leave. The other told us that the ward was fully staffed most days but that even when staffing was short, staff continued to try their best to support patients. We saw that each patient had their care team details attached to the front of their bedroom door, so they knew which staff were caring for them.

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

The wards had a consultant psychiatrist who worked part time and a fulltime associate specialist doctor. The doctor and consultant provided out of hours duty cover to respond to emergencies.

### Mandatory training

Staff had completed and kept up-to-date with their mandatory training. At the time of the inspection some training fell just below the provider's target of 90% compliance. Training that did not meet their internal compliance levels were: Basic Life Support & Automated External Defibrillation - which includes Ligature (87.5%), Immediate Life Support & Automated External Defibrillation (87.5%), Prevention Management of Violence & Aggression - Initial Teamwork / PSTS Training (75%) and Prevention Management of Violence & Aggression - Personal Safety (81.3%). Senior leaders gave explanations for the lower levels of compliance which included a new member of staff being added to the database, staff members being booked onto the next available courses which were due in the next two months, and where a staff member had completed their training on the day before the inspection so this had not been included in the data refresh.

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, basic and immediate life support and automated external defibrillator training, food safety, equality and diversity and health and safety. We also saw evidence of an all staff email that had been sent to announce that the service was introducing mandatory training for Autism and Learning Disability and that this was due to be allocated to staff on the same day as we inspected.

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 and seclusion only after attempts at de-escalation had failed. The ward staff participated in the provider's restrictive interventions reduction programme.**

# 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, 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. Risk assessments were updated every three months unless there was an identified change in risk. Any changes made would be reflected when the risk assessment updated daily. At the time of the inspection, all patients' records were identified as low risk of self-harm and suicidality.

Patients also had individual risk assessments in place for example, for the use of the kitchen on the wards. All patients had their own bedroom keys.

## Management of patient risk

Staff knew about any risks to each patient and acted to prevent or reduce risks. For example, one patient had a risk of seizures and there were appropriate risk management plans in place to help staff manage this. Managers also told us that since the last inspection, there was now multidisciplinary team (MDT) input into the assessment of referrals. This enabled more holistic and thorough screening of the presenting risks, and whether these could be safely managed on the ward. Managers also told us that there were agreements in place with commissioners so that if any admissions became unmanageable, these patients would return to their referring location. They gave an example of this happening in November 2022 with a former patient whose risk increased within two weeks.

Staff identified and responded to any changes in risks to, or posed by, patients. Managers held daily flash meetings with the sister site, Cygnet Hospital Woking, to discuss a range of information which included any emerging risks or incidents.

Staff followed procedures to minimise risks where they could not easily observe patients. The wards had CCTV which was reviewed regularly for audit purposes and when incidents occurred to identify learning. Staff ensured that all patients had hourly observations, although this was increased if the presenting risk required this. All staff were required to read the providers observation policy and complete a competency assessment prior to taking part in any observations.

Staff followed trust policies and procedures when they needed to search patients or their bedrooms to keep them safe from harm. The wards had experienced incidents with contraband being bought onto the ward. As a result, management put in place secure lockers allocated to each bedroom at the entrance to the ward. This was to encourage patients to place items such as cigarettes and lighters into the lockers, as sometimes they were reluctant to hand these in to staff due to allegations of loss/ theft. Managers told us that since the instalment of these lockers, the incidents relating to contraband had reduced. Staff were also aware of the search policy and told us that they searched patients upon return from leave and carried out random bedroom searches.

Staff shared key information to keep patients safe when handing over their care to others. A daily handover took place every morning and every evening to ensure that staff were aware of any changes to patient presentation including risk concerns and medicine changes.

## Use of restrictive interventions

Levels of restrictive interventions were low and /or reducing and staff participated in the provider's restrictive interventions reduction programme, which met best practice standards. The service recorded 13 restraints on both wards over the past 12 months.

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 (PMVA) training was mandatory for all staff who worked with patients.

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 three uses of rapid tranquilisation for both wards over the past 12 months. Staff explained how de-escalation methods would be made prior to the use of RT.

## 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.**

The hospital had fortnightly meetings with the local authority safeguarding teams to discuss safeguarding incidents and concerns. This ensured that the hospital was not stand alone when it came to safeguarding and were working alongside the local authority to action, report and seek advice quickly and efficiently. The service also kept a log of referrals to monitor ongoing investigations and actions.

Staff received and kept up to date with their safeguarding training. There was a system to alert managers when staff needed to complete or refresh their training.

Staff understood what safeguarding was and knew how to make a safeguarding referral and who to inform if they had concerns. The provider had a full-time social worker based onsite who was part of a wider social work team shared with their sister site. The social worker was available tor safeguarding advice, and there were also allocated safeguarding leads across the sites which were clearly identified in the staff induction booklet.

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 high quality clinical records – whether paper-based or electronic.**

Staff could access patient notes easily. Staff completed patient progress notes using the service's electronic record system which also contained risk assessments and care plans. The care plans included assessment and plans for personal needs, communication and social needs, mental health needs, rehabilitation needs, potential risks, physical health and arranged leave.

Records were stored securely. Previously we had been concerned as to the privacy of patient notes being completed on Milligan ward as these were being done in a communal area and visible to others. However, since the last inspection the service had created a small office room for staff to complete notes which was private. Some staff had complained that the room was particularly small and that it was not comfortable.

## 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.**

# Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

Staff followed systems and processes to prescribe and administer medicines safely. We reviewed the medicine management systems on both wards and found that staff managed medicines safely and securely. We found that these processes were completed in line with the provider's policy and that there were no gaps in recording. Medicine cards were audited twice a week and staff also completed a daily medicine error check twice a day.

Previously we had concerns around the correct procedures being followed for medicine being taken out for leave (TTO's), particularly around these being given with the correct instructions and in appropriate packaging. To resolve this issue, the service now used TTO packs provided by the independent pharmacy contractor and these ensured that staff prepared and dispensed TTO medicines safely and appropriately.

Staff reviewed each patient's medicines regularly and provided advice to patients and carers about their medicines. Doctors reviewed patients' medicines on a regular basis during ward rounds, or as required if there was a change in the patient's presentation. Patients and carers could also access a pharmacist if they wanted to discuss their medicines in more detail.

Staff completed medicines records accurately and kept them up-to-date. The service used an external pharmacy service to provide oversight of medicines and documentation. The pharmacist visited weekly to carry out these checks.

Staff stored and managed all medicines and prescribing documents safely. All medicines and prescribing documentation were stored in the clinic room which was kept locked. Controlled drugs were managed in line with national regulations. Medicine was in date and not overstocked, and stock checks were carried out twice weekly, these checks were audited.

Staff followed national practice to check patients had the correct medicines when they were admitted, or they moved between services. Staff reviewed patients' medicines and clinical records when they were admitted, to ensure they had the correct medicines.

The service ensured people's behaviour was not controlled by excessive and inappropriate use of medicines. When rapid tranquilisation was used on patients, staff understood the need for monitoring patient's physical health post dose and how this should be recorded. The service also had a new process whereby staff also completed a document when rapid tranquilisation was used and sent this to the quality assurance team. This provided assurance and oversight that this was being used appropriately.

Staff reviewed the effects of each patient's medicines on their physical health according to NICE guidance. The lead physical health nurse ensured that patients had the appropriate physical health care plans in place within 72 hours of admission and that physical health monitoring, including that of clozapine and stool monitoring, was being carried out. Staff told us that physical health observations were carried out daily on admission and weekly thereafter. Staff made sure patients had access to physical health care, including specialist clinics such as "well man", vaccines and diabetes management alongside a GP who attended the service every week.

Staff learned from safety alerts and incidents to improve practice. All medicine related incidents were reported via the incident management systems. We saw a recent example of learning taken from a medicines incident which had led to a change in practice to minimise the risk of reoccurrence. For example, where two patients had similar names and were both on depot medicines, the wrong one was given to one patient. The learning taken included the process of two nurses overseeing depot medicine preparation and administration, as well as visible signage in the clinic room as a reminder of this process and both nurses to go through depot medicine prescribed on that shift to ensure policy has been followed.

# Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

## 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.**

Incidents were discussed at handovers and hospital daily flash meetings.

Staff knew what incidents to report and how to report them. Staff reported serious incidents clearly and in line with trust policy. Staff made appropriate notifications to external agencies such as the CQC and the local authority when required. Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation when things went wrong.

The service recorded all incidents using an electronic incident management system. Senior leaders kept data on recorded incidents to monitor changes or increases in incident type and/or timeframes. Data given to us from the provider showed that in the last 12 months they had recorded 290 incidents, however 265 of these were categorised as "no harm" incidents. The main themes seen in the incident data provided and within the incident records reviewed onsite included contraband (dangerous items & drugs), absence without official leave (AWOL), verbal threats to staff members and actual physical violence to another patient. Local leadership on the ward were not clear on the themes of incidents and explained that this was due to the compliance team having this insight.

Most staff told us that they received debriefs and support following incidents. We saw evidence that lessons learned, including those from other Cygnet locations, were shared in weekly staff bulletins called "Woking Weekly" as well as ward-based staff team meetings which were minuted. A lockable storage space had been put in place on the entrance/exit to the Marlowe ward. Managers told us that this had been put in place to enable patients to keep items such as lighters and cigarettes in there and to have their own access to these upon accessing leave. This was to minimise incidents around allegations of theft, as well as contraband being brought onto the wards.

## Is the service effective?

Insufficient evidence to rate

We looked at the Effective domain to see how the provider had addressed the requirement notices for this domain from the last inspection. However, we did not inspect all the key lines of enquiry for Effective so we have not re-rated this domain.

Previously we advised the provider to ensure care plans were in place for patients diagnosed with autism. On the day of our inspection there were two patients with a diagnoses of autism. Although both patients had PBS plans in place which identified triggers and how best to work with them, this information was stored electronically on a separate drive and was not recorded clearly within the patients' care plans. Given the use of agency staff on the wards who may not be

familiar with these individuals, this could impact the care and appropriate risk management of these patients. Following initial feedback, the senior leaders and wider directors reviewed this and developed a more suitable template to ensure that this information is captured fully within the care plans. We have since received evidence of this update that is now in place.

We saw improvements with the MDT input within care plans. For example, where plans were described it was clear which staff members, inclusive of MDT, would assist in helping the patient achieve these goals.

Previously, we also told the service that care plans must ensure the involvement of patients. We did see patient voice was evident throughout most care plans. Where patients did not contribute to their care plans, in most it was recorded that the patient had declined. Both patients we spoke with told us that they were involved in their care planning and had seen a copy and signed their care plans.

Previously we raised concerns regarding the therapeutic activity on the wards meeting the needs of the patient group. We saw evidence of appropriate activities taking place on the ward, as well as a notice board in the communal area advertising several paid vocational opportunities. Most patients were out on community activities and leave during our inspection. Staff did tell us that motivation was still a barrier in getting patients to engage with activities but that they tried their hardest to achieve this. One patient was working in a paid vocational role in the kitchen.

## Is the service well-led?

Requires Improvement

Our rating of well-led stayed the same. 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. However, not all managers were visible in the service and approachable for patients and staff.**

The service had an experienced senior leadership team. The hospital manager moved to the hospital in November 2021, having been a former hospital director of another independent hospital group. The clinical/deputy hospital manager had been at the hospital for almost eight years. Both came from an experienced background of mental health nursing and line management.

The structure of the reporting lines within the hospital had been changed so that the roles of compliance and human resources (HR) sat directly under the hospital manager to allow for greater oversight of these functions. Leaders told us that the regional Cygnet support was positive.

The ward manager was supported by their direct line managers in the senior team who spent time on site to support with weekly audits and regular supervision. The ward manager had also been enrolled on a level five leadership course. A deputy manager was also on the wards to strengthen the leadership. Senior leaders told us that they also attended the site for handovers, team meetings and night shifts once a month, in order to meet with staff and to offer support.

However, not all managers were visible within the service. Some staff told us that the ward manager was not always visible on the wards although the senior nurses and deputy manager were supportive and available when needed. The consultant psychiatrist was also not visible on the wards for both staff and patients other than during ward rounds, and some staff felt that a greater presence on the wards would have a positive impact for both patients and staff.

## 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 leadership team had communicated their vision for the service to frontline staff. Most staff spoke enthusiastically about the improvements that had been made with the service, both environmentally but also therapeutically. Previously staff felt that they were not supporting the right patients within the service and whilst there was still one patient on the wards where consensus was that the service was not appropriate for them, plans were underway to move this patient to an alternative setting closer to their home and most felt that the model was working well. Although, some staff still felt that some patients were too unwell to engage with a rehabilitation setting.

The model of care for the service had been reviewed and we saw evidence of a clear care model that met the definition of a high dependency inpatient rehabilitation service. Leaders told us that admissions were not previously being reviewed holistically and as such, other members of the MDT were not part of assessing whether an individual was suitable for the service. Managers and staff told us that they were able to offer more individualised programmes of care and treatment that focused on the journey to discharge. The recent stability of the MDT team contributed to this improvement. This pathway showed clear stages to move patients onto their recovery and discharge, with each stage identifying the role of medical, nursing, psychology, OT and MDT within these. Although, with discharge planning only evident within one of the seven care plans reviewed, there was clearly still a need for this to be embedded fully. Leaders identified that fortnightly MDT ward round summaries included these discussions but acknowledged that these needed to be featured in care plans.

Leaders told us that future visions for the service included exploration of barriers to discharge to ensure there was a forward focus on being a community facing rehabilitation service.

## Culture

**Most staff felt respected, supported and valued. They said the trust promoted equality and diversity in daily work and provided opportunities for development and career progression. Staff felt they could raise most concerns without fear.**

Most staff were confident that the leadership would deal with any concerns. Although, three staff raised concerns around the staffing matrix for Milligan ward and told us that there had been assurances from management that the staffing would be increased, however this had not happened.

Most staff felt able to raise concerns without repercussions. However during inspection we were alerted to one issue relating to how staff concerns were received. We fed this back to leaders at the end of the inspection. All staff were aware of the whistleblowing policy. The service had an external freedom to speak up guardian who visited the site, as well as internal employees who were allocated as freedom to speak up ambassadors that staff could speak to for advice and support.

Leaders shared lessons learnt when something went wrong and told staff about any actions taken to prevent the same happening again. They explained that they had a supportive approach, rather than a blame culture when things went wrong.

We observed supportive and cohesive team working and the atmosphere appeared relaxed and encouraging. Staff told us that they were proud of the service, the teamwork amongst staff and being able to provide better care to the patients on the ward. Leaders told us that morale had improved and felt that improvements with fixed staffing had assisted with this.

Staff received good training and support and had opportunities for development and career progression. Leaders told us about plans to expand apprenticeship offers to student social workers, as well as the occupational therapy apprenticeships they currently had in place. Further, a physical health nurse was pursuing her nurse prescribing course which the service were funding.

The service recognised compliments given to staff both in team meetings and shared in the wider weekly staff bulletins. We saw recent compliments for the wards including one from a patient thanking staff for their assistance and complimenting the time they spent on the ward, and another from a relative of a patient who complimented staff for their kindness, patience and support.

We observed that the wider organisation was considering the impact of the cost of living crisis on the wellbeing and livelihood of their staff. They had set up a survey to seek feedback from staff as to what they would find most helpful to assist. This included suggestions of donation boxes of essential items, more food available during shifts, staff morale and building activities. Staff on the wards recently had a team away day which was funded by the service.

## 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 had developed a well-understood, comprehensive governance structure. The senior management team worked closely together, and we saw evidence of risk issues being discussed at daily flash meetings and monthly clinical governance meetings. Information for escalation from handover meetings was cascaded to the daily flash meetings and clinical governance meetings were thorough. Clinical governance meetings took place monthly and covered a wide range of information, including incidents, restraints, use of rapid tranquilisation, enhanced observations, safeguarding, compliance, training, meaningful activity, feedback from patients, carers and advocates, recruitment and retention and lessons learnt. In addition, leaders held weekly incident review meetings in order to identify and review any themes and trends in incidents in order to identify any risks to clinical governance earlier. Although, local leadership was not able to evidence knowledge of the top risks, themes of incidents and complaints and told us that this was due to compliance functions being overseen and managed by the compliance team.

Leaders provided us with a “clinical managers audit” which is an audit tool they had devised based on actions from CQC, internal quality visits, as well as any other areas identified as needed. The clinical leaders will be going onto the wards twice a month with the ward manager to go through this checklist. Some of the items that will be audited include care plans, clinic rooms, RT, and observations/ discharge. Although there are currently weekly checklist reports completed, this process will provide visual assurance and oversight in the monitoring of operational quality and will also feed into the wider governance framework.

# Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

## 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.**

There was an appropriate clinical governance structure in place to ensure information and risk was escalated and managed in a timely manner. Senior leaders confirmed that organisational policies and procedures from the wider provider were applied to the operational running of the hospital and that these were clear and regularly reviewed. Leaders and staff told us that all significant information was distributed in daily handovers, weekly staff bulletins and monthly team meetings. We saw evidence of this in the examples of the weekly bulletin and team meeting minutes. Senior leaders had also attended these meetings to relay information to staff where necessary.

Previously we raised concerns around the appropriate oversight of the provision of activities being delivered on the high dependency rehabilitation wards. Leaders told us that the activity coordinators monitored the activity of patients every week and sent in a report. When the benchmark of 25% was not being met, leaders requested more information. Staff told us that patients were given individualised therapeutic timetables and there had been improvement work to the programmes to make these more tailored through the creation of pathways and stages of motivation. We saw evidence of appropriate activities taking place on the ward, as well as a notice board in the communal area advertising several paid vocational opportunities. In addition, both the patients we spoke to told us that they could engage in regular activities both on and off the wards.

The service had an overall risk register which covered high risk areas of the hospital and described mitigations to manage the risks. This was reviewed and updated monthly or whenever a new risk was found. On review of the risk register, there was one identified local risk for the high dependency rehabilitation service around patient's suitability and staff training, and specifically ensuring high dependency rehabilitation standards were met. This had been marked as complete on the register, as the service identified that the action plans created from this had been accomplished. The wards had introduced a multidisciplinary meeting to discuss any new referrals deemed appropriate to be admitted to the rehabilitation wards. Leaders told us that there had been a significant change in the manageability of risk on the wards since this had been embedded. Whilst staff overall felt there had been improvements, some staff were still unsure whether some patients were suitable for the rehabilitation model. We also saw evidence of a clear inclusion and exclusion criteria which supported staff to decline inappropriate referrals and managers told us that there were local agreements with commissioners that in the event that any admissions become unmanageable, they are able to return back to their referring location. Although, this arrangement was not formalised in the service line operating framework.

Although ward managers could escalate local concerns to the risk registers, due to this function being overseen by the compliance team, they were not able to evidence knowledge of the top risks for the wards when asked. This was the same for the themes of incidents and complaints.

## Information management

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

We saw discharge planning discussed as part of the ward rounds, however we only saw discharge plans recorded in one of the seven care records we reviewed. Senior leaders acknowledged the importance of detailed discharge planning as

part of an effective rehabilitation service, however we did not see that they were exercising sufficient oversight in this aspect of patient's care plans. Given the significance of discharge for patients within a rehabilitation service, without this clearly reflected within care plans, there is little oversight or outcome measuring as to the effectiveness of the care and treatment of someone within the service.

Staff had access to the equipment and information technology (IT) needed to do their work. The electronic system containing patient information worked well and all staff could access the system. Staff had their own individual computer log in to access patient records to ensure confidentiality.

The service was engaged in a local quality improvement project around AWOL's following an increase in this incident type. Leaders told us that this was still work in progress and that there had been no identified themes, with most AWOL's being spontaneous due to the nature of the service. There had already been reflection that an exterior fence at the location had not been as high as it should have been, and this had now been addressed.

### Engagement

**Managers engaged actively 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.**

The service held meetings monthly with various stakeholders including local NHS trusts and commissioners.

The service also had a number of resources available to engage staff in providing feedback about the service. This included a yearly staff survey, annual satisfaction audits and more local supervision processes. The service were recruiting for volunteers to be part of a staff relations group which would assist in providing a more frequent feedback channel to senior management. Leaders gave the example of feedback received from support workers not feeling valued and in response to this the service had introduced a support worker forum.

Patient feedback was captured regularly at the ward community meetings, people's council and through ward rounds where they completed feedback forms on their own progress. At discharge, staff offered patients a feedback survey. The hospital used a "you said, we did" format for supporting patient feedback, although this was not dated and so it was not clear when the issues had been raised and how up to date the responses were. Staff actively sought the views of carers via carers leads and a friends and family survey.

### Learning, continuous improvement and innovation

Leaders encouraged continuous improvement with plans for the twice monthly clinical checklist quality walkarounds where a senior leader would visit each ward and carry out checks alongside the ward managers. Any identified areas for improvement would be fed into action plans.

The service currently had Accreditation for Inpatient Mental Health Services (AIMS) which recognises high standards of organisation and care. Later this year, they were hoping to reapply for their reaccreditation.

Leaders had identified nurses on the sister site who had a specialism in learning disability and autistic spectrum disorder. They were looking to utilise their skills and experience by seeking their support on the wards where patients have these diagnoses, and to assist in formulating their care and treatment plans.

# Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

In order to assist with wellness and retention of staff, the service had put in place a wellness calendar marking memorable dates/weeks and events such as gifts for patients and staff on Valentine's Day and Easter, tea parties on the King's coronation and National Tea Day, and picnics and BBQs in the summer.

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

Good

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

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<br>Diagnostic and screening procedures<br>Treatment of disease, disorder or injury | Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment<br>The provider did not ensure that the ligature risk assessment for Marlowe ward accurately reflected the identified ligature risks of the bedroom environment and that the mitigations for these were accurate. For example, although the bedrooms were suitably rated as high risk, there were identified ligature risks that were shown as low risk. The mitigation provided in the assessment for one of these risks was also not accurate with what was in place at the time. (Regulation 12: Safe care and treatment) |

| Regulated activity | Regulation |
|---|---|
| Assessment or medical treatment for persons detained under the Mental Health Act 1983<br>Diagnostic and screening procedures<br>Treatment of disease, disorder or injury | Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment<br>The provider did not review the staffing matrix on Milligan ward to ensure its appropriateness for the safety of staff and patients. Staff raised concerns with regards to their safety when it was expected that one support worker would be on the ward with four patients. Although there had not been any reported incidents as a result of this lone working and staff confirmed that there was support from staff on Marlowe ward if an incident was to occur or if cover was needed for breaks. Management assured staff that they would review and increase the staffing numbers, yet this had not been done. (Regulation 12: Safe care and treatment). |

| Regulated activity | Regulation |
|---|---|

This section is primarily information for the provider

# Requirement notices

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 provider did not ensure appropriate oversight as to the recording and documentation of individualised discharge plans within patient's care records. We saw discharge planning discussed as part of the ward round, although we only saw discharge plans outlined in one of the seven care records we reviewed and there was clearly still a need for this to be embedded fully. Leaders acknowledged that these needed to be captured in care plans. (Regulation 17: Good governance)