Cygnet Lodge Woking

Quality Report

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

Ratings

Overall rating for this location	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive?	Good
Are services well-led?	Good

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

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

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

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

Summary of findings

Overall summary

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

- The service provided safe care. The ward environments were safe and clean. The wards had enough nurses and doctors. Staff assessed and managed risk well. They minimised the use of restrictive practices, managed medicines safely and followed good practice with respect to safeguarding.
- Staff developed holistic, recovery-oriented care plans informed by a comprehensive assessment. They provided a range of treatments suitable to the needs of the patients cared for in a mental health rehabilitation ward and in line with national guidance about best practice. Staff engaged in clinical audit to evaluate the quality of care they provided.
- The ward teams included or had access to the full range of specialists required to meet the needs of patients on the wards. Managers ensured that these staff received training, supervision and appraisal. The ward staff worked well together as a multidisciplinary team and with those outside the ward who would have a role in providing aftercare.
- Staff understood and discharged their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, and understood the individual needs of patients. They actively involved patients and families and carers in care decisions.
- Staff planned and managed discharge well and liaised well with services that would provide aftercare. As a result, discharge was rarely delayed for other than a clinical reason.
- 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.

However:

- The laundry room on one of the wards inspected was unlocked, despite a sign on the door stating that the room should always be locked.
- The blood monitoring machine on Marlowe ward needed calibrating.
- Patients told us they were not sufficiently involved in education or vocational activities in the community and we did not see these opportunities reflected in patient care plans.
- Data from the friends and family questionnaire was difficult to quantify as the results were combined with Cygnet hospital. This meant it would be difficult for the service to act on feedback to improve the service.

Summary of findings

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Good

Cygnet Lodge, Woking

Services we looked at
Long stay or rehabilitation mental health wards for working-age adults

Summary of this inspection

Background to Cygnet Lodge Woking

Cygnet Lodge Woking is a high dependency, locked rehabilitation service for men with complex mental health needs. The service us purpose-build and located in a residential area close to Cygnet Hospital Woking. The service has 31 beds split across three wards. Shakespeare ward has 11 beds, Marlowe ward has 12 beds and Milligan ward has eight beds.

Patients are usually admitted to Shakespeare ward with a planned treatment journey to progress to Marlowe and finally Milligan ward before being discharged a placement or the community.

The service is registered to provide the following regulated activities:

- Assessment or treatment for persons detained under the Mental Health Act 1983
- Diagnostic and Screening Procedures
- Treatment of disease, disorder and injury

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

The service was last inspected in June 2017 under its previous name of Park Grange. The service was rated 'Good' in all domains.

Our inspection team

The team that inspected the service comprised three CQC inspectors, one nurse specialist advisor with knowledge and experience of working within mental health rehabilitation services and an expert by experience.

Why we carried out this inspection

We inspected this service as part of our ongoing comprehensive mental health inspection programme.

How we carried out this inspection

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

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

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

During the inspection visit, the inspection team:

- visited all three wards at the service, looked at the quality of the ward environment and observed how staff were caring for patients
- spoke with 10 patients who were using the service
- spoke with the registered manager / operations director, hospital manager and managers or acting managers for each of the wards
- spoke with 14 other staff members; including the responsible clinician, doctors, nurses, occupational therapists, psychologists and the contracted pharmacist
- attended and observed a hand-over meeting, flash meeting and a multi-disciplinary team meeting;

Summary of this inspection

- looked at 11 care and treatment records of patients
- looked at seven supervision and appraisal records of staff
- carried out a specific check of the medication management on two wards and,
- looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the service say

Patients were mostly positive about their treatment. Eight of the 10 patients that we spoke with said that staff were mostly respectful, polite, kind and caring. Patients said that they generally felt safe on the wards, although the wards were sometimes noisy. They said that they had access to spiritual support and knew how to complain.

There was mixed feedback about patients' understanding of their treatment pathway and the expectations to work towards discharge. Patients said that activities were usually available Monday to Friday, but there was limited availability at weekends. Two patients said the activities offered were the best they had experienced. Patients said that staff encouraged attendance of activities by offering incentives. For example, patients could attend a particular group outing if they had attended three groups within a week.

Patients said that the food was of a good quality and the portion size was good.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Good

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

- All wards were safe, clean, well equipped, well furnished, well maintained and fit for purpose.
- The service had enough nursing and medical staff, who knew the patients and received basic training to keep patients safe from avoidable harm
- 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.
- 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 had easy access to clinical information, and it was easy for them to maintain high quality clinical records – whether paper-based or electronic.
- 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 physical health.
- The wards had a good track record on safety. 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.

However:

- The laundry room on one of the wards inspected was unlocked, despite a sign on the door stating that the room should be kept locked.
- The blood monitoring machine on Marlowe ward needed calibrating.

Summary of this inspection

Are services effective?

Good

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

- Staff assessed the physical and mental health of all patients on admission. They developed individual care plans, which they reviewed regularly through multidisciplinary discussion and updated as needed. Care plans reflected the assessed needs, were personalised, holistic and recovery-oriented.
- Staff provided a range of care and treatment interventions suitable for the patient group and consistent with national guidance on best practice. This included access to psychological therapies, support for self-care and the development of everyday living skills, and to meaningful occupation. Staff ensured that patients had good access to physical healthcare and supported patients 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.
- The ward teams included or had access to the full range of specialists required to meet the needs of patients on the wards. Managers made sure they had staff with a 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.
- Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care. The ward teams had effective working relationships with other staff from services that would provide aftercare following the patient's discharge and engaged with them early in the patient's admission to plan discharge.
- Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice and discharged these well. Managers made sure that staff could explain patients' rights to them.
- Staff supported patients to make decisions on their care for themselves. They understood the provider's policy on the Mental Capacity Act 2005 and assessed and recorded capacity clearly for patients who might have impaired mental capacity.

Are services caring?

Good

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

Summary of this inspection

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

Are services responsive?

Good

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

- Staff planned and managed discharge well. They liaised well with services that would provide aftercare and were assertive in managing the discharge care pathway. As a result, patients did not have excessive lengths of stay and discharge was rarely delayed for other than a clinical reason.
- 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 a good quality and patients could make hot drinks and snacks at any time.
- The wards met the needs of all patients who used the service – including those with a protected characteristic. Staff helped patients with communication, advocacy and cultural and spiritual support.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team and the wider service.

However:

- Patients told us they were not sufficiently involved in education or vocational activities in the community and we did not see these opportunities reflected in patient care plans.
- Data from the friends and family questionnaire was difficult to quantify as the results were combined with Cygnet hospital. This meant it would be difficult for the service to act on feedback to improve the service.

Are services well-led?

Good

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

Summary of this inspection

- Leaders had the skills, knowledge and experience to perform their roles, had a good understanding of the services they managed, and were visible in the service and approachable for patients and staff.
- Staff knew and understood the provider's vision and values and how they were applied in the work of their team.
- Staff felt respected, supported and valued. They reported that the provider promoted equality and diversity in its day-to-day work and in providing opportunities for career progression. They felt able to raise concerns without fear of retribution.
- Our findings from the other key questions demonstrated that governance processes operated effectively at ward level and that performance and risk were managed well.
- Ward teams had access to the information they needed to provide safe and effective care and used that information to good effect.
- Staff engaged actively in local and national quality improvement activities.

Detailed findings from this inspection

Mental Health Act responsibilities

We do not rate responsibilities under the Mental Health Act 1983. We use our findings as a determiner in reaching an overall judgement about the Provider.

Staff followed the provider's policy for the Mental Health Act. Training in the Mental Health Act was part of the mandatory training. Data provided during the inspection showed 100% compliance with training in the Mental Health Act on Marlowe and Milligan wards and 89% compliance on Shakespeare ward.

Mental Health Act administrators completed regular audits of paperwork including patients' rights, capacity and consent to treatment. Staff informed patients about their rights when they were admitted to the ward and repeated when necessary.

Information about advocacy services was displayed in all wards. An Independent Mental Health Advocate visited the ward twice weekly to support informal and detained patients.

Mental Capacity Act and Deprivation of Liberty Safeguards

Data provided by the service showed 100% compliance with training in the Mental Capacity Act. Doctors assessed capacity during medical reviews. Managers gave an example where staff had assessed a patient's capacity and arranged a best interest meeting because the patient was refusing medicines to treat a life-threatening illness.

We saw evidence that staff completed regular audits for the Mental Capacity Act and Deprivation of Liberty Safeguards.

Long stay or rehabilitation mental health wards for working age adults

Good

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

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

Good

Safe and clean environment

The wards were clean, and furnishings and décor were in reasonable condition. Communal areas were cleaned daily. However, the bathroom of an empty room was dirty. Inspectors raised this with staff who said that rooms were cleaned before being allocated to patients. Staff completed regular risk assessments of the ward environment.

Patients could lock their bedroom doors and doors could be unlocked by staff if necessary. Vision panels on bedroom doors could be opened or closed by staff and patients. There was a pay phone on each ward.The payphone on Marlowe ward was not working. However, patients could use their own phones or the ward phone in the interim. The door to the laundry room on Marlowe ward was unlocked despite a sign on the door to keep the door locked. Inspectors raised this with the ward manager who acted on this information. Staff said the door should be locked due to risk assessment of patients. The laundry room on Milligan ward was unlocked due to the patient's progression through treatment.

Shakespeare ward was on the ground floor of the hospital. The nursing office had a view onto the communal lounge and dining area. The therapy kitchen was locked apart from when it was used to deliver cooking activities with the patients. Patients had access to hot and cold drinks and snacks in the dining area. There was a quiet lounge, clinic room, activity room with desktop computer, de-escalation room and a shared bathroom. All bedrooms had en-suite showers and toilet facilities. Staff escorted patients to the garden through several locked doors. The garden was shared with Marlowe and Milligan wards.

Marlowe ward was on the first floor of the hospital and mirrored Shakespeare ward in its design. Milligan ward was over three floors. There was a lounge, dining room, kitchen and clinic room and two bedrooms with en-suite facilities on the ground floor. A further four bedrooms and a shared bathroom and shower room were on the first floor. The second floor had two small studio flats with a bathroom, kitchenette, living and dining area and sleeping area.

There were no specific medicine lockers in patients' bedrooms. However, there were small lockable cupboards that could be used for personal items or medicines.

There was closed circuit television in all communal areas and corridors. Staff monitored closed circuit television on a screen in the nursing office. Mirrors were mounted to allow line of sight around corners on the ward corridors. There were fixed alarms inpatient bedrooms and bathrooms and staff carried personal alarms. Staff were always present in the communal areas on all wards.

There was inconsistent use of anti-ligature door handles and some fixed ligature points on the wards. Staff accompanied patients in the garden which contained several fixed ligature points. A ligature point is anything that can be used to tie a cord or other material for the purpose of strangulation. Staff completed individual risk assessments for patients to identify patients at increased risk of suicide by ligature. Ligature cutters were available in the staff office. There had been no ligature incidents in the 12 months prior to the inspection. We reviewed a

comprehensive ligature assessment which included a ligature photo booklet used as a quick reference point and to quickly orientate new staff to the ward. The photo booklet showed staff how ligatures could be used as an anchor point. The hospital had recently introduced staff training for self-harm and suicide.

The hospital had created an information leaflet about Covid19, a new virus which could make people sick and spread easily. The leaflet contained information for patients about what it is, how it is spread, the symptoms, how it can be prevented and who patients could speak to for advice.

The de-escalation room contained a sofa and a beanbag that were used to manage violence and aggression. The room had an en-suite shower and toilet. The wall mounted case for a television was empty. Staff said that the hospital planned to redecorate this space. The room had been used for seclusion on one occasion and staff had followed the provider's seclusion policy.

Clinic Rooms and equipment

The clinic rooms were clean and well maintained. Staff had access to resuscitation equipment and emergency drugs that were checked regularly. However, the blood monitoring machine on Marlowe ward needed calibrating. Blood monitoring machines should regularly be calibrated to ensure the accuracy of the reading. There were clear procedures for checking controlled drugs. Staff kept records of disposed and expired medicines. There was a clear process for ordering medicines.

The cupboards on Marlowe ward were tidy and there was no excessive stock or medicines being stored. However, the cupboards on Shakespeare ward were crowded with the risk of items falling.

Infection control information was clearly displayed including hand washing signs and advice.

Safe staffing

The service had recruited to nursing and support worker vacancies. One nurse was in pre-employment, one vacancy had been filled by a contracted agency nurse and a nurse and two support workers were due to start employment on 1 April 2020.

Data provided by the service showed that between 1 October 2019 and 31 December 2019, 77 shifts had been filled by bank staff to cover sickness, absence or vacancies on Shakespeare ward and 12 shifts on Marlowe and Milligan wards. During the same period 82 agency staff had covered sickness, absence or vacancies on Shakespeare ward and 102 on Marlowe and Milligan wards. Eight shifts had not been filled on Shakespeare ward and nine on Marlowe and Milligan wards during this period.

Data provided by the service showed a 6% sickness rate on Shakespeare ward and 2% sickness rate on Marlowe and Milligan wards. Five staff had left Shakespeare ward and seven had left Marlowe and Milligan wards between 1 January and 31 December 2019.

Managers used the standards for mental health rehabilitation services guidance to calculate the number of nurses and support workers required each shift. Managers discussed staffing levels during the daily flash meeting and could adjust staffing levels to take account of patient mix.

Wards operated two 12 hour shifts per day. Staffing numbers on Shakespeare ward consisted of two nurses and three support workers during the day and one nurse and three support workers at night. On Marlowe ward, there were two nurses and four support workers during the day and two nurses and three support workers at night. One nurse and one support worker from Marlowe ward was allocated to Milligan ward.

Medical staff

There was 24-hour on call medical cover. Medical staffing included the ward doctor, a practice nurse and a full-time specialist doctor who was the responsible clinician.

Mandatory training

There was 94% compliance with mandatory training. Training included safeguarding, prevention and management of violence and aggression, infection control and the Mental Health Act. The hospital manager confirmed that following training that had been delivered after our inspection, 100% of staff on Shakespeare ward and 88% of staff on Marlowe ward had completed basic life support and automated external defibrillator training and all staff had completed immediate life support training.

The online training tool showed any outstanding training. The system emailed staff at regular intervals when training was overdue. Online training included watch and go videos which explained how to manage difficult situations, supportive increased observations, concentration skills,

learning from mistakes and what to say when someone disagrees with you. There were specialist resources such as videos on restraint and restrictive practice that staff had contributed to.

Staff were reimbursed if they preferred to complete online training at home.

Assessing and managing risk to patients and staff

Initial assessments were completed by the provider's specialist nurse assessors. Assessments considered family, social, forensic, substance misuse, psychiatric and medicines history. Staff screened all referrals into the service. An initial care and treatment plan was developed that included psychological input and an occupational therapy assessment that demonstrated an aim to provide structure and reintegration in the community. All care and treatment records reviewed contained good quality and detailed assessments.

All except one of the 11 care records reviewed contained a comprehensive up to date risk assessment. The patient whose care record only had a preliminary risk assessment had arrived at the service the day before our inspection. The record included a decision regarding the level of observations until the patient had been reviewed by the multi-disciplinary team. Staff recorded daily risk in the patient's progress notes.

The service used a short-term assessment of risk and treatability(START)risk assessment. The comprehensive assessment considered a range of risks including social skills, relationships, occupation, relational, self-care, mental state, substance misuse, external triggers, social support, violence, self-harm, suicide, unauthorised leave, attitudes and medicines. The assessment included a risk management plan, mini formulation and control measures. Risk assessments included assessment and monitoring of physical as well as psychological risks. We saw evidence of staff regularly reviewing risks and up to date formulation plans.

Management of patient risk

The provider had a range of policies to support staff manage patient risk. This included search, ligature and observation policies.

Patients were given a welcome pack when they were admitted to the ward, the pack included information about the ward and expectations about behaviour.

Staff considered triggers to behaviour using antecedent, behaviour and consequence charts. Staff developed a positive behaviour plan with all patients. We saw evidence of staff assessing and completing risk assessments to include physical health needs. This included risk of use of shower chair, falls and pressure areas.

Staff discussed risk during handovers, daily flash meetings and multi-disciplinary meetings. Staff monitored closed circuit television and followed the provider's observation policy.

All staff completed training in the prevention and management of violence and aggression. Staff used verbal and non-verbal de-escalation techniques where possible. There were regional and local champions who promoted least restrictive practice.

Staff searched patients and rooms if recorded in patient care plans. Staff were encouraged to search only if they suspected a patient had contraband items.

There were set times that patients could smoke in the garden. Staff escorted patients in the garden to smoke.

Use of restrictive interventions

There had been one episode of seclusion in the nine months prior to our inspection. The period of seclusion had lasted seven hours on Shakespeare ward before the patient had been transferred to a psychiatric intensive care unit.

The service had a key performance indicator for the use of restraint. The provider was a member of the Restraint Reduction Network and had introduced 'reducing restrictive practice' champions on each ward. The service promoted initiatives to reduce all restrictive practices including physical restraint. Staff completed a restraint audit to monitor both the use of restraint and the level of restraint that involved the use of rapid tranquilisation.

Data provided by the service showed that there had been 15 episodes of restraint on Shakespeare ward between 1 July and 31 December 2019. Seven of these had involved the same patient, two were prone restraint and one led to the use of rapid tranquilisation. During the same period on Marlowe ward, there had been eleven episodes of restraint, five involved the same patient and one episode had led to prone restraint. There had been no episodes of rapid tranquilisation reported on Marlowe ward during this period. Prone restraint means an individual was held face-down on the ground.

Long stay or rehabilitation mental health wards for working age adults

Good

There had been five instances of rapid tranquilisation in the three months prior to our inspection. All related to the same patient who had subsequently been transferred to a psychiatric intensive care unit. We saw that staff had attempted or provided physical health monitoring after rapid tranquilisation had been administered.

Training had been arranged the week of our inspection to improve staff's knowledge about monitoring rapid tranquilisation.

Safeguarding

Data provided by the service showed that there was 100% compliance with staff completing online safeguarding training. A member of staff who was a social worker delivered additional face to face training specific to the service. A senior social worker from Cygnet hospital supported staff from the service regarding safeguarding concerns. The service held regular meetings with the local authority safeguarding team.

Staff discussed safeguarding concerns during daily flash meetings and monthly safeguarding meetings. Safeguarding concerns were reported on the electronic reporting system. Staff moved patients to other wards if there were safeguarding concerns.

There was a room at the service away from the wards that was used when children visited patients.

Staff access to essential information

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

Medicines management

The service contracted an external pharmacist to provide stock and dispense named patient medication. The pharmacist reviewed prescription charts and provided a schedule of medicines management audits. Audits included compliance with the Mental Health Act, high dose antipsychotic audits, high dose prescribing, clinic room audits, controlled drugs and clozapine audits.We reviewed an audit which showed changes and improvements made in response to audit findings. For example, changes to medicine cards.

Staff received notification for any queries, errors, advice and audits recorded on the electronic reporting system. The service used a scoring system to determine the scale of the error and what action should be taken to support staff. This included a reflective account and where appropriate, a further competency assessment.

The medical director and clinical manager worked closely with the pharmacist to improve compliance with the Mental Health Act. The pharmacist provided training to staff on medicine related topics.

We reviewed 12 prescription charts. All were in good order and contained photo identification. We saw that staff monitored high dose anti-psychotic medications and recorded when patients refused an electro-cardiogram. Staff recorded patients consent in forms to authorise treatment. There was evidence of the monitoring of constipation for patients prescribed clozapine on Marlowe and Milligan wards. However, one prescription chart on Shakespeare did not evidence monitoring of constipation for a patient prescribed clozapine, which was corrected when raised.

We saw conflicting allergy information on one prescription card and another card contained another patient's capacity assessment. Staff rectified this when raised by inspectors.

Staff monitored the side effects of medicines using Glasgow Antipsychotic Side-effect Scales. The self-reporting questionnaire is aimed at identifying the side effects of antipsychotic medication. Staff developed care plans if risk was identified.

Staff recorded the use of both oral and intramuscular rapid tranquilisation. The use of rapid tranquilisation was monitored through the monthly restraint audit and the ward manager's report that was included in the monthly integrated governance meeting.

Track record on safety

The service reported 21 incidents between 1 January and 31 December 2019. Of these, 13 concerned patients absent without leave, two related to absconsion whilst in the community, three were missing persons, two allegations of abuse and one where a patient was found with contraband items. Both allegations of abuse were reported to the police and the local authority safeguarding team. Four of the incidents regarding patients going absent without leave involved patients climbing the garden fence.The service

Long stay or rehabilitation mental health wards for working age adults

Good

had installed additional lighting on the fence to reduce this risk and staff always accompanied patients in the garden. The remaining nine incidents involved patients returning late from section 17 leave. Section 17 leave is formal permission for patients detained under the Mental Health Act to leave the service for an agreed period. The service had arranged for a sniffer dog to attend the service to reduce the risks of substances on the ward.

The service had submitted eight notifications to Care Quality Commission during the same period.

Reporting incidents and learning from when things go wrong

Staff reported incidents on the provider's electronic incident reporting tool. All staff were able to describe what should be reported. Incidents rated moderate and above were cascaded to managers for review.

Learning from incidents was shared during team meetings and reflective practice. Staff discussed what had gone well as well as any learning from incidents. All incidents were discussed during the monthly information governance meetings. An example of changes made as part learning was that staff should always take a phone when escorting patients on leave so that they could contact the service quickly. Information about corporate learning was shared on staff noticeboards.

Staff discussed incidents during handovers, flash meetings and team meetings. Incidents were also discussed during reflective practice and supervision. Staff told us that they were debriefed and felt well supported following an incident. Staff gave an example where they had been contacted to check on their wellbeing after they had been involved in an incident.

We reviewed four incidents reported on the electronic system. We saw that all incidents had been recorded, reviewed and responded to within a reasonable timeframe.

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

(for example, treatment is effective)

Good

Assessment of needs and planning of care

Specialist nurse assessors completed a comprehensive pre-admission initial assessment. All pre-admission assessments were reviewed by the responsible clinician and a manager and then discussed at a multi-disciplinary meeting before a patient was accepted for admission.

Psychology staff assessed patients within 48 hours of admission so that they could access groups and one to one sessions.

We saw consistent quality in all the care records reviewed. All 11 of the care and treatment records reviewed contained good quality and detailed assessments.

All 11 records reviewed contained a range of assessments to ensure the patients needs were met. Assessments included the model of human occupation screening tool (MOHOST), adaptive behaviour assessments, budgeting assessments, physical health assessments, psychology assessments and mental capacity assessments.

Assessment and management of physical health included electrocardiograms, blood monitoring, GP reviews, monitoring clozapine and hypercholesterolemia. High dose anti-psychotic therapy care plans were reviewed during every ward round.

Staff developed care plans that were personalised, holistic and recovery orientated. Care plans demonstrated psychological and occupational therapy input with an aim to provide structure and progression onto a recovery pathway and reintegration with the community. Staff reviewed care plans regularly. There was evidence of patient involvement, multi-disciplinary working and patients being offered a copy of their care plan.

Staff were encouraged to follow the subjective, objective, assessment and plan (SOAP) approach for progress notes. Progress notes were comprehensive and up to date.

Best practice in treatment and care

Long stay or rehabilitation mental health wards for working age adults

Good

Cygnet Lodge had achieved AIMS accreditation from the Royal College of Psychiatrists. AIMS is a quality assurance and accreditation process for mental health services.

Staff provided a range of care and treatment interventions suitable for patients and consistent with national guidance on best practice. Patients could access the recovery college based at Cygnet's hospital close by.

There was a jobs board in the activity room, although no jobs were displayed at the time of our inspection. Staff told us that patients had the opportunity to engage in a range of paid jobs offered by the service. These included working in the kitchen, leading the community meeting and gardening. Patients were encouraged to co-facilitate groups at the recovery college.

We saw evidence of exercise groups facilitated by the gym instructor, breakfast clubs, strengths and support needs, cooking and psychology groups including 'What is psychosis' and 'Developing skills in emotional regulation'. Following a visit from a Mental Health Act Reviewer, the service had restarted a 'pub group' once a month to promote responsible attitudes to drinking. Patients and staff told us how attendance at groups was encouraged by offering incentives and rewards.

The service offered exercise and health related groups including cycling, walking and the gym. A nutrition group had been recognised as an area of good practice by the National Institute for Health and Care Excellence.

Staff ensured patients had good access to physical health care. There was a practice nurse who led on physical health. All patients were registered with a local GP. The GP attended the service each week. Staff encouraged patients to make appointments with the GP where appropriate, to support reintegration into the community. The GP made referrals for specialist outpatient appointments.

Staff used Positive Cardio Metabolic Health Resource to monitor various aspects of patients' physical health including smoking, lifestyle, body mass index, blood pressure, glucose regulation and life skills. This resource supports the National Institute for Health and Care Excellence recommendations for monitoring physical health for psychosis and schizophrenia in adults. Staff used the Lester tool to colour code each item to ensure that early warning signs were identified and acted on appropriately. We saw examples how this approach helped to identify a patient who was borderline diabetic and was now cleared of symptoms because of the support put in place by staff.

All staff received physical health training as part of their induction. This included national early warning score (NEWS) to improve the detection and response to clinical deterioration of a patient's physical health, sepsis, use of choking screening tool and Glasgow Antipsychotic Side-effect Scale. Some staff had been trained in venepuncture and electrocardiograms.

Staff supported patients to lead healthier lives. For example, nutrition and weight management programmes, smoking, asthma, diabetes and substance misuse. The gym instructor encouraged patients to use the on-site gym. Patients were taught basic first aid and wound dressings in health promotion by the practice nurse.

Staff used a variety of recognised rating scales to assess and record severity and outcomes. For example, the Health of the Nation Outcome Scales, Model of Human Occupation Scale, Glasgow Antipsychotic Side-effect Scale, Short Term Assessment of Risk and Treatability, clinical outcomes in routine evaluation outcome measure, questionnaire about the process of recovery and the Historical Clinical Risk Management 20.

Staff used technology to support patients. Patients had access to a desktop computer in the activity room on Marlowe ward. Staff were in the process of arranging for a computer on Shakespeare ward, following feedback at a community meeting. Patients could also use a computer suite off the ward, if accompanied by staff.

The service was working closely with two local music studios for patients to record a CD and make a music video.

Staff participated in local clinical audits including the Mental Health Act and health and safety. The service had responded to three areas of action identified during the AIMS quality assurance and accreditation process by ensuring more patient involvement in their care plans; adding a mirror to Milligan ward to eradicate a blind spot and changing some paperwork.

Skilled staff to deliver care

There was a full range of specialists to meet the needs of the patients. The team included a consultant psychiatrist, specialist doctor, nurses, support workers, psychologists

and occupational therapists. A pharmacist visited the service weekly. Staff were experienced and qualified and had the right skills and knowledge to meet the needs of the patients.

The service had links with local universities and employed student nurses. Managers hoped to support nurse training and promote the service as an employer for newly qualified nurses to start their careers.

Agency staff completed mandatory training. Managers had approached agency staff and encouraged them to join the service permanently. Contracted agency workers were interviewed and received a more comprehensive induction than agency staff. The service had over recruited support workers who had been good candidates at interview. The service had built an internal bank of staff to reduce the need for agency workers.

All staff completed an induction when they began their employment. Bank staff completed the same induction and training as permanent staff. Support workers completed the care certificate. The care certificate is an agreed set of standards that define the knowledge, skills and behaviours expected of job roles in the health and social care sectors.

Staff received regular one to one and group supervision. Data provided by the service showed a 95% and 92% compliance with clinical supervision on Shakespeare and Marlowe and Milligan wards respectively. One to one supervision agendas included patient care, lessons learnt and training. Staff discussed key lines of enquiry, training, challenging issues and reflective practice during group supervision. We reviewed seven supervision records which showed that staff received regular supervision.

Staff received annual appraisals. There was a key performance indicator for completion of appraisals. Managers and staff that we spoke with confirmed that they had received an appraisal. We reviewed seven appraisals and saw that they were linked to the provider's values and included objectives for the following year.

The clinical psychologist facilitated reflective practice once a month. Staff told us the sessions were beneficial and provided good opportunities to reflect on strengths and weaknesses.

The service provided specialist training for staff including physical health care, understanding diabetes and dialectical behavioural therapy. Dialectical behavioural therapy is a type therapy that may be used to help those who are experiencing suicidal thoughts or have self-harm behaviours. The pharmacist delivered training about understanding medicines. Staff could apply for training as part of their continued professional development. Training provided broadly covered patients admitted to the service.

Multi-disciplinary and inter-agency team work

Staff held a daily handover and flash meeting. We observed a clear person-centred approach at the handover, flash meeting and multidisciplinary meeting. Discussions at the handover and flash meetings included staffing, risks, incidents, observations levels, training and discharge planning. We saw good multidisciplinary discussions about approaches for the patients and review of care plans with the psychologist. Staff discussed physical health concerns for patients, their leave and how it could be facilitated.

The multidisciplinary meeting was attended by a social worker, consultant psychiatrist, specialist registrar doctor, psychologist, support worker, practice nurse, registered mental health nurse and occupational therapist. We saw evidence of effective multidisciplinary working. Each patient had a ward review sheet that included risk, discharge planning, care planning, physical health and medicine review. There was a comprehensive review of each patient that included patient goals. Staff treated patients with compassion and demonstrated a clear person-centred approach. Staff reviewed care plans and discussed approaches used including relapse prevention and substance misuse groups. Staff gently encouraged patients to engage in group work. There was a clear consideration of where patients were being discharged and how they could be supported in the community.

The practice nurse provided support to the service and the nearby hospital. They said that the service would benefit from additional support to allow more time to audit and evaluate physical health plans.

Staff had effective working relationships with other teams including the nearby hospital, local GP surgery, pharmacist, social workers and community mental health teams.

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

Staff followed the provider's policy for the Mental Health Act. Training in the Mental Health Act was part of the

Long stay or rehabilitation mental health wards for working age adults

Good

mandatory training. Data provided during the inspection showed 100% compliance with training in the Mental Health Act on Marlowe and Milligan wards and 89% compliance on Shakespeare ward.

We spoke to a member of staff whose role was primarily that of a Mental Health Act administrator to prepare and check paperwork for detained patients. The remainder of their role was as a support worker on the wards. Staff could contact the Mental Health Act administrator for support and refer to the Mental Health Act policy for guidance.

We saw information about independent advocacy displayed on the wards. An independent mental health advocate visited the wards each week.

We saw evidence of staff regularly presenting detained patients their rights under the Mental Health Act with consideration of capacity and consent to treatment. Records showed staff appropriately referring patients for tribunals. Records showed evidence of staff advising informal patients of their rights. We saw evidence of patients' utilising their section 17 leave in the community.

There was a poster displayed by the exit door to the ward, with information about how informal patients could leave at any time.

Staff completed regular audits to ensure that the Mental Health Act was being applied correctly. Audits included patient rights, capacity and consent to treatment.

Good practice in applying the Mental Capacity Act

Staff followed the provider's policy for the Mental Capacity Act. Data provided by the service showed a 100% compliance with mandatory staff training in the Mental Capacity Act.

Records demonstrated staff consideration of patient's capacity and consent to treatment. Doctors considered capacity during medicine reviews. Staff gave an example of assessing capacity and arranging best interest meetings to support the management of a patient's physical health condition.

Staff monitored adherence and completed regular audits of the application of the Mental Capacity Act.

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

Good

Kindness, privacy, dignity, respect, compassion and support

We observed positive interactions between staff and patients. Staff demonstrated knowledge of patients and spoke about them with care, compassion and respect. Staff supported patients to understand and manage their care and treatment during multidisciplinary meetings.

Eight of the ten patients we spoke with said that staff were respectful, polite and knocked before entering their rooms. One patient said that some staff really made the effort. Another said that staff had supported him to visit his mum. Two patients said that most staff were respectful and polite, but some staff were not. One of the ten patients we spoke with said that staff were not caring or interested in their wellbeing.

Patients said that they had access to a chaplain for spiritual support. Most of the patients we spoke with told us they were non practicing, but found the visits from the chaplain helpful. One patient told us that they also occasionally visited the local church. Another patient told us they would like a bible study group. Patients said they enjoyed the mindfulness sessions facilitated by the local Buddhist monks.

Staff said they could raise concerns about disrespectful, discriminatory or abusive behaviour towards patients without fear of the consequences. Staff maintained the confidentiality of information about patients.

Involvement in care

Where possible, staff arranged for new patients to arrive at the service before lunch so that they could be properly shown round the ward, meet their peers, and be assessed in the environment.

All except one patient said that they were involved in their care planning to some degree. Records demonstrated evidence of patients' involvement in their care planning.

Long stay or rehabilitation mental health wards for working age adults

Good

Patients completed a ward review sheet prior to multidisciplinary meetings. The form included information about patient goals.

Patients could provide feedback and make suggestions to improve the service at the weekly community meetings. Examples of improvements made from this meeting included the addition of a computer on Shakespeare ward, the computer suite and patient Wifi on the wards.

Staff had achieved limited success in encouraging patients to attend the Information Governance and People's Council meeting to suggest how the service could be improved.

Involvement of families and carers

There was a carer's lead at the service. Families and carers were invited to care programme approach meetings. Staff facilitated visits from families. There was a room off the ward that could be used for visiting families and children.

The service produced a carer's information booklet and newsletter. The newsletter contained general information about the service and information about additional support for carers. The service arranged annual events for carers. Records showed evidence of staff asking patients about families and carers and requesting consent to speak with them.

There was a family and friend's questionnaire although the results were combined with the local Cygnet hospital. Data shown to inspectors was based on eight responses and was difficult to determine which question the responses related to.

The service used the 'Triangle of Care' Assessments for carers. The 'Triangle of Care' identifies how staff, carers and patients can work together to promote safety and recovery and sustain wellbeing.

Are long stay or rehabilitation mental health wards for working-age adults responsive to people's needs?
(for example, to feedback?)

Good

Access and discharge

Data provided by the service showed a 95%, 88% and 77% bed occupancy for Shakespeare, Marlowe and Milligan wards respectively between 1 July and 31 December 2019. Bed occupancy refers to the number of beds occupied by patients.

Data provided by the service showed an average length of stay as 488 days. Staff said that the length of stay varied and was often delayed by patients moving on placements or accommodation. Some placements were time-framed. This meant that there was an agreed period that patients could remain at the service.

The service had an exclusion criteria which included people with a recent history of sexual or violent offences. Managers said the service had received more referrals for patients with a higher level of acuity and complexity, which increased the importance of screening appropriately.

Some staff told us they were concerned at the level of risk associated with recent admissions and felt that some had been inappropriate. One member of staff told the inspecting team that managers seemed to have learnt from recent inappropriate admissions and appeared to now screen referrals more thoroughly. Ward managers told us they were supported to decline patients they felt would be inappropriate. Managers said that there had been a recent incident where a patient's mental health had quickly deteriorated which they believed had affected staff confidence. The incident had been managed appropriately and the patient had been transferred to a psychiatric intensive care unit. We saw five examples of patients assessed by the multidisciplinary team as inappropriate for the service between July 2019 and December 2019.

The service accepted referrals from across the country. At the time of our inspection, all patients were from another area. Managers said that staff escorted patients to see families if they wished. One patient we spoke with told us how staff had supported him to visit his family.

The service aimed to assess referrals within two working days. Delays to assessment were usually because of funding approval. Data provided by the service showed that between 1 July 2019 and 31 December 2019, the average time from referral to initial assessment was 2 days and initial assessment to admission was 21 days. The longest time for funding to be approved was 45 days. The service tried to develop close links with clinical commissioning groups to improve waiting times.

Long stay or rehabilitation mental health wards for working age adults

Good

Patients were moved between wards as part of their treatment journey. Most patients were admitted to Shakespeare ward and stepped down to Marlowe and Milligan wards when they were engaging in activities, were compliant with leave and there were no concerns. Patients on Marlowe and Milligan ward should be more able to engage in therapeutic activities, have more unescorted leave and be working towards discharge. However, staff told us that patients could be admitted to any ward, dependent upon their individual assessed needs. Staff sometimes moved patients between wards for safeguarding or risk reasons. For example, where there had been incidents of aggression between patients.

Staff and patients told us that patients sometimes refused to move wards. Patients told us that they preferred some wards because it had direct access to the garden. Not all wards had immediate access to the garden which sometimes placed tension on patients moving wards as part of the treatment pathway. Staff told us that if a patient refused to move wards, they could still access groups and activities from the step-down ward. Patients were told about the pathway when they were admitted to the service.

Staff tried to arrange admission and discharge at an appropriate time of day so that patients could be orientated appropriately to the environment.

Discharge and transfers of care

The service reported one delayed discharge between 1 January 2016 and 31 December 2019 which was affected by agreement for funding for the patient's next placement.

Discharge planning commenced at the point of admission. Discharge planning was regularly discussed and reviewed during ward round meetings and care programme meetings. Records reviewed showed evidence of discharge planning and staff liaison with commissioners. However, some patients told us they didn't feel they were being pushed to engage in community vocational activities to work towards discharge.

The facilities promote recovery, comfort, dignity and confidentiality

Patients had their own bedrooms with lockable doors and an en-suite toilet. Patients were able to open and close the vision panels on their doors. All rooms contained integrated furniture with a wardrobe and lockable cupboard. The service provided televisions if required and patients were able to personalise their rooms. The bedrooms seen during the inspection appeared untidy and grubby. Staff supported patients with personal hygiene and daily living skills. The en-suite toilet in an empty room was dirty. Staff assured us that all rooms were cleaned thoroughly before they were allocated to a patient.

Staff and patients had access to the full range of rooms and equipment to support treatment and care. Shakespeare and Marlowe wards had a small clinic room, activity rooms, laundry room, kitchen, lounge and dining areas. The kitchens were locked but patients had access to hot and cold drinks and snacks in the dining area. There was a quiet lounge on Marlowe ward and patients could use a room off the ward to see visitors and children.

Patients had access to a range of daily activities including mindfulness, creative arts, breakfast club, computer club, cooking, karaoke football, movie night, monthly day trip and the gym. Records showed staff efforts to encourage engagement in activities. Staff had introduced incentives for patients to attend activities, which included a group outing when patients had attended three groups within a week.

Groups offered included managing aggression, relapse prevention, substance misuse, vocational skills, managing anxiety and music. Staff arranged for the fire service to visit the service to deliver a group about fire setting.

The pay phone on Shakespeare ward was not working. However, patients were able to use their mobile phones and could use the ward phone if this was not possible. Patients had access to a computer and internet in the activity room. Following a request at a community meeting, the service had arranged restricted Wifi for patients.

Patients on Shakespeare ward had immediate access to a garden. The door to the garden was kept locked apart from agreed times when patients could use the garden to smoke. Detained patients could smoke at set times throughout the day. The number of times that patients could smoke had been increased following a request at a community meeting. Staff said they tried to encourage patients to reduce or stop smoking, although it was a challenge.

Patients said the food was of a good quality and the portion size was good.

Patients' engagement with the wider community

Long stay or rehabilitation mental health wards for working age adults

Good

Only two of the records reviewed showed evidence of staff discussing community-based training, education or employment with patients. One of the patient's records reviewed had only been admitted the day before our inspection. We received mixed feedback from patients about their knowledge of education and work opportunities in the community or about the recovery college.

Patients told us there were regular group outings to the local town. Patients with unescorted leave could use the hospital shuttle bus or apply for a freedom pass for the local bus service.

Records showed evidence of staff requesting details of family and carers. One patient told us how staff had supported him to visit his family.

Meeting the needs of all people who use the service

Wards were accessible for patients with disabilities or mobility issues. Wards had access to a lift and doors and corridors were wide enough to allow wheelchair access.

There was a welcome pack for each of the wards. The pack included information about the ward, patient's rights, expectations, advocacy support and how to complain.

All leaflets on the ward were in English. Staff told us that they could request information in other languages and easy-read format. A leaflet about Covid19 contained information in a pictorial and written format. Staff could arrange interpreters and signers where required.

Patients told us the food was of good quality and their dietary needs were met. Menus were discussed during the weekly community meetings.

Patients said that their spiritual needs were met. A chaplain visited the service each week and Buddhist monks facilitated mindfulness sessions. Staff escorted patients to religious venues including mosques or temples if requested.

Listening to and learning from concerns and complaints

Data provided by the service showed that the service had received 19 complaints between 1 January 2019 and 31 December 2019. Six of the complaints concerned quality of care, the remaining 13 concerned safety, the conduct of nursing staff, allegations of patient to patient assault, staff attitude, complaint handling, the conduct of medical staff, communication, access to records and a member of the public complaining about a patient's behaviour in the community. Of these 19 complaints, three had been upheld, two partially upheld and one withdrawn.

Staff followed the provider's complaints policy. Complaints were initially reviewed by ward managers and escalated to senior managers if patients were not satisfied with the outcome.

Managers held discussions with staff when a complaint concerned an individual and was upheld or partially upheld. Complaints about quality of care were discussed in supervision and staff meetings.

Staff discussed complaints and learning during team and governance meetings. Staff met regularly with the independent mental health advocate to discuss concerns. Induction training had been reviewed to include training on boundaries and interaction with patients.

Information about how patients could complain was displayed on notice boards and was included in the welcome pack. Notice boards included information about how to raise concerns with external agencies, including the Care Quality Commission.

Patients discussed complaints in the patient community meetings. Patients could appeal against a decision about their complaint if they were not satisfied with the outcome.

Shakespeare and Marlowe wards had each received five compliments between 1 January 2019 and 31 December 2019.

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

Good

Leadership

Leaders had the skills, knowledge and experience to perform their roles. They had a good understanding of the service and could clearly explain how the teams were working to provide high quality care.

There was a dedicated hospital manager for the service, who knew the service well. The registered manager /

operations director was also responsible for Cygnet hospital, which was close to the service. The full-time consultant psychiatrist provided medical leadership for the service and the clinical services manager was shared with Cygnet hospital.

Managers operated an open-door policy. Staff told us that the hospital manager was visible in the service and approachable for patients and staff. They said that the hospital manager regularly visited wards to check on staff and patients.

Leadership opportunities were available for staff. We heard examples where staff had progressed their career with the support of local managers.

Vision and strategy

Staff knew and understood the provider's vision and values. They could explain how these were applied in their work. Vision and values were communicated to staff during induction and were part of the appraisal process.

Culture

Staff felt respected, supported and valued. They said that the team was supportive and there was a good ethos with a clear direction at the service. They told us that managers were supportive and compassionate.

Staff said there were regular meetings to discuss and raise concerns. They said they felt listened to and managers acted on reasonable ideas.

Staff said that they felt able to raise concerns without fear of retribution and were aware of the whistle-blowing process.

We reviewed seven appraisals which included objectives for the following year and how the service could support development. Managers considered succession planning during supervision and appraisals. We saw examples how the provider had supported opportunities for career progression.

Governance

There was a clear framework of what should be discussed at ward, team, or directorate level to ensure that essential information, such as learning from incidents and complaints, was shared and discussed. The corporate governance tree demonstrated how ward to board processes ensured information was cascaded and shared appropriately.

Managers completed a monthly report that included incidents, restrictive practice, use of restraint, use of rapid tranquilisation, enhanced observations, therapeutic hours, medicines management, complaints, compliments, supervision, appraisals and training. The report was reviewed during the monthly integrated governance meeting. Information from the monthly People's Council, medication management, clinical audit, service user engagement, Mental Health Act, security, infection control and the risk register were discussed during this meeting. Minutes contained actions to be reviewed.

Information for escalation from handover meetings was cascaded to the daily flash meetings where staff discussed staffing, skill mix and safeguarding. There was a daily multidisciplinary meeting where topics discussed included risk, patient's mental state and leave. There were fortnightly multidisciplinary meetings to review patients' treatment. The service had tried to encourage patient engagement with an allocated slot at the governance meeting.

The HR and training coordinator sent regular reports to managers. Compliance with training was reviewed during supervision.

There was a staff representative who attended staff representative group meetings to share concerns and good practice. The chair of the service representative group was invited to the hospital heads of department meetings.

We saw examples of changes made from incidents and complaints. This included staff taking a phone when escorting patients on leave and the introduction of patient Wifi on wards.

Staff participated in local audits. We saw a schedule of audits that included an allocated auditor and actions for review. Audits included care records, observation and monitoring closed circuit television, health and safety, infection control, self-medication, safeguarding, blanket rules, the Mental Health Act and suicide.

Long stay or rehabilitation mental health wards for working age adults

Good

Staff worked closely with internal and external teams including GPs, dentists, social workers and community mental health teams to ensure that the needs of the patients were met.

The service had an 'acts of random kindness' award and an employee of the month scheme.

Management of risk, issues and performance

There was access to the risk register at ward and directorate level. Ward managers could escalate concerns so that senior managers were aware. Senior managers decided if an issue needed to be added to the risk register. Staff could indirectly escalate concerns to the risk register via incident reporting.

The service had a business continuity plan for emergencies. Managers told us that current concerns related to Covid19. The service had introduced precautions and were working within their business continuity plans. Managers were concerned about the potential impact on staffing. The service had produced an information leaflet for patients and had provided question and answer sessions in the morning community meetings.

Information management

The service used systems to collect data from wards that were not over burdensome for staff. Staff used an online training system that identified outstanding training for staff when they logged on. Staff received emails one, two or three months prior to training expiring and if training was outstanding.

Staff had access to equipment and technology to do their work. Staff used a combination of electronic and paper records. Staff uploaded documents such as positive behaviour plans, care plans and risks assessments onto patient records. Staff recorded progress notes on an electronic record.

Staff had their own individual computer log in to access patient records to ensure confidentiality. Paper records were kept in a locked cabinet in the nursing office.

Team managers had access to information to support them in their role. They received regular information about performance, staffing and patient care.

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

Engagement

Staff had access to up to date information through handovers, meetings and the intranet. Patients were encouraged to be involved in service developments via the patient representative and people's council meeting. The service produced a quarterly newsletter for carers which provided general information about the service, upcoming events and support available.

Patients and carers had opportunities to give feedback using the friends and family survey. However, data reviewed during the inspection showed that much of the information was combined with Cygnet hospital.

We heard examples of improvements made in response to patient feedback. For example, patients who had been risk assessed by staff able to use their own mobile phones on the ward.

Learning, continuous improvement and innovation

Staff said that they felt listened to and supported to suggest improvements to the service.

In July 2019, the service achieved accreditation for the quality network for mental health rehabilitation services organised by the Royal College of Psychiatrists.

The service implemented improvements in admission and discharge process and care and treatment to achieve AIMS accreditation. For example, improved written information for patients and carers, increasing the frequency of community meetings, patient access to pharmacist advice and a multidisciplinary review of all patients within one week of admission.

The service was working with a patient to use a digital monitoring device for their diabetes to reduce the need for restrictive interventions.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider SHOULD take to improve

- The provider should ensure that staff ensure identified doors are locked.
- The provider should ensure that all medical equipment is calibrated.
- The provider should ensure that patients are aware of and encouraged to attend community orientated care, education and vocational opportunities.
- The provider should be able to analyse the data from friends and family questionnaire specific to the service to ensure they can respond to the feedback.