Cygnet Behavioural Health Limited

Cygnet Churchill

Inspection report

22 Barkham Terrace
80 Lambeth Road, Lambeth
London
SE1 7PW
Tel: 02087356150
www.cygnethealth.co.uk

Date of inspection visit: 11 October 2022
Date of publication: 02/12/2022

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

Ratings

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

Summary of findings

Overall summary

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

- We rated acute wards for adults of working age as good overall with requires improvement for the safe domain. We rated long stay or rehabilitation mental health wards for working age adults as good for well-led. The hospital remained good overall.
- The ward environment was clean, well equipped and well furnished. The ward had enough nurses and doctors. Staff assessed and managed risk well. They minimised the use of restrictive practices and followed good practice with respect to safeguarding.
- Staff developed holistic, recovery-oriented care plans informed by a comprehensive assessment. Staff assessed the physical and mental health of all patients on admission. They provided a range of treatments suitable to the needs of the patients and in line with national guidance about best practice. Staff engaged in clinical audit to evaluate the quality of care they provided.
- Staff supported patients with activities outside the service, such as work, education and family relationships.
- The ward teams had access to a range of specialists to meet the needs of patients on the ward. Managers ensured that these staff received training. The ward staff worked well together as a multidisciplinary team and with those outside the ward who would have a role in providing aftercare.
- The service used systems and processes to safely prescribe, administer, record and store medicines. Staff regularly reviewed the effects of medications on each patient's mental and physical health.
- Staff understood 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.
- The service was well led, and the governance processes ensured that ward procedures ran smoothly. The service informed CQC of all statutory notifications.
- Leaders had the skills, knowledge and experience to perform their roles. They had a good understanding of the service 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 applied to the work of their team. Staff felt respected, supported and valued. Staff could raise any concerns without fear.

However,

- Whilst the ward had a ligature risk assessment, the risks were not as well mitigated as they could have been. Staff did not always know where ligature risks were on the ward.
- Some staff did not ensure that they varied when they checked patients. When patients were checked 4 times per hour for their safety, the checks were not always carried out at 4 random times throughout the hour.
- The ward had introduced fans onto the ward following a risk assessment. However, routine oversight of the fans' use had not yet been incorporated into ward systems, such as the daily environmental checklist.
- Handover documentation and daily allocation sheets were completed each day; however, they were not always completed in full to include staff members' allocated roles.
- Controlled drugs were not always checked by 2 registered nurses as per hospital policy. The ward was not able to provide assurances that their blood glucose monitor was fit for use.
- Restraint documentation within incident reports did not always show which staff were involved or the role they played in the restraint.
- Patient awareness of the advocacy service and the complaints procedure was patchy.

Summary of findings

- Staff had regular appraisal and managerial supervision, but staff were not having regular monthly clinical supervision and monthly reflective practice sessions for staff were poorly attended.
- The team meeting did not routinely cover matters such as incidents, safeguarding and the learning from these.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Acute wards for adults of working age and psychiatric intensive care units	Good	
Long stay or rehabilitation mental health wards for working age adults	Good	

Summary of findings

Contents

Summary of this inspection

Background to Cygnet Churchill

Cygnet Churchill is an independent hospital providing mental healthcare for adult men.

The hospital has four wards.

Juniper Ward is a 17-bed acute ward. The ward provides care for patients experiencing an acute episode of mental illness and requiring an emergency admission.

Maple Court, Mulberry Court and Elm Court are wards providing inpatient rehabilitation services for patients requiring recovery-orientated care.

At this inspection, we inspected the acute ward for adults of working age. We also reviewed the reporting of statutory notifications for rehabilitation services for patients requiring recovery-orientated care.

All of the beds on Juniper Ward were commissioned by a local NHS mental health trust. All of their referrals were from the trust's local boroughs.

The service is registered to provide:

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

• Treatment of disease, disorder or injury.

The hospital director is the registered manager. A registered manager is a person who is registered with the Care Quality Commission (CQC) to manage the service.

The hospital was last inspected in October 2019. The service was rated good overall and for all the key questions apart from Well-Led, which was rated as requires improvement. The hospital was issued 1 requirement notice at the time. This notice was to ensure the CQC was kept informed of all statutory notifications.

What people who use the service say

Most patients were very complimentary about their stay in hospital and the staff team. Patients told us staff always had smiles on their faces, that staff were friendly, and they were supported to attend external appointments and activities. A patient told us this was the best hospital they had been in. Another patient said there was mutual respect between staff and patients, and he felt they treated him as an individual.

However, some patients reported there were not enough staff. One patient said there was poor communication between staff when it came to their leave plans, and another said they had not been offered any 1:1 sessions.

Twelve patients responded to a patient survey carried out in September 2022. The survey showed most patients felt safe on the ward and felt staff were caring. Most patients felt involved in their care and treatment, and felt the ward supported their individual diverse needs.

Summary of this inspection

However, some patients reported the food was poor, some felt there were not enough staff, and some were not aware of the advocacy service available to them.

How we carried out this inspection

The team that inspected this service consisted of 2 CQC inspectors, an expert by experience and a specialist advisor who had experience working in acute mental health services.

To get to the heart of patients' experiences of care and treatment, we always ask the following five questions:

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

These questions therefore formed the framework for the areas we looked at during the inspection.

During the inspection visit, the inspection team:

- visited the service, observing the environment and how staff were caring for patients
- spoke with 7 patients who were using the service
- spoke with 18 members of staff including, the hospital director, clinical service manager, medical director, consultant psychiatrist, ward doctor, team leads, nurses, support workers, mental health act administrators, an occupational therapist, psychologists and the human resources manager
- reviewed 3 patient care and treatment records; we also looked at specific documentation related to the Mental Health Act
- checked how medication was managed and stored, including reviewing prescription charts
- reviewed information and documents relating to the operation and management of the service.

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

Outstanding practice

We found the following outstanding practice:

- The hospital offered a therapeutic earnings programme for all patients on the ward. This was an opportunity for patients to take on different roles within the hospital and be paid. For example, shopping assistant, dining room assistant and patient representative.

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.

Summary of this inspection

Action the service MUST take to improve:

- The service must ensure that ligature risks are reviewed regularly and, where possible, reduced. Managers must ensure staff, including short-term staff, are fully aware of the remaining risks. Regulation 12(2)(b)
- The service must ensure all members of staff completing intermittent observations of patients vary the times they complete the checks Regulation 12(2)(b)

Action the service SHOULD take to improve:

- The service should ensure handover documents and daily allocation documentation are completed in full.
- The service should ensure it has oversight of the use of fans in patient's bedrooms and communal areas.
- The service should ensure it has assurance that blood glucose monitors are suitable for use.
- The service should ensure it documents the full details of any restraints on the ward, for example the staff involved.
- The service should ensure controlled drugs are checked as per hospital policy.
- The service should ensure all patients are aware of the advocacy service and the complaints procedure.
- The service should ensure patients are able to make themselves a drink without needing to ask staff for cups.
- The service should ensure it encourages and supports ward staff to attend reflective practice sessions.
- The service should ensure the ward team meetings routinely cover key areas, such as incidents, safeguarding and any lessons learnt.
- The service should ensure all staff have monthly clinical supervision as per hospital policy.

Our findings

Overview of ratings

Our ratings for this location are:

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

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

Good

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

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

Requires Improvement

We rated safe as requires improvement.

Safe and clean care environments

The ward was clean, well equipped, well furnished, well maintained and fit for purpose. Whilst the ward had a ligature risk assessment, the risks were not as well mitigated as they could have been.

Safety of the ward layout

Staff completed and regularly updated a risk assessment of ward areas. Staff had removed or reduced the risks they identified in most parts of the ward. For example, by ensuring some rooms were only used under staff supervision, such as the laundry room, and ensuring a staff member was always in communal areas. However, the bedroom doors on the ward were a ligature risk, and patients had access to them without staff supervision. These doors were on the ligature risk assessment with staff observations as the mitigating factor.

Despite these observations, there had been a serious incident involving the bedroom door within the last 6 months. The service had no plan to replace or modify the doors.

Following this incident, staff received more training on how to correctly observe patients to ensure they were safe, and managers carried out monthly simulation training to help staff manage emergency situations. Managers also spoke of empowering nursing staff to increase patient observation levels themselves when they were concerned, and not wait until the multidisciplinary team (MDT) review.

Whilst the ward had a ligature map in place, the map did not clearly demonstrate the ligature points throughout the ward. The map was colour coded by hand-drawn pen marks, however, it was unclear what each mark was showing due to colours being used on top of each other. This increased the risk of unfamiliar staff not being able to clearly understand where the ligature points were. The managers were aware of this concern and were in the process of updating the map.

Since the inspection, the ward had completed their updated ligature risk map to include pictures of the ligature points, as well as a letter coded system to show where the specific ligature points were within the ward.

Managers reported all new staff had an induction which included information on ligature points. There was also mandatory training for all staff on ligature rescue, this had been completed by 77% of staff.

We found some staff we spoke with were still unaware of the potential ligature anchor points, and, therefore, how to mitigate them. However, others were able to discuss the ligature points, including the learning from the recent incident.

Staff could observe patients in most areas of the ward. There was a blind spot at one end of the corridor where patients could not be observed. There were convex mirrors on this corridor, however, they did not allow full observation of this area. The ward manager's office was located in this area, which provided some security within their working hours.

All patients not on close observations were observed every hour to ensure their safety. In addition to this, staff carried out daily environmental checks of the ward. This was to identify any new environmental risks or maintenance issues.

Staff had easy access to alarms and patients had easy access to nurse call systems. All bedrooms were fitted with alarms. Staff carried personal alarms on them at all times.

The hospital had a fire evacuation procedure, which included 6 monthly drills. Learning from these drills had included always ensuring a named fire marshal was identified and ensuring staff had training on personal emergency evacuation plans (PEEPs). These were completed on admission, and updated as necessary. Debriefs were held with staff after a fire drill to share their experiences and learning.

A fire marshal was allocated on each shift and there was a site fire warden. We saw this information displayed on a whiteboard on the ward. However, this information was missing on the daily allocation sheets, particularly for night shifts, as well as missing from nursing handover sheets. This had been picked up by the ward in August 2022, however, the were still gaps in documentation at the time of inspection.

Some patients and staff reported the ward became very hot during the summer. One patient had been admitted to hospital during the heatwave with suspected heat stroke. The ward had introduced fans onto the ward following risk assessment. However, routine oversight of the fans' use had not yet been incorporated into ward systems, such as the daily environmental checklist.

Maintenance, cleanliness and infection control

The ward area was clean, well maintained, well-furnished and fit for purpose. All areas we viewed were clean and tidy. Furniture looked well maintained.

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

Staff followed infection control policy, including handwashing, and hand sanitiser was readily available. The hospital's COVID-19 policy did not include wearing face masks at the time of inspection; however, some staff were still wearing them as a personal choice. Following our inspection, the hospital had a positive case of COVID-19. Their policy stated all staff needed to wear masks for 10 days following a positive test on the ward.

Clinic room and equipment

The clinic room was fully equipped. Staff checked, maintained, and cleaned equipment. Cleaning records were maintained. Clean stickers were used in clinic rooms to easily show staff when equipment was last cleaned.

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

Good

Equipment within the clinic room was serviced regularly and were all in date. However, the ward was unable to provide assurance that the blood glucose testing kit was suitable for use. This meant there was a risk that the blood glucose readings for patients may not have been accurate.

Room temperatures and fridge temperatures were monitored daily. Staff escalated concerns to seniors when temperatures exceeded recommended ranges.

The clinic room had accessible resuscitation equipment and emergency drugs that staff checked weekly. However, we noted 3 weeks between June 2022 to August 2022 where these checks had not been completed.

The resuscitation bag had been replaced the day before our inspection due to it being used for an anaphylaxis emergency.

Safe staffing

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

Nursing staff

The service had enough nursing and support staff to keep patients safe.

The service had reducing vacancy rates. The ward had been actively recruiting for registered nurses and support workers since January 2022. They had an open day as well as offering interviews slots most weeks. At the time of inspection, the service had 2.5 vacancies for registered nurses. The service had, however, recruited 4 new registered nurses who were due to start shortly. There were 2.8 vacancies for support workers, which were being covered by the hospitals own pool of bank staff.

Bank usage for registered nursing staff was reducing each month. For example, in October 2021 3% of shifts were covered by bank registered nurses, compared to 1% of shifts covered by bank registered nurses in September 2022. Agency usage of registered nurses varied throughout the year, for example, 9.1% in March 2022 and April 2022 and 4% in October 2022.

Bank usage for support workers was reducing each month. For example, in October 2021 9% of shifts were covered by bank support workers, compared to 2% of shifts in September 2022. Agency support worker shifts varied throughout the year, for example, 22% of shifts were covered by bank support workers in February 2022, compared to 1% in September 2022. This fluctuation was due to the acuity of the patients, depending on their admissions at the time.

In the last 12 months 25 shifts were not filled, which was 0.49% of all shifts in this time.

The hospital had recruited a pool of bank staff to cover available shifts, and, where possible, managers requested agency staff who were familiar with the service.

Managers made sure all bank and agency staff had a full induction and understood the service before starting their shift. Bank staff also received training and supervision from the hospital.

The service had low turnover rates. Since April 2022 the service had not had any staff leave Juniper Ward.

Levels of staff sickness were low. The highest rate of sickness in the last 6 months was 1.36% in June 2022.

Managers supported staff who needed time off for ill health. Mangers reported offering welfare calls while staff were off and having return to work meetings once a staff member was better.

Managers accurately calculated and reviewed the number and grade of registered nurses and support workers needed for each shift. For a day shift, the ward allocated 3 registered nurses and 5 support workers. For a night shift, the service allocated 2 registered nurses and 4 support workers.

The ward manager could adjust staffing levels according to the needs of the patients. Additional staffing could be booked if a patient required a higher level of observation or there were pre-booked activities which affected staffing, such as lengthy escorted leave.

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

Patients rarely had their escorted leave or activities cancelled, even when the service was short staffed. Patients sometimes had their leave delayed, such as when a number of patients requested escorted leave at the same time.

Staff shared key information to keep patients safe when handing over their care to others. The nursing team held handovers at the start of their shifts. A multidisciplinary team (MDT) handover occurred each weekday morning. Whilst handovers occurred regularly, we noted handover sheets were not always completed with all of the information related to the shift, for example, who was responsible for holding the medicines keys, who the first aider was, and who was the allocated fire marshal. One handover sheet had no date and the name of the staff member who had completed the handover document was missing.

Medical staff

The service had enough daytime and night-time medical cover and there was a doctor available to attend the ward quickly in an emergency. The ward had a consultant psychiatrist, a specialist trainee and a ward doctor. The consultant worked 3 days per week. The specialist trainee covered most of the consultant's duties for their non-working days. Other consultant cover was provided by the hospital's full time medical director.

At nights and weekends the doctors worked a rota system. There was a consultant on call, as well as a specialist trainee at all times. These doctors were available for telephone support, and were able to attend the ward in an emergency. The doctors were in charge of creating the on-call rota themselves.

The service did not require locum cover.

Mandatory training

Staff had completed and kept up-to-date with their mandatory training.

Managers monitored mandatory training and alerted staff when they needed to update their training. Staff were reminded in team meetings to complete their outstanding training.

The mandatory training programme was comprehensive and met the needs of patients and staff. It included topics such as responding to emergencies, relational security, infection control, safeguarding and life support training.

Overall, staff on this ward had undertaken 87.5% of the training that the service had set as mandatory.

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

Good

Doctors within the service received ongoing training through the hospital's provider. Training was held monthly and was chaired by Cygnet Churchill's medical director, as they were the academic lead for London and South Cygnet hospitals.

Assessing and managing risk to patients and staff

Staff assessed and managed risks to patients and themselves well and followed best practice in anticipating, de-escalating and managing challenging behaviour. Staff used restraint only after attempts at de-escalation had failed. However, incident reports did not always show which staff were involved with the restraint.

Assessment and management of patient risk

Staff completed risk assessments for each patient on admission. Staff reviewed this risk regularly, including after any incident. However, we saw 1 example where a risk assessment had not been updated for 7 days following an assault on a staff member.

Patient risk was discussed in handover meetings which were attended by all nursing staff on shift. The MDT reviewed patients' risks at daily handover meetings and at weekly ward rounds

The ward's consultant was in the process of introducing a new assessment tool onto the ward. The tool would serve as a brief predictor of violence for an individual patient. The consultant had presented their idea to the medical director, and a ward trial was planned.

All patients were checked once per hour. Some patients were on continuous observations which meant a member of staff was allocated to be with the patient at all times, for their safety or the safety of others. Other patients were on intermittent observations, which involved staff checking in with them 4 times per hour. Whilst most staff checked patients at random times throughout the hour in line with best practice, we did see evidence of some staff checking patients at set predictable times throughout the hour.

Staff identified and responded to any changes in risks to, or posed by, patients. For example, staff increased the level of observation for a patient when risks increased.

Convex mirrors and closed-circuit television (CCTV) were in place to monitor safety on the ward. CCTV was installed in all areas of the ward except for patient's bedrooms and bathrooms. The service had recently updated their CCTV cameras to allow a better quality picture and night vision, as well as increasing the number of cameras on the ward. It was not possible to monitor the CCTV live from the nursing office. Managers instead retrospectively reviewed CCTV following any incidents or concerns.

Staff adhered to best practice in implementing a smoke-free policy. The service provided a smoke-free environment. Patients were offered nicotine replacement therapies including patches and gum.

Use of restrictive interventions

Staff followed the National Institute for Health and Care Excellence (NICE) guidance when using rapid tranquilisation.

Between April 2022 and September 2022 there was 1 incident where medication was administered to a patient by rapid tranquilisation.

We saw the ward carried out monthly audits looking at the administration of rapid tranquilisation, which included ensuring physical health monitoring took place after any usage of this medication.

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

Good

Staff on the ward received training on the management of actual or potential aggression. At the time of inspection 93% of staff had completed this training. We were informed a further 3 staff members had completed this too, however the system had not updated to record their compliance.

Staff made every attempt to avoid using restraint by using de-escalation techniques. Staff restrained patients only when these failed and it was necessary to keep the patient or others safe. Between October 2021 and September 2022 there had been 42 restraints carried out on the ward. Fourteen of these restraints were carried out in October 2021.

Prone restraint, where a patient was in a face down position, occurred 3 times. Staff told us they moved to less restrictive holds as soon as safely possible.

We observed an incident where a patient's behaviours were escalating and staff did not physically intervene. Instead they used de-escalation techniques to support the distressed patient, such as by providing distractions.

Staff had introduced 'grab and go' boxes. These were boxes filled with different activities and were used to positively distract a patient. A support worker was allocated each day to run an activity using the 'grab and go' box in the evenings. The occupational therapists had been working adjusted hours to support staff to build confidence in running these evening sessions.

The service regularly reviewed blanket restrictions on the ward. Subject to an individual risk assessment, patients were able to use their own mobile phones whilst on the ward. Patients were able to use short charging cables in their rooms which reduced the risk of ligatures.

Whilst the ward had a kitchen which was available to patients, patients told us they needed to ask a nurse to get them a cup. One patient reported this often took some time.

The ward was not involved in a formal reducing restrictive intervention programme. However, other wards within the hospital were and had shared their learning with Juniper Ward. Following this learning the ward reviewed observation levels daily, reviewed leave regularly, and kept patients involved in discussions about their care.

Staff recorded episodes of restraint on the hospital's electronic incident reporting system. The incident reports did not always show which staff were involved with the restraint. Managers told us this information should have been included in the incident report and was down to staff error.

Safeguarding

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

Staff had training on how to recognise and report abuse and they knew how to apply it.

Staff kept up-to-date with their safeguarding training. All staff were required to complete an introductory level 2 safeguarding training, 89% of staff had completed this. Clinical staff were also required to complete level 3 safeguarding training, 83% of staff had completed this.

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

Good

Staff knew how to recognise adults and children at risk of suffering harm and worked with other agencies to protect them. Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff told us they would inform their seniors and safeguarding lead with any concerns within the week. Out of hours, staff would speak with an on-call manager and raise concerns directly with the local authorities or police when needed.

In the last 12 months the ward had referred 18 safeguarding concerns to local authorities.

The hospital had a vacant post for a social worker, the hospital was in the process of recruiting a locum staff member to cover this post. A social worker assistant had recently been appointed for the hospital; the hospital was carrying out their pre-employment checks. The clinical service manager was the safeguarding lead for the hospital.

Children were not able to visit the ward or the hospital.

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.

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

The hospital mostly used electronic records. The recording of physical health observations was done via paper records.

The service had created flow chart diagrams to show staff where specific files were saved on their shared drive and online system to allow easier access to records.

When looking at the electronic records it was not clear where blood test results were stored. Doctors reported blood results came to them via an email. All doctors had access to this email address but storage of results was not consistent. The results were discussed and documented on the ward round template each week, but this was not easily searchable.

Records were stored securely. All staff required an individual username and password to access the electronic patient record system.

Records were also held in paper folders in the nursing office in case of IT outage.

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. However, controlled drugs were not always monitored in line with hospital policy.

Staff followed systems and processes to prescribe and administer most medicines safely. Nurses administered medicines and signed prescription charts to show they were given as intended.

Staff reviewed each patient's medicines at weekly ward rounds and provided advice to patients and carers about their medicines.

A pharmacist attended the ward weekly to screen prescription charts and to complete medicines reconciliations. They also completed regular audits which were shared with the ward's managers. However, the pharmacist did not attend ward rounds and did not speak directly with any patients.

Staff stored and managed all medicines and prescribing documents safely. Medicines and prescription charts were kept in the locked clinic room.

The service held controlled drugs on site. These medications were checked every day, however on 1 occasion in October 2022 we noted only 1 nurse signed for the medicine check. There was no witness as per hospital guidance. The pharmacy controlled drugs audit showed 4 occasions where medicines were not signed by 2 staff in September 2022.

Staff reviewed the effects of each patient's medicines on their physical health according to NICE guidance. When patients were admitted, an attempt was made to take baseline blood and electrocardiogram (ECG) readings. Monitoring was attempted when changes were made to medication in line with NICE guidance. All staff had completed their mandatory training in physical health.

All registered nurses had competency tests to administer medicines. However, 1 of these competency tests had recently expired.

Track record on safety

There had been 3 serious incidents within the last 12 months.

Staff discussed serious incidents that had happened on the ward within handovers, team meetings and governance meetings and they shared lessons learnt. Senior staff met regularly to review incidents and share learning across wards.

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.

In the 12 months between October 2021 and September 2022 there were 233 incidents on the ward. There had been 3 serious incidents in this time.

The hospital had an electronic system for recording incidents. All staff had access to this system to facilitate prompt reporting. Staff knew what incidents to report and how to report them.

The senior team debriefed and supported staff after an incident. Staff reported debrief meetings occurred after any incident or restraint.

Reflective practice sessions were offered on the ward for staff, however uptake for these sessions had been low.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations where possible. Investigations routinely involved the review of CCTV footage.

Changes had been made as a result of incidents. For example, following an increase in the number of detained patients leaving the hospital without being granted leave, the ward introduced a more robust risk assessment which was to be completed before a patient left the ward. This allowed staff to see if the patient was safe to leave the ward, as well as

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

Good

have the necessary information should any incident need to be escalated to the police. They had also ensured the reception doors could be locked to reduce the likelihood of someone attempting to leave the hospital without this being agreed with the ward team. Staff received simulation training on how to effectively manage a range of emergencies following the serious incidents on the ward.

One serious incident related to a patient seriously injuring themself on a corner of a bed. Following this incident, all 11 beds with the same design were adapted to ensure the risk was reduced.

Local lessons learnt were shared with staff during team meetings and following governance meetings. Lessons learnt were also sent out to staff via email and discussed in clinical supervision where needed. In addition, Cygnet-wide learning was shared with all staff each month via email.

Staff understood the duty of candour. When things went wrong, staff apologised and gave patients honest information and suitable support.

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

Good

We rated effective as good.

Assessment of needs and planning of care

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

Staff completed a comprehensive mental health assessment of each patient either on admission or soon after. When patients were admitted they were reviewed by a doctor for an initial assessment, which included a physical health assessment and an assessment of their risk.

Staff developed individual care plans for patients that met their mental and physical health needs. Care plans were reviewed regularly through multidisciplinary discussion and updated as needed. Care plans reflected the needs identified at assessments.

Care plans were written together with the patients and included specific plans for the individual, such as where they were at risk of falls. Care plans were updated when a patient's needs changed, for example, following a patient having an allergic reaction, a risk of anaphylaxis care plan was created.

Patients had their physical health assessed soon after admission and regularly reviewed during their time on the ward. This included blood tests and electrocardiograms (ECGs) where needed.

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

Good

Best practice in treatment and care

Staff provided a range of treatment and care for patients based on national guidance and best practice. They ensured that patients had good access to physical healthcare and supported them to live healthier lives. Staff used recognised rating scales to assess and record severity and outcomes. They also participated in clinical audit.

Staff provided a range of care and treatment suitable for the patients in the service and it was consistent with national guidance on best practice. Treatments were delivered in line with guidance from the National Institute for Health and Care Excellence (NICE). Doctors prescribed medicines appropriately with input from pharmacists to ensure that national guidance was followed. Psychologists provided group therapy session, individual therapy and art therapy for patients and occupational therapists provided a timetable of activities and support with activities of daily living.

Staff made sure patients had access to physical health care, including specialists as required. For example, staff supported a patient to an appointment at a specialist eye hospital. The hospital had a physical health nurse specialist and the team carried out audits to ensure patient's physical health needs were monitored as per hospital policy.

Patients were referred to the ward from local boroughs. Most patients were, therefore, registered at a local GP. If a patient was not registered with a GP, they were able to be seen by a nearby practice for primary care support as a temporary patient as per the hospital's service level agreement.

Staff helped patients live healthier lives by supporting them to take part in programmes or giving advice. The hospital had a gym. This was supported by 2 fitness instructors who carried out ECGs on patients prior to them using the facilities. We saw patients being given information on nutrition and healthy eating in an activity group on the ward.

Smoking cessation service leaflets were available on the ward. Cygnet did not provide patients with free vapes. The ward manager had secured 3 month funding for these vapes from a local NHS trust.

Staff used recognised rating scales to assess and record the severity of patients' conditions and care and treatment outcomes. At the time of inspection, the service used the Global Assessment of Progress (GAP) to assess a patient's needs. The ward's consultant psychiatrist was in the process of updating the ward round documentation to include another outcome measure, the Clinical Global Impression Severity Scale (CG- I/S), which they felt would enable a better understanding of patient treatment outcomes.

Staff took part in clinical audits. A range of audits were carried out on the ward. Audits looked into areas such as physical health, medication, patient observations and care planning.

Audits were carried out by a range of senior staff within the ward. The results and actions were then shared with the wider team. These were shared with staff in team meetings, governance meetings or individual supervision.

Managers used results from audits to make improvements. For example, reminding staff of the infection control procedures such as being bare below the elbow while on the ward.

Skilled staff to deliver care

The ward team included the full range of specialists required to meet the needs of patients on the ward. Managers made sure they had staff with the range of skills needed to provide high quality care. However, the hospital's social worker post remained vacant.

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

Good

Managers supported staff with appraisals, supervision and opportunities to update and further develop their skills. However, some staff did not always receive clinical supervision in line with hospital policy. Managers provided an induction programme for new staff.

The service had a full range of specialists to meet the needs of the patients on the ward. For example, nurses, support workers, doctors, psychologists, occupational therapists, activity coordinators and a physical health specialist.

The ward was in the process of recruiting an assistant psychologist. The social worker post for the hospital was vacant. The hospital managers were looking to fill this post with a locum staff member.

Managers gave each new member of staff a full induction to the service before they started work. The hospital had a 2 week induction which included training as well as time shadowing activities on the ward.

Managers supported staff through regular, constructive clinical supervision of their work. Staff on the ward had monthly clinical supervision, as well as 3 monthly managerial supervision. At the time of inspection, 89% of staff had managerial supervision within the last 3 months, and 62% had received clinical supervision within the last month.

Managers supported staff through constructive appraisals of their work. All staff on the ward had an appraisal in the last 12 months.

Managers made sure staff attended regular team meetings or gave information to those that could not attend. The ward had a monthly team meeting. This meeting had a standard agenda to ensure they discussed operational updates, audits, training compliance and staff feedback at all meetings. Records were kept following these meetings and shared with staff who did not attend. Whilst some meetings discussed incidents, the meeting did not have fixed agenda points such as incidents, safeguarding and the learning from these. This could lead to important information and updates not being shared with staff.

Managers recognised poor performance, could identify the reasons for this and dealt with these. The ward manager gave examples of recognising and managing poor performance, for example, providing extra training and having open discussions with the staff member concerned.

Multi-disciplinary and interagency team work

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

Staff held regular multidisciplinary meetings to discuss patients and improve their care. Multidisciplinary handover meetings took place every weekday morning. Nursing handover meetings took place between shifts. Staff made sure they shared clear information about patients and any changes in their care.

The ward had effective working relationships with other teams in the organisation. For example, the hospital director attended meetings with other regional hospitals. The consultant for the ward also had regular meetings with the consultants from other hospitals within Cygnet to share learning and good practice.

Ward teams had effective working relationships with external teams and organisations. For example, care co-ordinators were invited to ward rounds to discuss treatment and discharge planning. The ward had weekly meetings with their commissioners to discuss patient care, as well as daily meetings to discuss bed availabilities.

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

Good

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

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

Staff received and kept up-to-date with training on the Mental Health Act and the Mental Health Act Code of Practice. The ward's compliance rate for this training was 96%.

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

Staff had access to in-house support and advice on implementing the Mental Health Act and its Code of Practice. The hospital had a Mental Health Act administration team to support the ward with their detained patients' documentation. This team carried out regular audits.

Staff knew to contact the Mental Health Act administrators for support when needed.

Patients had easy access to information about independent mental health advocacy. We saw leaflets for the advocacy service on the ward. However, some of the patients we spoke to were not sure when they were able to speak with them.

Advocates visited the ward twice a week and were contactable by phone outside of these times. They could also attend meetings requested by patients, such as ward rounds.

Staff explained to patient their rights under the Mental Health Act in a way that they could understand, repeated as necessary and recorded it in the patient's notes. We saw evidence of patients' rights being shared with them regularly.

Staff made sure patients could take section 17 leave (permission to leave the hospital) when this was agreed with the Responsible Clinician. One patient told us he felt decisions being made around his leave took a long time to be decided as they had to wait for a review by the Responsible Clinician.

Staff stored copies of patients' detention papers and associated records correctly and staff could access them when needed. These were held electronically on the hospital shared drive.

Managers received support from Mental Health Act administrators. Managers were informed of upcoming important dates, such as section expiry dates within the next 2 months.

Good practice in applying the Mental Capacity Act

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

Staff received training in the Mental Capacity Act and Deprivation of Liberty Safeguards. The service had a compliance figure of 96% for this mandatory training.

The hospital had a policy on Mental Capacity Act which was available to all staff on the hospital's shared drive.

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

Good

If staff had concerns about a patient's capacity, they would raise the concerns with their managers or the doctors on the ward.

Staff gave patients support to make specific decisions for themselves before deciding a patient did not have the capacity to do so.

We saw examples of staff assessing capacity to consent when a patient needed to make an important decision.

The ward completed regular audits to ensure their capacity assessments were carried out in line with hospital policy.

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

Good

We rated caring as good.

Kindness, privacy, dignity, respect, compassion and support

Staff treated patients with compassion and kindness. They respected patients' privacy and dignity. They understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition. However, some patients told us they were not offered 1:1 time with staff and staff were often busy.

Staff were discreet and respectful when caring for patients. We saw examples of staff interacting with patients in a kind and caring manner. Most patients spoke positively about their experiences on the ward. Patients said staff treated them well and behaved kindly.

Most patients said staff gave them help, emotional support and advice when they needed it. However, 1 patient said they did not receive any 1:1 time with staff. Another patient said staff were always visible, but they often had to wait to speak with someone as staff were busy. One patient told us they felt there was often noise on the ward at night.

Staff supported patients to understand and manage their own care, treatment or condition. The multidisciplinary team discussed a range of treatment options with patients in their weekly ward rounds. Patients were encouraged to ask questions about their treatment in these meetings.

Staff directed patients to other services and supported them to access those services if they needed help. For example, patients told us they had been escorted to the dentist and hospital appointments.

Staff understood and respected the individual needs of each patient. One patient told us he felt there was no stereotyping on the ward. He said staff understood his history and treated him as an individual.

We saw staff supporting patients to continue their interests whilst in hospital, for example, a patient was supported to attend tennis groups twice per week.

Staff followed policy to keep patient information confidential. Eighty-nine percent of all staff had completed information governance training.

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

Good

Involvement in care

Staff involved patients in care planning and risk assessment and actively sought their feedback on the quality of care provided. However, some patients told us they did not have access to their care plans.

Staff ensured that patients had easy access to independent advocates. Most patients we spoke with were aware of the advocacy service..

Involvement of patients

Staff introduced patients to the ward and the service as part of their admission. One patient said they were not introduced to patients when they arrived, but they felt they had a warm welcome to the ward.

Staff involved patients in their care planning. Patient views were included in their care plans, in their own words. However, some patients told us they did not have copies of their care plans.

Staff involved patients in decisions about the service, when appropriate. For example, the patients were directly involved in setting up the activity timetable every 16 weeks.

Patients could give feedback on the service and their treatment and staff supported them to do this. Patients were able to give feedback to any staff member. The ward had formal complaint leaflets as well as electronic feedback forms displayed on a noticeboard.

A weekly community meeting took place on the ward. Patients were able to discuss what went well with their week, as well as provide feedback and share concerns with staff. These meetings also supported all patients to share with staff how safe they felt on the ward. Meeting minutes were displayed for patients to review on the ward notice board. There was a monthly people's council meeting, which involved patients coming together from the whole hospital to share their views and discuss improvements. Recent improvements suggested included making more use of the garden space and allowing all patients to have their own keys to their bedrooms.

Staff made sure patients could access advocacy services. Advocates visited the ward twice per week and information about the service was displayed on the wall of the ward. Some patients told us an advocate had supported them. However, a patient said they did not know when the advocate was available. The ward informed patients what advocacy services were and how they can access this support in the patient's weekly community meeting.

The advocates fed back concerns raised with them to ward seniors. For example, patients had raised concerns about ward round times changing and not being communicated with patients. A plan was put in place to print out a schedule for ward round on the day showing the most up to date times for patients to be seen.

The ward carried out annual patient surveys. Twelve patients responded to the most recent survey in September 2022. This survey showed 9 patients were satisfied with the accommodation provided, 8 patients felt safe on the ward, 9 patients felt staff were caring, 10 patients felt involved in their care and treatment, and 10 patients felt the ward supported their individual diverse needs.

However, 6 patients reported the food was poor, 5 patients felt there were not enough staff, and 5 patients were not aware of the advocacy service available to them.

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

Good

Involvement of families and carers

Staff informed and involved families and carers appropriately.

Staff and patients informed us visitors were allowed every evening and at weekends. Patients told us their families were involved in their care and staff members kept family updated on their care.

When family members were involved in the patient's care, staff contacted carers following incidents.

Family members were invited to attend ward rounds, either in person or via video conferencing facilities. The ward had recently updated their ward round template to ensure carer feedback was discussed for each patient.

At the time of inspection, a carer group had not taken place. There were plans for a meeting in October 2022, but it was cancelled due to train industrial action. This group was rescheduled for November 2022.

Juniper Ward had recently begun trialling a pilot of the 'triangle of care'. This approach focused on strengthening the communication between the patient, the family and staff.

The hospital carried out annual family and friends' surveys, the last survey was carried out in December 2021. Five carers from Juniper Ward responded to the survey. Feedback from these carers was very complimentary. Carers felt the ward catered to their specific needs as carers, they said care plans were explained to them, and they felt staff were approachable and polite. All carers reported they would recommend the service to others. One carer said they lived outside of London and were supported to attend ward round and speak with the doctor via video conferencing facilities. One carer reported they did not know how to make a complaint. All carers said they knew who to contact if they had a concern for their family member.

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

Good

We rated responsive as good.

Access and discharge

All beds were commissioned by a local NHS trust. Managers had regular meetings with commissioners regarding their bed state. When a patient was ready for discharge the referring service sought appropriate accommodation.

Bed management

All beds on Juniper Ward were commissioned by the local NHS mental health trust. The service did not, therefore, have any out of area placements.

Bed occupancy on the ward was high. Over the last 6 months the lowest occupancy was 92% in June 2022. The ward was at 100% capacity in September 2022. Staff reported a new patient would be admitted quickly following a discharge. Patients would be admitted at all hours as emergencies. An on-call doctor would be responsible for the clerking assessment out of hours.

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

Good

Managers regularly reviewed the length of stay for patients to ensure they did not stay longer than they needed to. Managers had daily bed management meetings with their commissioners, as well as weekly meetings to discuss their current patients and their treatment plans.

When patients went on leave there was always a bed available when they returned.

Managers reported being able to decline referrals if they were unsuitable for the ward or the ward already had a number of patients on enhanced observations.

If a patient required more intensive care this was discussed with the commissioners. The commissioners would then look to transfer the patient to a psychiatric intensive care unit within their trust.

Discharge and transfers of care

Managers monitored the number of patients whose discharge was delayed and reported these figures to their commissioners. The ward informed commissioners of any patients who had been on the ward longer than 8 weeks. At the time of inspection, 3 patients' discharges had been delayed. All three patients were awaiting suitable accommodation placements.

Staff carefully planned patients' discharge and worked with care managers and coordinators to make sure this went well. Community teams were invited to weekly ward rounds to discuss care and treatment plans. They could attend these meetings in person or via video conferencing facilities. Accommodation aftercare was organised by the patient's local community team.

Facilities that promote comfort, dignity and privacy

The design, layout, and furnishings of the ward supported patients' treatment, privacy and dignity. Each patient had their own bedroom with an en-suite bathroom and could keep their personal belongings safe. There were quiet areas for privacy. Patients we spoke with said the food was of good quality and patients could make hot drinks and snacks at any time. However, some patients told us they needed to ask for cups from staff to make a drink.

Each patient had their own bedroom with an en-suite bathroom. Staff told us that patients could personalise their bedrooms if they wanted.

Patients had a secure place to store personal possessions. Patients were encouraged to store valuable items in the nursing office. There was also a patient storage room, which was locked, for bigger items.

Staff used a full range of rooms and equipment to support treatment and care. For example, a gym, therapy kitchen, music room and activity room. Rooms off the ward were only used under staff supervision.

The ward had a low stimulus room where patients could go to relax and to have some quiet time.

There was a room on the ward, and a room near reception where patients could meet with visitors in private.

Patients could make phone calls in private. Patients were able to use their own mobile phones, including in their own rooms. A cordless ward phone was also available for patients to use.

The service had an outside space that patients could access easily. The hospital garden was small; however, the hospital was located opposite a park. Staff organised activities in the park, which patients could attend following a risk assessment.

Patients could make their own hot drinks and snacks as the ward had a kitchen, although some patients told us they had to ask staff for cups.

The service offered a variety of good quality food. Patients we spoke with reported they were happy with the range and quality of food provided. However, half of patients reported the food being poor in the recent patient survey.

Patients' engagement with the wider community

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

Staff made sure patients had access to opportunities for education and work. The hospital offered a therapeutic earning programme for all patients on the ward. This was an opportunity for patients to take on different roles within the hospital and be paid. For example, a shopping assistant, dining room assistant and a patient representative.

The hospital's occupational therapist had been in contact with a local college to arrange classes for the needs of their patient group, for example, short courses and workshops as opposed to longer courses. The ward had also supported patients to complete online training when this was deemed more suitable.

The ward offered a weekly program of activities provided by the occupational therapists and ward psychologist. The programme was updated every 16 weeks to include activities the current group of patients enjoyed. These included physical activity groups, life skills groups, mindfulness sessions and leisure activities. The occupational therapy assistant offered community outings every other weekend, such as bowling, visiting parks, and visiting museums.

The ward's occupational therapist made links with patient's community occupational therapists to support their transition once discharged. They had also set up external links, such as cooking groups, which patients could attend from November 2022.

Staff helped patients to stay in contact with families and carers. This included supporting patients to have visits from family members and inviting family members to weekly ward round meetings.

Meeting the needs of all people who use the service

The service met the needs of patients, including those with a protected characteristic. Staff helped patients with cultural and spiritual support. However, the ward was not set up to support a patient with mobility issues.

The service could support and make adjustments for people with specific needs. For example, ensuring documentation was in an easy read format. The ward was not, however, suitable for someone with mobility issues as there were no accessible toilets or baths and there was no access to a hoist. The acoustics within the ward also made it difficult for people who wore hearing aids to hear.

Managers made sure staff and patients could get help from interpreters or signers when needed.

The service provided a variety of food to meet the dietary and cultural needs of individual patients. For example, halal and vegan food.

Patients had access to spiritual, religious and cultural support. For example, staff spoke about supporting patients to observe Ramadan. Patients had also been supported to have leave to attend Church. The minutes for the patient community meeting recorded the different religious holidays that were in the coming months. These minutes were displayed on the ward and shared with staff via email.

Staff completed training to support a range of patients, for example, supporting autistic people and supporting people with a learning disability.

Listening to and learning from concerns and complaints

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team and wider service. The recent patient survey showed 5 patients were not aware of the complaints procedure.

Patients and carers were able to raise any concerns with the ward directly. There was a formal complaints route as well as an informal feedback route. The ward encouraged patients to provide informal feedback to staff regularly. This included in their weekly community meeting, daily morning planning meeting, monthly people's council or at ward rounds.

The service displayed information about how to raise a concern in patient areas. There were feedback forms available on the noticeboard, as well as a QR code to complete feedback electronically.

Patients told us they felt able to raise concerns with staff; however, in the patient survey 5 patients reported not knowing the complaints procedure.

Staff understood the policy on complaints and knew how to handle them. The ward had 5 days to acknowledge a complaint and 28 days to provide a full response.

A senior member of staff was allocated to investigate complaints depending on the concern raised.

The service had received 5 formal complaints in the last 12 months. All of these complaints were sent an initial acknowledgement within 1 day of receiving the complaint. Four of the complaints were resolved within 28 days. One complaint took longer to resolve as the ward was awaiting a response from the complainant.

Managers shared feedback from complaints with staff and learning was used to improve the service. For example, following a complaint from a carer the service aimed to ensure they shared rationales for treatment and discharge for more transparency in care.

The service used compliments to learn, celebrate success and improve the quality of care. Compliments were logged by the admin team. The ward shared good practice and compliments in team meetings and also shared them by email.

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

Good

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

Good

We rated well-led as good.

Leadership

Leaders had the skills, knowledge and experience to perform their roles. They had a good understanding of the service they managed and were visible in the service and approachable for patients and staff. However, some reported staff within corporate Cygnet were less supportive.

The ward managers and hospital seniors were present on the ward. They had a good understanding of the service they managed, as well as their patients' needs, risks and circumstances.

Many of the hospital seniors had been in their post for many years, including the consultant psychiatrist, medical director and clinical service manager. The hospital director joined the hospital in April 2022, but had extensive experience working within the field prior to joining the team. The ward manager had been in their post since January 2022, but they had been working on the ward as a clinical team lead when appointed as manager.

Staff said they found their managers to be visible and approachable. They could get support from them when they needed it. Most staff told us the senior managers within corporate Cygnet Health Care were visible on the wards, visiting the hospital every 2 weeks.

Leaders spent time on the ward and were available for discussions and support as needed.

Vision and strategy

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

The hospital had a range of values. These were grouped into the categories, care, respect, empower, trust and integrity. All staff had completed training on the providers values.

The staff we spoke with were able to talk about the values and demonstrate how they were meeting them. For example, they felt staff on the ward were caring and respected patients. They felt they had good supportive and therapeutic relationships with patients.

Culture

Staff felt respected, supported and valued. They said the hospital promoted equality and diversity in daily work and provided opportunities for development. However, some felt the training budget needed to be increased. Staff could raise any concerns without fear.

Staff reported good team working across the whole ward team. Staff felt able to approach anyone within the multidisciplinary team for support and advice.

Staff knew about the role of the hospital's Freedom to Speak Up Guardian and knew how to contact them. Information about the Freedom to Speak Up Guardian was displayed on the ward. The ward had an internal guardian for the hospital, as well as someone to raise concerns with at a corporate level.

Staff had access to support for their own physical and emotional health needs through an employee assistance programme. Senior staff followed up on staff wellbeing following leave from work. A psychologist also provided reflective spaces however these were poorly attended by staff.

Managers dealt with poor staff performance when needed. Managers gave clear examples of the process they followed to manage poor performance. This included providing additional training and support, and disciplinary action when necessary.

The service offered development opportunities, such as training, however some said they hoped the budget for external training could be increased to support newer staff members with their development and understanding.

The ward had planned an away day, however this had to be cancelled due to a COVID-19 outbreak. Managers were looking to re-book this day in the near future.

The ward recognised staff success within the service. Staff were able to vote for employee of the month within the hospital, as well as attend Cygnet Health Care wide annual award ceremonies. The Cygnet Churchill occupational therapy team won the award for flagship occupational therapy team at the most recent occupational therapy awards. The medical director won 'Innovator of the Year' at the most recent psychiatrist awards for their quality improvement work across the hospital as well as Cygnet-wide rehab wards.

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. However, team meetings did not always cover incidents and learning.

Leaders ensured there were structures, processes and systems of accountability for the performance of the service. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

There was a clear framework of what must be discussed in hospital level governance meetings to ensure that essential information such as, incidents, safeguarding concerns, complaints and operational issues was shared and discussed. However, these same topics were not standard agenda points in the ward team meeting. These areas were sometimes covered, but not in every meeting. Nursing staff did not attend the governance meetings, this could therefore lead to some information and learning not being shared with the team.

Staff had implemented recommendations from reviews of incidents, complaints and safeguarding alerts at ward level. For example, ensuring all bed frames had no sharp corners following an incident on the ward.

Staff participated in local clinical audits. The audits were sufficient to provide assurances and staff acted on the results when needed. Audits were carried out on areas of care such as care planning, risk assessments, physical health observations and infection control.

However, the ward had not always made improvements when concerns were noted. For example, staff were aware the allocation sheets were not being filled correctly in August 2022. This was brought up in a team meeting, but the issue remained at the time of inspection.

Management of risk, issues and performance

Leaders managed performance using systems to identify, understand, monitor, and reduce or eliminate risks. The ward reviewed patient safety following incidents, however bedroom doors did not appear on the ward's risk register as an area of concern. Managers had not ensured that staff knew about risks on the ward.

Staff maintained and had access to a risk register. Staff working on the ward could escalate concerns via the ward manager.

Staff concerns in the service matched those on the risk register, for example COVID-19 outbreaks and a lift that had been broken for some time. Whilst the risk register contained concerns around the ligature map's practicality, the risk register did not include specific risks, such as the ward bedroom doors. The ward had a serious incident earlier in the year involving these doors.

The ward had previously struggled to recruit nurses and support workers. At the time of inspection, they had, however, been successful in filling all of their nursing posts. Agency usage for support workers varied each month. The social worker post for the hospital remained vacant. Managers were in discussions to negotiate the pay being offered. In the meantime, the clinical services manager was the safeguarding lead.

Ward staff told us that handovers and ward rounds were an effective way of ensuring all staff were aware of the current patient risk. However, not all staff we spoke with were aware of the ligature points on the ward, and not all staff were carrying out intermittent observations in line with hospital policy.

The ward had seen a reduction in the use of restrictive practice over the past 12 months. Whilst Juniper Ward had not been part of the formal improvement project, learning from the other wards within Cygnet Churchill was shared with the ward staff. Initiatives used on the ward included regularly reviewing leave, involving families in care and having patients involved in the planning of their care and activities.

The hospital had reviewed patient safety following incidents. For example, following a rise in patients leaving the ward without permission, the service updated their pre-leave risk assessment form to ensure the patients were safe when they leave the ward. They also designed cards with the ward information on should they be running late or needed to call the ward. Following the serious incident involving the ward bedrooms doors, managers increased staff training and awareness on how to manage these incidents. However, the ward did not have further plans in place to ensure the safety of their patients and their unrestricted access to ligature points, such as bedroom doors.

The ward had recently enhanced their CCTV, allowing better investigations following any incidents.

The service had a business continuity plan which covered a range of possible incidents and recovery plans. Plans included emergency contact details and actions staff should take in the event of an emergency.

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

Good

Information management

Teams had access to the information they needed to provide safe and effective care and used that information to good effect. Some staff reported problems using video conferencing facilities, and others felt there should be more laptops on the ward.

The service used systems to collect data from ward that were not over-burdensome for frontline staff. The ward manager and senior staff had access to information to support them with their management role. This included information on the performance of the service, staffing and patient care.

Staff had access to the equipment and information technology needed to do their work. The information technology infrastructure generally worked well and helped to improve the quality of care. However, some staff told us the hospital's computers had difficulty connecting to some video conferencing platforms. Staff also told us more laptops on the ward would be useful for completing nursing notes and training.

Information governance systems included confidentiality of patient's records. Training in information governance was included in the ward's mandatory training. At the time of inspection 89% of staff had completed this training.

Staff made notifications to external bodies as needed. The service submitted statutory notifications to CQC when required. The service notified the local authority of the safeguarding concerns found on the ward.

Engagement

Patient, carers and staff were able to provide feedback to the service. Managers used this feedback to make improvements.

Staff and patients had access to up-to-date information about the work of the service, for example, through the intranet, team meetings, community meetings and people's council meetings.

Feedback was encouraged, and people were supported to provide feedback in a way that was best for them. Feedback could be given in community meetings, people's council meetings, direct to staff, or through the formal complaints procedure. Patients and carers also had the opportunity to feedback their thoughts on the hospital's annual survey.

The ward had recently introduced a change to their ward round template to ensure they capture the carers views at each review.

Managers and staff had access to the feedback from patients, carers and staff and used it to make improvements. For example, ensuring the TV was more accessible to patients on the ward and keeping carers up to date with the progress and plans for their family members on the ward. A patient also requested for their vegan food to be served separately from the main food, which was arranged.

Patients were involved in planning the activities taking place on the ward, and they could attend community meetings and people's council meetings to share their thoughts and concerns. Patients and experts by experience were involved in the interview panels when the hospital recruited new staff.

Learning, continuous improvement and innovation

Staff collected and analysed data about outcomes and performance.

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

Good

Staff were to be given the time and support to consider opportunities for improvements and innovation at their upcoming team away day.

The ward collected data on patient outcomes in the form of the Global Assessment of Progress (GAP). The ward was in the process of implementing a different outcome measure, the Clinical Global Impression / Severity Scale (CG- I/S). They hoped this would improve the data and ability to track progress in patient treatment.

The ward was not part of any formal quality improvement projects. Managers told us the main goal for this ward had been to stabilise their staffing. As staffing was in a better position they were beginning to think about improvements. Managers said the ward's away day would be a time for staff to think the changes that would benefit the ward most. They would then use this feedback to decide the new improvement projects.

Whilst this ward did not take part in the reducing restrictive intervention project, learning was shared with Juniper Ward by other wards within the hospital.

Managers told us they had been preparing to apply for accreditation with the Royal College of Psychiatrists early next year.

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 well-led?

Good

Our rating of well-led improved. We rated it as good.

Information management

The service submitted statutory notifications to CQC when required.

At the last inspection, we found the service did not send notifications to CQC every time they made a safeguarding referral to the local authority.

As part of the registration conditions, the service was required to notify CQC of any incidents relevant to allegations to abuse or abuse in relation to a service user.

At this inspection, we found the service was informing CQC of all notifiable incidents.

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
Treatment of disease, disorder or injury Assessment or medical treatment for persons detained under the Mental Health Act 1983	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Staff did not do all that is reasonably necessary to mitigate risks such as ligature anchor points. Not all staff were aware of the ligature anchor points on the ward. Staff did not undertake intermittent observations of patients in line with the provider's observation and engagement policy