Cygnet Health Care Limited

Cygnet Lodge Lewisham

Quality Report

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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from people who use services, the public and other organisations.

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Overall summary

At Cygnet Lodge Lewisham there were enough staff on duty to meet people's needs. Detailed environmental and individual risk assessments were carried out and action taken to manage the risks identified. Medicines were managed safely. Staff knew how to recognise and report potential abuse in order to protect people. The service had a good safety record. Incidents were fully investigated to identify learning. Learning was shared with staff to minimise risk of reoccurrence. A detailed ligature risk assessment had been completed and an action plan was being developed to ensure that staff knew about all identified risks and they were managed safely.

The needs of people using the service were assessed in detail. This included their physical as well as mental health needs and there was on-going monitoring of their needs. Most care plans and individual risk assessments were reviewed and updated after new risks were identified but some were not. Staff followed best practice guidelines when providing care and treatment. Staff received the training and supervision they needed to enable them to care for people appropriately. The staff team worked well together to meet the needs of people. Staff used the Mental Health Act and Code of Practice correctly.

Staff were kind and respectful towards people using the service and were positive when planning their care and support. Care was person-centred and people were involved in developing their own care plans. Staff recognised people's individual needs and understood how to care for them. Families and friends were involved in care when this was appropriate. People gave feedback about the service and this was listened to by staff and managers.

People could take part in a range of activities and groups both inside and outside the service. Staff focussed on people's recovery and helped them build on their strengths. There were paid work opportunities within the service. People knew how to make a complaint and staff responded appropriately when they did. Meals were cooked on site and there was a good choice available. The chef actively sought people's views about the meals they would like. People had access to outside space.

Staff knew the vision and values of the organisation. There were good systems in place to measure how well the service was providing care and treatment. The manager knew that staff had received the training they needed and conducted checks to see that policies and procedures were being followed. Staff actively learned from incidents, complaints and feedback from people and staff, and took action to improve the quality of service.

Mental Health Act responsibilities

At the time of the inspection 13 of the 14 people using the service were detained under a section of the Mental Health Act 1983 (MHA). One person had been conditionally discharged from their section.

Staff received training in the MHA and had good understanding of the main provisions of the Act and MHA Code of Practice.

People using the service had access to an independent mental health advocate who could support them. The advocate for the service reported a good working relationship with staff at the service. Discussions of people's rights were regularly repeated and recorded in people's records.

MHA documentation had been completed appropriately. Consent to treatment and capacity requirements were mostly adhered to and copies of consent forms were attached to medicine administration records. A standard form was used to record a discussion of consent and the treating clinician's assessment of patients' capacity to consent to treatment. These were completed with people on a regular basis.

We found a lack of clarity in respect of the recording of the capacity and consent to treatment interview for two people. In addition, in the records of one person we found a section 17 leave form that had been superseded by a more recent form and had not been cancelled. The out of date form remained in the person's records which was potentially confusing for staff and the person concerned.

Mental Capacity Act and Deprivation of Liberty Safeguards

Summary of findings

Staff had received training in the Mental Capacity Act 2005 (MCA). However, their understanding of the legislation and how it affected their everyday clinical practice varied. Some staff had a good understanding of the MCA and how it applied to their clinical practice. However, others could not clearly explain the details of a mental capacity assessment. The manager told us MCA training had been combined with MHA training and this may not have been the most effective way of ensuring all staff understood the MCA.

There had been no applications made under Deprivation of Liberty Safeguards.

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

There were enough staff on duty to meet people's needs. Detailed environmental and individual risk assessments were carried out and action taken to manage the risks identified. Medicines were managed safely. Staff knew how to recognise and report potential abuse in order to protect people. The service had a good safety record. Incidents were fully investigated to identify learning. Learning was shared with staff to minimise risk of reoccurrence. A detailed ligature risk assessment had been completed and an action plan was being developed to ensure that staff knew about all risks identified and they were managed safely.

Are services effective?

The needs of people using the service were assessed in detail. This included their physical as well as mental health needs and there was ongoing monitoring of their needs. Although most care plans and individual risk assessments were reviewed and updated when new risks were identified, this did not always happen. Staff followed best practice guidelines when providing care and treatment. Staff received the training and supervision they needed to enable them to care for people appropriately. The staff team worked well together to meet the needs of people. Staff used the Mental Health Act and Code of Practice correctly.

Are services caring?

Staff were kind and respectful towards people using the service and were positive when planning their care and support. Care was person-centred and people were involved in developing their own care plans. Staff recognised people's individual needs and understood how to care for them. Families and friends were involved in care when this was appropriate. People gave feedback about the service and this was listened to by staff and managers.

Are services responsive to people's needs?

People could take part in a range of activities and groups both inside and outside the service. Staff focussed on people's recovery and helped them build on their strengths. There were paid work opportunities within the service. People knew how to make a complaint and staff responded appropriately when they did. Meals were cooked on site and there was a good choice available. The chef actively sought people's views about the meals they would like. People had access to outside space.

Summary of findings

Are services well-led?

Staff knew the vision and values of the organisation. There were good systems in place to measure how well the service was providing care and treatment. The manager knew that staff had received the training they needed and conducted checks to see that policies and procedures were being followed. Staff actively learned from incidents, complaints and feedback from people and staff, and took action to improve the quality of service.

Summary of findings

What we found about each of the main services at this location

Long stay/rehabilitation mental health wards for working-age adults

Summary of findings

What people who use the location say

People using the service we spoke with had mixed opinions about the service but most were positive about the support, care and treatment offered to them. Staff were described as kind and caring.

Some people told us their bedrooms were cold but we noted that that an engineer was attending to the heating system during our inspection of the service.

There was a patient representative who was able to put forward people's views and concerns about the service at regular meetings with managers. People knew who the representative was. The representative also took part in interviews for new staff.

Some people said they had been very involved in planning their care and could choose the activities they wanted to take part in. People particularly appreciated the opportunities to undertake paid work within the service.

Areas for improvement

Action the provider SHOULD take to improve

- The provider should ensure the management of identified ligature risks in the service is made explicit for staff following the detailed assessment carried out in November 2014.
- The service should ensure risk management plans are clear for all identified risks affecting individuals and that all care plans are reviewed and updated when new risks are identified.
- All staff should have a good understanding of the Mental Capacity Act and Deprivation of Liberty Safeguards and the implications and impact of the legislation on their clinical practice.

Good practice

- People using the service were able to carry out paid jobs in the service which helped increase their confidence. Job descriptions were prepared and people applied and were interviewed for the roles.
- The service user representative for the service took part in interviews for new staff.

Cygnet Lodge Lewisham

Detailed findings

Services we looked at:
Long stay/rehabilitation mental health wards for working age adults;

Our inspection team

Our inspection team was led by:

Team Leader: Judith Edwards, Care Quality Commission

The team that inspected the service consisted of six people, one expert by experience, three inspectors, one Mental Health Act reviewer and a senior nurse.

Background to Cygnet Lodge Lewisham

Cygnet Lodge Lewisham is provided by Cygnet Health Care Limited.

The service is a rehabilitation unit located in a residential street in Lewisham. The service has 17 beds and is a service just for men.

We have inspected Cygnet Lodge Lewisham three times since 2010 and reports of these inspections were published between September 2011 and January 2014. At the time of this inspection Cygnet Lodge Lewisham was not meeting an essential standard relating to the notification of other incidents (regulation 18 of the Care Quality Commission (registration) regulations 2009). This was inspected as part of the comprehensive review and we found the service was now formally reporting to the Care Quality Commission when things had gone wrong or allegations had been made.

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 get to the heart of the experience 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 this service and asked other organisations for information.

During the inspection visit the inspection team:

- visited the service;
- spoke with seven people who were using the service;
- spoke with the manager of the service and senior staff within the organisation;
- spoke with eleven staff working in the service;

Detailed findings

- interviewed the quality manager with responsibility for the service;
- interviewed an independent advocate who regularly visited the service; and
- attended part of a multi-disciplinary ward round.

We also:

- looked at 10 treatment records of people using the service;
- observed how staff were caring for people;
- carried out a specific check of medication management in the service; and
- looked at a range of records and documents relating to the running of the service.

Is the service safe?

Our findings

Safe and clean ward environment

- The service had 17 beds which were all for men. On the day of the inspection there were 14 males using the service, 13 of whom were detained under the Mental Health Act 1983.
- An annual ligature risk assessment had been carried out and a number of risks in the environment had been identified. There were some ligature risks in non-public areas such as people's bedrooms, which we also noted. Where individual risks were identified these were being managed through individual risk assessment and by restricting access to some high risk areas. Another, more detailed, assessment of ligature risks in the service had been carried out on 18 November 2014 shortly before our visit. The ligature audit form included photographs of the individual risks identified. The manager told us an action plan was being drawn up to address the issues raised in the assessment and ensure all necessary mitigating actions had been taken to keep people safe. At the time of the inspection the action plan had not been completed.
- There was a fully equipped treatment room with resuscitation equipment which was readily accessible to staff. Records showed that emergency equipment was checked regularly by staff to ensure it remained fit for purpose. Other medical equipment was checked weekly and cleaned. Stickers were dated and applied to equipment to notify staff when it was last cleaned. This helped minimise the risk of cross infection. Medical devices were calibrated regularly and staff were trained and knew how to use equipment effectively.
- All areas of the unit were generally clean. People looked after their own bedrooms and were supported and encouraged by staff to keep the areas clean and clutter free as much as possible. Furniture and fittings were maintained to a satisfactory standard. Some people raised concerns that their bedrooms were cold. Problems with the boiler and heating system were being addressed by a professional on the day of our visit.
- Environmental risk assessments and checks were carried out regularly. These included fire safety checks and security checks. Regular drills ensured people knew what to do in the event of a fire.
- Staff had access to an alarm in an emergency. Drills and simulations were carried out once a quarter to ensure staff were prepared for an emergency and knew what to do in response. Fire drills were carried out unannounced. Evacuation plans were in place for people that recognised individual circumstances. The most recent fire drill had been held in September 2014.

Safe staffing

- There were sufficient staff on duty to care for people safely. There were two qualified nurses and three health care support workers on duty during the day and two qualified nurses and one health care support worker on duty at night. A senior nurse was always on duty. If required staff could obtain additional support from another Cygnet service which was close by.
- Staffing levels were reviewed annually to ensure levels of staffing set were safe. Staffing numbers and skill mix had been changed to reflect the increasing acuity of people using the service.
- There were few staff vacancies, namely one for a qualified nurse and one for a health care support worker. The manager told us two of the nurses were relatively junior in terms of experience so they aimed to employ a more senior nurse in order to ensure the team as a whole was sufficiently experienced and the skill mix appropriate.
- Bank and, very occasionally, agency staff were used to address any shortfalls in staffing. Additional staff were employed when the needs of people changed, for example when they needed one to one support from staff. People using the service told us there were enough staff and they were always able to take up agreed escorted leave from the service although they sometimes needed to be flexible about the time they went out.
- There was adequate medical cover. The ward doctor felt well supported by the consultant psychiatrist who was part time.

Assessing and managing risk to patients and staff

- All people using the service were individually risk assessed. Risk assessments included the use of the HCR-20, an internationally recognised structured threat assessment tool, every three months. Where risks were

identified action was taken to mitigate the risks. For example, levels of observation of people increased in line with the level of risk identified to ensure people were safe.

- The social worker in the service led on safeguarding for the service and was available to advise staff about any concerns they had. There was a poster on display in the staff office which outlined the local safeguarding referral process. This reminded staff about what they needed to do to raise a safeguarding alert in a timely manner and was particularly useful out of hours when the safeguarding lead was not necessarily contactable.
- Staff we spoke with had all received training in safeguarding vulnerable adults and children and knew the types of concerns they should refer and where they should refer them. Safeguarding was discussed at people's individual ward rounds.
- There had been several safeguarding concerns in the service that had been appropriately referred to the local authority safeguarding team. No children were allowed into the service but staff supported people to visit child relatives off-site when this was appropriate.
- Medicines were stored in locked cabinets. A pharmacist attended the service weekly and checked that medicines were managed safely. Drug fridge temperatures were checked and recorded every day to ensure that medicines requiring cold storage remained effective. Out of date medicines were recorded and disposed of appropriately. Medicine administration records we reviewed were completed accurately. People's allergies were noted on their medicine administration records. When medicines were not given a reason was recorded. The competency of staff to administer medicines safely was checked by the service.
- Some people were supported to self-medicate. Arrangements were in place to support people to do this safely and effectively. Locked storage was provided in people's rooms and staff carried out spot checks to ensure people were taking their medicines as prescribed.
- There were no inappropriate restrictions on people. The manager told us there was a problem with the sale of illegal drugs in the local area. Some people were searched on their return to the unit. There was a search policy in place to make sure this was carried out respectfully and with people's consent. The need for random searches was included in the admission agreement signed by the person using the service. Random drug screening was carried out for people who were considered high risk and this formed part of their care plan. A substance misuse group was provided to support people although this was not always well attended. The service had good links with the local police and community support team.
- Restraint was rarely used by staff. The service was focussed on rehabilitation and recovery and most people were not acutely unwell. Staff told us that they had to physically restrain people on rare occasions. This had last occurred during an incident the day before our visit when a person was restrained before being transferred out of the service. A quarterly audit of restraint dated November 2014 contained two records of restraint being used. The interventions had occurred for a maximum of five minutes and both people had been seen by a doctor afterwards to ensure no injuries had been sustained. Both people had been offered a debrief following the restraint. The service did not have seclusion facilities.

Track record on safety

- Incident records showed there had been very few incidents in the service. Where these had occurred there were detailed reports of the incident and action taken in response.

Reporting incidents and learning from when things go wrong

- All staff we spoke with knew the type of incidents they should report and how to report them. At our last inspection of the service we had identified an allegation of abuse that had been reported to the local authority safeguarding team but had not been notified to CQC as required by regulation 18 of the Care Quality Commission (Registration) Regulations. During this inspection we did not identify any allegations or incidents that we had not already been notified of. The service was compliant with this regulation.
- Incidents, safeguarding concerns and complaints were analysed to identify themes and trends and thereby learning for the service.
- All incident reports were reviewed by the manager and action plans were put in place where learning and the potential to improve was identified. This aimed to

decrease the risk of similar incidents happening again. For example, a pharmacist's medicines audit had identified that a number of prescriptions had no signature. Staff took the action necessary to improve practice. This was done by conducting medicine competency checks for all nurses and the introduction of a new system of checking medicines as they were administered. This had resulted in a reduction in the number of similar incidents.

- Incident reports were detailed. The outcomes of investigations were clearly recorded and learning from incidents was shared with staff. Incidents were reviewed at a monthly incident learning meeting chaired by the registered manager. Minutes of incident learning meetings identified themes and lessons learnt.
- Staff meeting minutes showed that learning from incidents at Cygnet Lodge Lewisham and other services was discussed with staff so action could be taken to prevent reoccurrence. The manager described learning from the outcome of coroners' inquests involving other services provided by Cygnet Health Care Limited. For example, changes were introduced to improve communication to staff about new admissions to the service. This included the introduction of a transfer handover sheet to record important information about the new admission in a clearly recognised place. This helped ensure staff were aware of the risks affecting people and enabled them to address safety issues immediately.

Is the service effective?

Our findings

Assessment of needs and planning of care

- Detailed assessments were carried out before people were admitted to the service. Initial care and treatment plans were in place before a person was admitted. This included a contingency plan which was agreed with the commissioners of the service. Some people visited and stayed at the service prior to being formally admitted which allowed the service and the person to decide whether Cygnet Lodge Lewisham was appropriate for their individual needs.
- Individual risk assessments were updated regularly to make sure they took account of current risks. This included using the HCR-20, a set of professional guidelines for violence risk assessment and management based on a recognised judgement model, and the Short-Term Assessment of Risk and Treatability (START). There were plans for the psychologist to provide three days training to staff on the use of START so that the assessment could be used more widely and effectively in the service.
- The occupational therapist used the Model of Human Occupation Screening Tool (MOHOST) to assess people's skills and this formed the basis of individual progress measurement.
- People using the service carried out a self-assessment and were encouraged to come to a shared understanding with staff about their needs and how they could be supported to achieve their goals. The recovery star was also used to identify people's strengths and individual goals. Care plans were developed over several weeks with people and then regularly reviewed and updated as necessary.
- Care plans were recovery oriented. The service used 'my shared pathway' to develop care plans with people. Plans covered eight key domains and different domains were led by different members of the multi-disciplinary team. For example, the 'insight' domain was led by the psychologist and the doctor led on the physical health domain.
- People had care plans in place that addressed their assessed needs and most individual risks identified. Many care plans were detailed and clearly linked to assessment of needs and risks. Some examples showed excellent levels of detail and understanding. They had been updated regularly and following incidents, including the identification of safeguarding concerns, to ensure they remained current. However, we did find an example where a risk was identified for one person in relation to their refusal to take prescribed medication for a physical condition. We were unable to locate a risk management plan that addressed risks to the person's health arising from this. Similarly we found two examples where people's specific needs were not reflected in their current care plans.

Best practice in treatment and care

- The quality assurance manager provided information on recent updates on National Institute for Health and Care Excellence (NICE) guidelines at integrated governance meetings. Organisational policies were reviewed and developed in line with new guidance. These were sent to the registered manager electronically who then cascaded them to staff. Staff signed to confirm they had read and understood new and revised policies.
- The service conducted audits of compliance with organisational policies and NICE guidelines to ensure they were being implemented effectively. Medical staff followed NICE prescribing guidelines.
- A new detailed physical health assessment was being rolled out for people. This identified people's physical health needs, baseline physical observations and lifestyle; and longer term goals in respect of , for example, smoking cessation, diet and diabetes where relevant. The service ran a weekly physical health care clinic in the unit and people were registered with local GP practices. Physical health care was provided in partnership with other professionals such as a local practice nurse where appropriate. Good links had been developed with a diabetes specialist nurse. People had access to a local and emergency dentist and were referred to specialists where appropriate. There was discussion of people's physical health needs in the weekly ward round.
- People underwent regular blood tests in the service, where relevant, to identify potential ill-effects from particular prescribed medicines.
- Support was provided to people to help them stop smoking. For example, nicotine replacement therapy was available for people.

Is the service effective?

- The service measured outcomes for people using recognised rating scales. This included Health of the Nation Outcomes Scales (HoNOS) and progress measured using the recovery star. The psychologist used psychometric tests, conducted every three months, to measure outcomes for people.

Skilled staff to deliver care

- Care and treatment was delivered by a team of multi-disciplinary professionals. There was a full-time psychologist and assistant psychologist in the service. The head of psychology covered Cygnet Lodge Lewisham and another local Cygnet service. The consultant psychiatrist had been granted practising privileges at the service and there was a full-time ward doctor who was present on the ward from 9-5 from Monday to Friday. A social worker was shared with another local service of the provider.
- Staff received training in a range of areas relevant to their role. This included training in risk assessment, safeguarding vulnerable adults, infection prevention and control, basic or intermediate life support, breakaway and patient safety and fire safety. Training records showed that most staff were up to date with the statutory and mandatory training required. Staff were able to attend additional training where this was identified as important to their professional development.
- Staff received regular one to one clinical and managerial supervision. Staff had received an annual performance appraisal in the last 12 months. The manager had access to a supervision dashboard which ensured they had oversight and could ensure supervision was being completed as required. An electronic database alerted the manager when annual performance appraisals were overdue. Staff described receiving good support from managers.
- The manager told us that the needs of people using the service had changed over recent years and training and learning opportunities had been developed to ensure staff continued to meet changing needs. Bespoke workshops and courses had been provided by other services in the Cygnet Health Care group, for example, on working with people with personality disorders and people with learning disabilities. Reflective practice meetings had been introduced and were facilitated weekly by a psychologist or head of psychology. Debriefing for staff was provided following incidents.
- Medical staff received appropriate training, regular clinical supervision and an annual appraisal.

Multi-disciplinary and inter-agency team work

- A commissioner of the service told us that fortnightly service user review documents noting people's progress, provided to the commissioner, were always on time, concise and clear.
- Multi-disciplinary team (MDT) work was effective. MDT involvement in care planning encouraged different disciplines to work together for the benefit of people using the service.
- Working relationships with people's local community mental health teams and care co-ordinator were mostly good. Some people using the service were a long way from their homes so the service involved care co-ordinators by telephone. The manager told us that it could sometimes be difficult to engage care co-ordinators and described how they had contacted commissioners to raise concerns about non-attendance at care programme approach (CPA) meetings. This sometimes caused delays in discharge but the service was doing everything they could to facilitate this. The service was proactive in trying to ensure that people stayed at the service no longer than they needed to.
- All people using the service were seen by the psychologist within seven days of admission.
- Case conference workshops were held for some individuals using the service to discuss their needs in more depth. Care conference records showed that detailed team discussions had taken place that addressed people's complex needs in relation to engagement and moving on from the service. The process helped identify multi-disciplinary plans and key messages to convey to the person in terms of recovery and optimism.

Adherence to the MHA and the MHA Code of Practice

- At the time of the inspection nearly all of the people using the service were detained under the Mental Health Act 1983 (MHA). One person had been conditionally discharged from their section.

Is the service effective?

- Staff received training in the MHA and had good understanding of the main provisions of the Act and MHA Code of Practice.
- People using the service had access to an independent mental health advocate who could support them. The advocate for the service reported a good working relationship with staff at the service.
- MHA documentation had been completed appropriately.
- Discussions of people's rights were regularly repeated and recorded in people's records.
- Consent to treatment and capacity requirements were mostly adhered to and copies of consent forms were attached to medicine administration records. A standard form was used to record a discussion of consent and the treating clinician's assessment of patients' capacity to consent to treatment. These were completed with people on a regular basis.
- However, in the record of the capacity and consent to treatment interview for one person, the treating clinician had indicated that the person lacked capacity to consent to treatment. A note on the form stated 'Takes MH medication/refuses physical health medication'. As a result the person's capacity to consent to treatment for mental illness was unclearly stated. The person was currently being treated under the authority of a form T2. We were unable to locate a request for the person to be seen by a second opinion appointed doctor (SOAD). When we spoke with the manager of the service about this they said they had struggled with this particular issue and had asked for legal advice for clarification.
- In another record of the capacity and consent to treatment interview, the treating clinician had not recorded the outcome of their assessment of the person's capacity to consent to treatment. A note on the form stated 'He understands the indications of medication and consequence of dropping it. He lacks insight though and is ambivalent'. The treating clinician then went on to indicate that the person consented to treatment. As a result the person's capacity to consent to treatment and consent status was not clearly stated.
- In the records of one person we found a section 17 leave form that had been superseded by a more recent form and had not been cancelled. The out of date form remained in the person's records which was potentially confusing for staff and the person concerned.

Good practice in applying the MCA

- Some staff had a good understanding of the Mental Capacity Act 2005 (MCA) and how it applied to their clinical practice. However, others could not clearly explain the details of a mental capacity assessment. The manager told us MCA training had been combined with MHA training and this may not have been the most effective way of ensuring all staff understood the MCA.
- There had been no applications made under Deprivation of Liberty Safeguards.

Is the service caring?

Our findings

Kindness, dignity, respect and support

- Staff were warm and kind towards people and their relatives.
- Commissioners who gave us feedback by email told us that people using the service appeared very happy on the unit.
- A peer social group had recently been set up which involved people using the Cygnet Lodge Lewisham service as well as people using Cygnet services in Blackheath and Beckton.
- People were supported to visit families and friends. For example, staff had arranged overnight stays for people whose families lived far from the service.
- Staff showed respect and kindness towards people who use the service when they attended a ward round to discuss their care and treatment. Staff displayed hope and optimism when planning care and support with people.

The involvement of people in the care they receive

- The care plans we reviewed were comprehensive, individualised and incorporated people's views with regard to their care and treatment.
- People using the service were involved in audits of the unit. A service user representative had carried out a 'first impressions' audit which provided feedback to staff from the perspective of a person using the service.
- People who used the service led a number of sessions in the unit such as a daily planning meeting, where people discussed their plans for the day and a regular community meeting involving people and staff. A service-user council met monthly and was attended by a representative of Cygnet Lodge Lewisham and another local service. The representative put forward the views of people using the service on the care and treatment provided by the service.
- In addition to regular meetings, people were able to give feedback on the service they received via an annual survey. The service analysed the completed surveys and an action plan had been put in place to address the areas where concerns were identified. For example, some people had raised concerns about the approachableness of the consultant psychiatrist. The service had taken action to ensure that all people admitted to the service were introduced to the consultant as soon after admission as possible.
- An independent advocacy service was available to people and the advocate sometimes attended ward rounds and other meetings to support people in voicing their views. We spoke with the advocate who described the ward rounds as patient centred and said the multi-disciplinary team were successful in involving people.
- Scheduling of ward round appointments took account of the wishes of people who use the service. Ward round guidance was available for people in pictorial form to support their understanding of the meeting and process. In the ward round we attended a person was very involved in a discussion of their needs and able to express their views. The service was open and transparent with people. For example, there was an open discussion of risk with a person in the ward round.

Is the service responsive?

Our findings

Access, discharge and bed management

- There were specific admission criteria in place. The current mix of people using the service was considered when assessing new referrals to ensure that people's needs could be met without compromising the care and treatment given to existing users of the service.
- Commissioners who gave us feedback via email told us admission procedures and exit planning were generally smooth. Staff provided weekly written updates on progress to peoples' care co-ordinators and commissioners.
- Discharge planning started soon after admission. Length of stay was estimated early on and discussed at the first CPA meeting held six to eight weeks after admission. 'My shared pathway' care plans included discussion of future plans. People who lived a long way from the service were usually discharged to a service nearer their homes so that they would be able to engage in their local community prior to their final discharge form hospital.
- The average length of stay in the service was 17 months. One person had been in the service for five years but had recently been conditionally discharged from their section and was due to be discharged from the service. Discharges were usually planned well in advance, although sudden withdrawal of local funding could result in an abrupt discharge.
- Discharge was sometimes delayed due to a lack of suitable accommodation for people to move to. The service was proactive in encouraging care co-ordinators to attend care programme approach meetings and consider people's return to the community or more appropriate accommodation. Ensuring timely discharge was seen as a challenge for the service.

The ward optimises recovery, comfort and dignity

- People were able to personalise their bedrooms with their own belongings. A person using the service showed us around the service and their bedroom and was very positive about their experience of the service.
- People were encouraged to keep in touch with friends and family and visiting was flexible. Visitors could come to the service between 10.00am and 8.00pm although they were encouraged not to visit when this clashed with the person's therapy programme.
- People were able to carry out paid jobs in the service which helped increase their confidence. Job descriptions were prepared and people applied and were interviewed for the roles. Tasks included buying newspapers for the service, tidying up tea and coffee cups and acting as the service user representative. The service user representative attended meetings with staff and took part in interviews for new staff.
- Meals were freshly cooked on site. The chef came to community meetings with people to gather their feedback on meals and take suggestions for changes in the menus. He made special meals for special occasions including people's birthdays. The chef was creative in his approach. For example, he had provided oysters on one occasion as people said they had not tried them before. One person was supported to prepare and cook his own meals.
- A programme of activities was provided throughout the week including some at weekends. Activities were designed to meet people's individual needs and were based on feedback from focus groups of people using the service held by the psychologist. More formal therapeutic groups addressed people's needs in relation to substance misuse, moving on from the service and skills development. These all supported the recovery of people using the service.
- Staff described how it could be difficult to get people to engage in the activities and groups offered. To address this, the activities programme was regularly reviewed and individual one to one activities provided if this was more helpful in meeting the person's needs. For example, the psychologist took one person out for lunch in a restaurant as a way of engaging with them and had taken another person ice skating. Audits of activities were carried out to ensure people were being offered a minimum of 25 hours of structured activity every week.
- The service had good links with a mental health worker at the local job centre and staff provided examples of people who had managed to work whilst admitted to the service.

Is the service responsive?

- The service promoted social inclusion. People using the service were encouraged to engage in activities in the local community. For example, one person attended weightwatchers, two attended a local gym and another attended a local African Caribbean day centre. One person told us how they used a music studio every week to record their own musical compositions which they shared with us. Numeracy and literacy classes were provided for people on-site. Opportunities to take up voluntary work were encouraged.
- People were encouraged and supported to self-medicate where this was appropriate. This was a three stage process which gave increasing responsibility to people to manage their own medicines as they progressed. People who were self-medicating kept their medicines in locked safes in their rooms. Staff carried out spot checks on people's medicines to ensure they were being taken as prescribed. Three people using the service were managing their own medicines at the time of our inspection.
- People had full access to outside space, in the back garden, without restriction.
- The meals provided were of good quality and people were provided with a choice of three main meals including a vegetarian option. All the meals were cooked on site

Meeting the needs of all people who use the service

- People's cultural, religious and spiritual needs formed part of a comprehensive needs assessment. People were supported to attend faith venues and faith representatives came to see people in the service. The service held themed days focussing on the different backgrounds of people using the service as a way of being inclusive. For example, there had been a Scottish day and a Jamaican day. The chef worked closely with people using the service to provide culturally appropriate meals and responded to people's food preferences.
- Interpreters were available to the service if help was needed with communication.
- People were supported to have relationships with people of the same or opposite gender. People were encouraged to tell staff about relationships so that they could receive appropriate support.

Listening to and learning from concerns and complaints

- Information on how to make a complaint about the service was readily available to people.
- Complaints were investigated and responded to promptly. Records of complaints were detailed and showed the action taken in response. Where wider learning was identified this was shared with staff and improvements made. For example, a person had complained about staff inconsistency in approach to contraband items on the unit. The manager subsequently identified there were two different lists of items in circulation which was causing confusion amongst staff. A new list was provided to staff to make sure everyone was clear what constituted a contraband item and rules could be applied consistently.
- Regular community meetings involving staff and people using the service allowed people to raise concerns about the service and supported a prompt response by staff.

Is the service well-led?

Our findings

Vision and values

- The vision and values of the provider (being respectful, empathic, responsible, honest and helpful) were on display in the service. Staff had received training about the organisational values and were familiar with them. Staff meeting minutes confirmed that the organisational values had been discussed with the team. When staff talked to us about the people they cared for it was clear they understood the values. The organisation had introduced values based recruitment to help ensure they employed the right staff.

Good governance

- An effective system of governance linked Cygnet Lodge Lewisham with the provider, Cygnet Health Care Limited. Local governance arrangements linked with the provider's executive management board and local board meetings took place bi-annually. This enabled the provider to have an overview of service performance.
- Quality monitoring and assurance systems were effective in identifying areas for improvement in the service. Action plans were put in place to address concerns and these were monitored to ensure progress was measured and planned improvements implemented.
- Monthly incident learning meetings took place jointly with another local Cygnet mental health service. The meeting identified themes emerging from incidents. Learning from the meetings was shared with staff at team meetings and with integrated governance meetings which were chaired by the quality assurance manager. Quarterly audits of the use of restrictive interventions, including episodes of restraint, had identified learning points in respect of record keeping and consistency. Action had been taken to address these concerns.
- Gibbs reflective practice model was used as the basis for reflective practice meetings. Records of reflective practice meetings showed in-depth reflection and analysis of incidents in the service. Actions were identified that addressed learning points for staff that had emerged from the discussions. This was another example of how the service tried to improve service delivery.
- A risk register for the service fed into the corporate risk register. This ensured the provider had an overview of risks affecting the service and encouraged a corporate response to concerns. The risk report showed that risks and their current controls, or actions taken to mitigate the risk were clearly recorded. Plans for further, more medium to long-term, actions were also identified. A named member of staff took ownership of, and responsibility for, delivering the actions. The registered manager clearly articulated current risks to us.
- A number of audits were carried out on a regular basis. These included audits of infection control and prevention measures, people's care records and clinical supervision records. Where shortfalls were identified action plans were put in place. Action plans identified a named lead person and date by which improvements would be made. Progress checks were recorded. This helped ensure actions were completed and the service continually improved.
- A broad self-assessment of the safety, effectiveness, caring, responsiveness and leadership of the service had been carried out in June 2014. The assessment had identified some areas for improvement. Actions had been taken to address most shortfalls identified. Actions were also taken to improve the service in response to feedback from people, for example, in response to key themes arising from the annual patient survey.
- A quality dashboard was used to bring together information from complaints, safeguarding, incidents, audits and internal assessments. This allowed managers to gauge overall performance at the service. Integrated governance meeting minutes showed detailed performance across similar topics for both Cygnet Lodge Lewisham and a neighbouring service. There were clear plans in place to address any identified gaps or shortfalls in performance.

Leadership, morale and staff engagement

- The service was well-led by the registered manager who was experienced and had been in post since 2008. Commissioners described the service as well-led and the leadership as "clear and effective."

Is the service well-led?

- Staff gave feedback about their experience at work through an annual staff survey. A staff representative group was held regularly to allow staff to voice their views with the provider. The provider had introduced an awards scheme as a way of improving morale amongst staff and recognising staff achievements. Independent external support was available to staff via an employee assistance programme. Morale amongst staff was generally positive.
- Staff told us that managers listened to and acted upon feedback. They felt able to raise any concerns they had about the service and service delivery and were confident they would be listened to.
- Minutes from staff meetings showed that the service had held a team building event recently. Action in response to feedback from staff was outlined in the staff meeting minutes which demonstrated that staff had been listened to.
- There were low levels of sickness absence in the service. A staff member told us how they had been well supported by the service during a period of absence.
- There was good team working in the service. Staff were positive about the multi-disciplinary team who worked well together to provide consistent care and treatment to people.

Commitment to quality improvement and innovation

- The service was open to feedback from others both within and outside the organisation and sought to continually improve service delivery. Colleagues from a local NHS trust had carried out an informal review of the service. They had shared ideas for improvements. The manager described how feedback from the visit had led to the development of collaborative risk assessment training involving staff and people who used the service.
- The psychologist used creative and innovative approaches to help people using the service engage in care, treatment and their own recovery. This included one to one work with individuals and providing practical group activities outside the service which helped improve people's life skills.