

Cygnet Clifton Limited

Cygnet Acer Clinic

Inspection report

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

Ratings

Overall rating for this location

Good



Are services safe?

Good



Are services effective?

Good



Are services caring?

Good



Are services responsive to people's needs?

Good



Are services well-led?

Good



Summary of findings

Overall summary

This was the first time we had inspected this ward. We rated it as good because:

- The service provided safe care. The ward environments were safe and clean. The wards had enough nurses and doctors. Staff assessed and managed risk well. They minimised the use of restrictive practices, managed medicines safely and followed good practice with respect to safeguarding.
- Staff developed holistic, recovery-oriented care plans informed by a comprehensive assessment. They provided a range of treatments suitable to the needs of the patients and in line with national guidance about best practice. Staff engaged in clinical audit to evaluate the quality of care they provided.
- The ward teams included or had access to the full range of specialists required to meet the needs of patients on the wards. Managers ensured that these staff received training, supervision and appraisal. The ward staff worked well together as a multidisciplinary team and with those outside the ward who would have a role in providing aftercare.
- Staff understood and discharged their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, and understood the individual needs of patients. They actively involved patients and families and carers in care decisions.
- The service managed beds well so that a bed was always available locally to a person who would benefit from admission and patients were discharged promptly once their condition warranted this.
- The service was well led, and the governance processes ensured that ward procedures ran smoothly.

Summary of findings

Our judgements about each of the main services

Service

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

Rating

Good



Summary of each main service

This was the first time we had inspected this ward. We rated it as good because:

- The service provided safe care. The ward environments were safe and clean. The wards had enough nurses and doctors. Staff assessed and managed risk well. They minimised the use of restrictive practices, managed medicines safely and followed good practice with respect to safeguarding.
- Staff developed holistic, recovery-oriented care plans informed by a comprehensive assessment. They provided a range of treatments suitable to the needs of the patients and in line with national guidance about best practice. Staff engaged in clinical audit to evaluate the quality of care they provided.
- The ward teams included or had access to the full range of specialists required to meet the needs of patients on the wards. Managers ensured that these staff received training, supervision and appraisal. The ward staff worked well together as a multidisciplinary team and with those outside the ward who would have a role in providing aftercare.
- Staff understood and discharged their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, and understood the individual needs of patients. They actively involved patients and families and carers in care decisions.
- The service managed beds well so that a bed was always available locally to a person who would benefit from admission and patients were discharged promptly once their condition warranted this.
- The service was well led, and the governance processes ensured that ward procedures ran smoothly.

Summary of findings

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Summary of this inspection

Background to Cygnet Acer Clinic

Cygnet Acer Clinic is an independent hospital based in North East Derbyshire.

It is made up of two wards;

Lower House- A 14 bed Long stay Rehabilitation mental health ward for adult female patients with complex mental health needs including personality disorder.

Upper House- A 14 bed acute ward for adult female patients with new or emerging complex mental health needs and who are in mental health crisis.

Both wards are registered with the care quality commission to provide:

- Assessment or treatment for persons detained under the Mental Health Act 1983
- Treatment of disease, disorder or injury.

There was a registered manager in post at the time of this inspection.

The hospital was last inspected in April 2021 when both wards provided long stay rehabilitation only. The rating was good in all domains and good overall.

Upper House was redeveloped and opened for patients 1 June 2021; This is the first inspection of this ward.

At this inspection we inspected Upper House Acute ward only.

This ward provided 14 beds; these beds were blocked booked by two clinical commissioning groups.

Prior to and during the inspection we received feedback from the host clinical commissioning group. They had no concerns about the ward and told us that they have a good level of continued communication between themselves and the hospital.

When we inspected the ward had 14 patients.

What people who use the service say

Patients and carers told us that they found the ward clean, one patient said that the décor was like a mural and can get comfy. One patient told us that the ward was spacious and that the buildings was nice.

Two out five patients told us that they get seen by medical staff weekly and that physical health nurse comes onto the ward too. One patient told us that they found it difficult to see the doctor. However, we saw evidence of the doctor being on the ward and attending ward rounds and multidisciplinary meetings. When the doctor isn't there the service had an on call system for doctor support.

Summary of this inspection

Patients said they felt safe on the ward.

Patients told us that medication was discussed weekly and patients can make requests also. They told us that they are involved in these discussions along with discussions about their care.

Patients told us that they are given support in mindfulness. However, one patient discussed not doing any exercise. We saw the activity timetable for the patients and local walks were encouraged and we saw patients using leave during the time of our inspection.

Patients told us that staff care, are polite and respectful.

We were told that patients and carers did not know about their care plans or have copies of their care plans. However, we observed that care plans were discussed and reviewed at every patient ward round where carers and family could attend. We also saw evidence of patients views in their care plans.

Patients were able to describe activities available on the ward and how they can access their leave.

They told us that the food was of good quality and there is always options available.

Patients told us that there was opportunities to discuss issues with an advocate and are able to make complaints if needed.

How we carried out this inspection

We carried out this unannounced, focused inspection on Upper House as this core service had only opened as an acute ward in June 2021 and had not previously been inspected. We looked at all five domains.

To carry out this inspection there was one inspector on site on 21 June 2022 and two inspectors on site on 28 June 2022.

An expert by experience made phone calls to carers and patients on 22 June 2022.

We spoke to 9 members of staff.

We spoke to five patients and one family member.

We attended a multidisciplinary daily meeting whilst on site.

We attended 3 patient ward rounds.

We looked at 5 patient care plans

We looked at six patient medical records.

We looked at the environment of the hospital including the clinic room.

We looked at a range of policies, procedures and other documents relating to the running of the hospital.

Summary of this inspection

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>.

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	Good	Good	Good	Good	Good	Good
Overall	Good	Good	Good	Good	Good	Good

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

Good 

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

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

Good 

Safe and clean care environments

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

Safety of the ward layout

Staff completed and regularly updated thorough risk assessments of all wards areas and removed or reduced any risks they identified. The security lead for each shift checked the wards risk assessment daily. Team leaders carried out twice weekly walk rounds twice weekly to make sure the risk assessments were complete. In addition, the maintenance team conducted daily health and safety checks. .

Staff could observe patients in all parts of the wards. Where sightlines to observe patients were impeded we found curved mirrors in areas of the ward so that staff could see any potential blind spots. Staff were assigned to do regular observations which meant walking and checking all the ward areas.

Patient bedroom and bathroom doors are designed to prevent holding, barring or blocking.

The ward complied with single sex accommodation, there was no mixed sex accommodation.

There were no unknown potential ligature anchor points in the service. Where there were potential ligature points these were recorded on the ligature heat map, staff knew about them and the anchor points were mitigated through risk management to keep patients safe.

Staff had access to alarms and patients had easy access to nurse call systems. We saw staff wearing alarms and patients had access to call systems on the ward. There were enough alarms for all staff. Alarms were checked daily.

During the inspection we found that the environment of the ward was calm and had been designed using muted colours with murals on the ward that also emphasised a peaceful and calming atmosphere. The ward was very open with wide corridors and high ceilings, and lots of natural light throughout each area. The quiet room had a large sky light and high ceilings to allow plenty of natural light.

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

Good 

During the inspection we found that the service utilised a calming suite to support de escalation for patients in distress and had chosen not to have a seclusion room. The room was located on the ward and had a low stimulation environment, there was suitable furnishings.

Maintenance, cleanliness and infection control

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

Staff made sure cleaning records were up-to-date and the premises were clean. During the time of the inspection all areas of the ward were clean and fresh in odour.

Staff followed infection control policy, including handwashing. The ward was a green site at the time of our inspection, this meant there was no one with COVID-19 at the ward. Staff still wore masks and we observed them being worn correctly. Hand gel was easily available for visitors, patients and staff throughout the ward.

Clinic room and equipment

Staff regularly checked that clinic rooms were fully equipped, with accessible resuscitation equipment and emergency drugs. All equipment including emergency drugs were clearly labelled and all items were well maintained and cleaned and were within their expiry dates. We found medicine stored correctly, cupboards were organised and tidy.

We found evidence that regular audits of the clinic room were completed.

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. Wards were staffed with the required number of staff during the inspection to support patients' individual needs. The service required two qualified nurses on day shifts and the same amount during the night. The service required five health care assistants during the day and the same amount during the night. On reviewing the duty rotas we saw that the service had the required numbers of staff to meet patients needs.

Managers only used bank staff that were familiar with the service and had completed a full induction and understood the service before starting their shift. We reviewed staff figures from January 2022 to June 2022 and no agency staff had been used.

The service had low turnover rates. We saw evidence that the turnover rate over the past 12 months was 37.65% and over the last 3 months was at a rate of 8.24%.

Managers supported staff who needed time off for ill health. At the time of our inspection levels of sickness were at 9.09% over the whole hospita.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants for each shift.

The ward manager could adjust staffing levels according to the needs of the patients. Staff told us that the team leader could also adjust staffing levels and then did when staffing numbers did not meet the required amount

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

Good 

Patients had regular one to one session with their named nurse.

Staff told us that that had enough time to spend with patients. They ensured that patients had one to one session with their named nurse. This was evidence in the patients that we reviewed. Staff prioritised section 17 leave for patients so they could to have access to activities in the community. With this as a priority staff told us that patients rarely had their escorted leave or activities cancelled, even when the service was short staffed.

The service had enough staff on each shift to carry out any physical interventions safely. Patients had access to the speciality Doctor who was based on the ward and also from a physical health nurse holds a well person's clinic once every two weeks.

Staff shared key information to keep patients safe when handing over their care to others. We saw evidence of handover documentation which was thorough. In addition, staff told us that copies of handovers were emailed to staff.

Medical staff

The service had enough daytime and night-time medical cover and a doctor available to go to the ward quickly in an emergency. The ward had access to on call doctors and could get to the ward with 30 minutes.

Managers could call locums when they needed additional medical cover. Staff told us that they had not required additional medical cover since the ward had opened.

Mandatory training

Staff had completed and kept up-to-date with their mandatory training. The mandatory training programme was comprehensive and met the needs of patients and staff. Out of the 15 training packages offered to staff none fell below 90% of achievement and seven of the 15 packages were at 100% achieved.

Managers monitored mandatory training and alerted staff via personal e-mail when they needed to update their training.

Assessing and managing risk to patients and staff

Staff assessed and managed risks to patients and themselves well and followed best practice in anticipating, de-escalating and managing challenging behaviour. Staff used restraint only after attempts at de-escalation had failed. The ward staff participated in the provider's restrictive interventions reduction programme.

Assessment of patient risk

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

We looked at six patients risk assessment records. We saw evidence that staff completed a referral acceptance score sheet (RASS) when a patient was referred to the service, this information would be included in the patients risk assessment. Members of the multi-disciplinary team reviewed this form and discussed the suitability of the patient for admission. Staff told us that the RASS is a tool that enables the correct decision to be made for admission of patients as the service considers the wellbeing of the patient dynamics on the ward at the time of referral and whether they can offer a safe and appropriate placement.

Staff reviewed patients' risk on a daily basis as part of risk management huddles and at every multidisciplinary care and treatment review. Staff updated risk management records after each review or any incident.

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

Good 

The acceptance criteria was rigorously adhered to this meant that successful admissions happened, and patients were cared from a staff team who were correctly trained and skilled.

Management of patient risk

Staff knew about any risks to each patient and acted to prevent or reduce risks. We saw how patient risks were discussed in daily handover meetings, morning multidisciplinary meetings, and patient ward rounds. All notes were on the 'My path' system for staff to access. Staff identified and responded to any changes in risks to, or posed by, patients and were able to discuss the new risks with management in these meetings.

Nursing observations were completed as prescribed and observation records were all present and correct. Staff followed trust policies and procedures when they needed to search patients or their bedrooms to keep them safe from harm. Staff told us that patients had a choice over male/female staff member to conduct searches to respect patient's wishes and religious beliefs. Multidisciplinary staff discussions determined the level of risk for each patient and the level of observation needed and searching.

Staff followed a code of conduct for ward behaviour and the provider had police liaison protocols in place.

The service uses the 'safewards' model of care and had implemented a joint patient and staff safewards committee to review how the ward works with this. This approach aims to reduce conflict between staff and patients which leads to fewer restrictive interventions.

Use of restrictive interventions

Levels of restrictive interventions were low. From January 2022 May 2022 there had been 157 incidents, 34 of those resulted in low level holds. No supine holds were needed and out of the 157 incidents only four prone restraints were utilised and this was a last resort in supporting the patients in distress. The service had received positive feedback from the host Clinical Commissioning Group regarding the low levels of restrictive interventions.

The service had a reducing restrictive practice lead in place at the time of our inspection.

Staff participated in the provider's restrictive interventions reduction programme, which met best practice standards. We saw how staff had carried out monitoring audits to share and compare with similar services in the Cygnet group. This meant that all services could learn from each other. Staff made every attempt to avoid using restraint by using de-escalation techniques and restrained patients only when these failed and when necessary to keep the patient or others safe.

Staff followed National Institute for Health and Care Excellence NICE guidance when using rapid tranquilisation. We saw evidence that showed during the past five months rapid tranquilisation was only used six times. Staff told us that the protocol was to offer this orally to the patient to give them the choice. Medicine records and daily care notes showed how patients were monitored following any rapid tranquilisation process.

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 received training on how to recognise and report abuse, appropriate for their role. Training records showed that 97% of staff were trained in level 2 and level 3.

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

Good 

Staff gave us some examples of safeguarding concerns including patient on patient assaults. Staff were able to explain how they reported safeguarding concerns who they reported them to. Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act.

Staff knew who the safeguarding lead was on the ward and that they could ask this person for additional advice and support on safeguarding when needed.

Staff knew how to recognise adults and children at risk of or suffering harm and worked with other agencies to protect them. The service worked closely with a safeguarding lead from the Clinical Commissioning Group. The local authority safeguarding lead told us they had no concerns and were complementary of the way the service kept them informed of any issues and would also seek out information if necessary.

Staff followed clear procedures to keep children visiting the ward safe. Children and families could visit the ward in a visiting room just outside of the ward area, toys, games and books were made available for children if needed.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff told us the procedure and were confident in following it.

We saw evidence from another ward at this hospital of how managers taken part in serious case reviews and made changes based on the outcomes. However, as this acute ward had not experienced any serious incidents to date we did not have direct evidence for the acute ward.

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 service used a system called 'My path'. Records were stored securely. They were all electronic and were password protected.

Staff informed us that when a patient was referred to them the care coordinator from the placing Clinical Commissioning Group would send over the relevant paperwork securely. We were informed that if more information was required they could easily request it.

Medicines management

The service used systems and processes to safely prescribe, administer, record and store medicines. Staff regularly reviewed the effects of medications on each patient's mental and physical health.

Staff followed systems and processes to prescribe and administer medicines safely.

We saw staff reviewed each patient's medicines regularly and care notes showed staff provided advice to patients and carers about their medicines. The staff member accompanying the inspector in the clinic demonstrated a good awareness of the patients and their medications and gave examples of patients who had needed some extra help understanding their medications. There were leaflets around the unit about the effects of medication.

We reviewed five patient's medication records. Staff completed medicines records accurately and kept them up-to-date.

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

Good 

Patients records showed that when rapid tranquilisation was used staff carried out all required pre and post monitoring of physical health.

Staff stored and managed all medicines and prescribing documents safely.

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

Staff learned from safety alerts and incidents to improve practice. There was a folder in the clinic with safety alerts highlighted and a sheet at the beginning of the folder for staff to sign to confirm they had read the safety alerts.

Medicine charts showed that staff did not control people's behaviour by excessive and inappropriate use of medicines.

Staff reviewed the effects of each patient's medicines on their physical health according to National Institute of Health and Care Excellence guidance.

Track record on safety

The service had a good track record on safety.

Reporting incidents and learning from when things go wrong

The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

Staff knew what incidents to report and how to report them. They would use their internal incident reporting system and the service as a whole worked towards any level of incident should be recorded. This was in line with the providers policy.

The service had no never events on the ward since the time of the ward being opened in June 2021.

Staff understood the duty of candour. Staff told us that they understood and the policy of being open and transparent and to give patients and families a full explanation if and when things went wrong.

Managers debriefed and supported staff after any serious incident. Staff told us they felt supported by management on this.

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

Staff received feedback from investigation of incidents, both internal and external to the service. We saw evidence that incidents were discussed in meetings and in governance meetings. As part of these meetings staff met to discuss the feedback and look at improvements to patient care.

There was evidence that changes had been made as a result of feedback. Although during the time of our inspection no major incidents had occurred on the ward. However, managers told us that when developing the acute ward, they had used lessons learned from lower house incidents to inform the new ward.

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

Good 

We saw evidence that patients attended community meetings and gave feedback. Minutes of these meetings showed that specific feedback went directly to the local governance meetings held by management and vice versa.

Managers shared learning with their staff about never events that happened elsewhere. Cygnet sent information about safety risks to share with other hospitals, the service then shared this with staff.

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

Good 

Assessment of needs and planning of care

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

We reviewed six patient records. Staff completed an initial mental health assessment of each patient on admission. This assessment included all previously known risk and care factors and a referrers summary of need. Staff completed all mental health assessments within 72 hours of admission.

Staff had completed and recorded physical health monitoring on admission and routinely thereafter – particularly when administering sedatives, or antipsychotic medicines.

Staff and managers understood that the first 24 hours of an admission for an acutely unwell patient would be difficult to carry out assessments. Staff allowed time for the patient to familiarise themselves with the new environment before completing the assessment.

Patients had their physical health needs assessed soon after admission and regularly reviewed during their time on the ward. We saw evidence that these assessments would take place alongside the mental health assessments and prior to any care and treatment review.

The service had a full range of physical health monitoring and a dedicated speciality doctor to review each patient's physical health needs as well as the physical health nurse who attended fortnightly.

Staff developed a comprehensive care plan for each patient that met their mental and physical health needs. We saw evidence that care plans were comprehensive and a 'live' document, care plans were updated daily and when needs changed. The plans we saw were personalised, holistic and recovery-orientated. During a multi-disciplinary meeting we observed the team discuss discharge of a patient who was only admitted two days prior, this was also reflected in the care plan. Care plans reflected patient's history including who is important to them.

Staff provided an activity and therapy programme relevant to the needs of the patients that was available seven days per week.

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, benchmarking and quality improvement initiatives.

The service had a full multidisciplinary team and a comprehensive staged model of care which staff were able to explain. We saw posters around the unit, designed to help patients understand the staged model of care.

Medicines records showed that prescribing was in line with national guidance. Invasive interactions such as restraint and rapid tranquilisation follow best practice and organisational policy and that there is clear documentation to demonstrate reasons why.

Managers ensured that all staff were trained in the use of National Institute for Health and Care Excellence guidelines relevant to inpatient care and that all qualified nurses have been assessed as competent in administering medications within the last year

Occupational therapy offered a variety of recovery based activities for the patients. We saw the service followed National Institute of Health and Care Excellence guidelines to care in line with best practice.

Staff made sure patients had access to physical health care, including a specialist doctor and physical healthcare nurse. We saw evidence of discussions with patients regarding contacting their local named General Practitioner. Staff identified patients' physical health needs and recorded them in their care plans.

Staff met patients' dietary needs and assessed those needing specialist care for nutrition and hydration. Dietary needs were displayed clearly in the kitchen of the ward. We saw that not only dietary needs were care planned, but also religious needs were also accounted. Staff told us that this information would be given on assessment of patient so it would be in place for the patient.

Staff helped patients live healthier lives by supporting them to take part in healthy eating programmes, smoking cessation or giving general advice. Patients had access to a comprehensive therapeutic activity programme which included physical activities, sleep hygiene and drop in sessions with both occupational therapy and psychology. A physical health nurse attends Acer Clinic twice a week. They were available to support patient's physical health needs and related care planning. Well Person's Clinics are facilitated every week at Upper House and patients have an appointment for this clinic fortnightly.

Staff used recognised rating scales to assess and record the severity of patients' conditions and care and treatment outcomes. We saw evidence of staff using Global assessment of functioning (GAF), Referral acceptance score sheet (RASS) and Health of the Nations Outcome Scores (HoNOS).

Staff took part in clinical audits such as monitoring the use of anti-psychotic drugs and symptom management, benchmarking and quality improvement initiatives. We saw evidence that outcomes from audits were discussed in monthly governance meetings. We also saw that staff used this meeting as a forum to discuss information from other relevant steering groups. They attend peer groups for care and treatment for acute unwell individuals (for doctors), an acute and PICU steering group (for managers and leaders).

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

Good 

Skilled staff to deliver care

The ward team included or had access to the full range of specialists required to meet the needs of patients on the ward. Managers made sure they had staff with the range of skills needed to provide high quality care. They supported staff with appraisals, supervision and opportunities to update and further develop their skills. Managers provided an induction programme for new staff.

The service had access to a full range of specialists to meet the needs of the patients on the ward. A full multi-disciplinary team was in place for the ward including specialist doctor, physical health nurse, occupational therapist, psychology assistant psychologist and therapy assistants.

Managers used supervision, competence assessment and appraisal to ensure staff had the right skills, qualifications and experience to meet the needs of the patients in their care, including bank staff. Staff told us that if any specialist training was needed managers would make it available. Staff told us that training needs were discussed in supervisions and improvement of skills was important to the service to improve care and treatment for the patients.

Managers told us that if bank staff were needed, they would be from within the staff team at the service or through the local Cygnet staff pool who would have the same level of training and skills. Agency staff were not being used at the time of our inspection.

There was a comprehensive induction and orientation program and ongoing training programme for all staff, including bank and agency staff. This included restraint training. Managers gave each new member of staff a full induction to the service before they started work. We saw evidence in staff files that induction packs were completed.

Staff completed annual appraisals and received regular supervision in line with organisational policy

Managers supported permanent non-medical staff and permanent medical staff to develop through yearly, constructive appraisals of their work. At the time of the inspection the compliance rate for annual appraisal was 92.5%.

Managers supported medical and non-medical staff through regular, constructive clinical supervision of their work. At the time of the inspection the compliance rate for supervision was 96.4%.

Managers made sure staff attended regular team meetings or gave information from those meetings if they could not attend. Staff confirmed they received minutes after team meetings, so they were up to date with discussions.

Managers identified staff basic and specialist training needs through supervision and appraisal and gave staff time and opportunity to develop their skills and knowledge. Staff gave an example where they requested to be trained in an area that was outside of their mandatory training and this was granted. The staff member is now able to perform blood tests on patients.

Managers recognised poor performance could identify the reasons and dealt with these. We saw evidence of supervision records where such issues were discussed.

Multi-disciplinary and interagency teamwork

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

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

Good 

Staff held regular multidisciplinary meetings to discuss patients and improve their care. We observed that these meetings were held daily with members of the care team and nursing team are present.

Staff made sure they shared clear information about patients and any changes in their care, including during handover meetings. We found evidence in meeting minutes that this happened, and staff told us that information was also emailed to them, so no information was missed.

Ward teams had effective working relationships with other teams in the organisation. Staff told us that they worked closely with the ward on lower house. During the development of the ward before opening the service made links with other Cygnet hospitals that had acute wards for women, staff were able to visit these wards to experience and understand an acute ward before taking back to Cygnet Acer upper house the learning they had received.

Ward teams had effective working relationships with external teams and organisations. Ward staff liaised with clinical commissioners, local authority safeguarding teams, community mental health teams and care program approach key workers as well as mental health crisis teams. During the inspection we received positive feedback about their interactions and knowledge of the service from local clinical commissioners and the safeguarding lead.

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

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

Staff received and kept up-to-date with training on the Mental Health Act and the Mental Health Act Code of Practice and could describe the Code of Practice guiding principles. 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 told us that the training was through their training programme 'Achieve' and the policies and information were available on the services intranet.

Staff knew who their Mental Health Act administrators were and when to ask them for support, this included support and advice on implementing the Mental Health Act and its Code of Practice. The mental health act administrator was based on the ward and worked full time. Staff told us that the administrator stored copies of patients' detention papers and associated records correctly and staff could access them when needed.

Patients had easy access to information about independent mental health advocacy and patients who lacked capacity were automatically referred to the service. We found posters clearly displayed on the walls around the ward. Advocacy feedback was seen in monthly governance meetings. We saw evidence that this issued to gather themes and any specific issues raised by patients.

Staff explained to each patient their rights under the Mental Health Act in a way that they could understand, repeated the information as necessary and recorded it clearly in the patient's notes. We observed patients ward rounds where patients' rights were discussed. One example was a recent admission and the discussion of why they patient was being detained for treatment was respectful and broken down to an easy understandable format for the patient involved.

Staff made sure patients could take section 17 leave (permission to leave the hospital) when this was agreed with the Responsible Clinician and/or with the Ministry of Justice. During patient ward round we observed that section 17 was discussed with each patient

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

Good 

During patient ward rounds we observed that staff discussed requesting an opinion from a Second Opinion Appointed Doctor (SOAD) when they needed to.

Informal patients knew that they could leave the ward freely and the service displayed posters to tell them this. Patients told us that they understood their rights and could leave when they wanted to. Staff told us that if an informal patient requested discharge, they followed the hospital policy and procedure to do this safely.

Care plans included information about after-care services available for those patients who qualified for it under section 117 of the Mental Health Act.

Managers and staff made sure the service applied the Mental Health Act correctly by completing audits and discussing the findings. We had no evidence to show that the service didn't do this.

Good practice in applying the Mental Capacity Act

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

Staff received and kept up-to-date with training in the Mental Capacity Act and had a good understanding of at least the five principles.

There was a clear policy on Mental Capacity Act and deprivation of liberty safeguards, which staff could describe and knew how to access. Staff knew where to get accurate advice on the Mental Capacity Act and deprivation of liberty safeguards. They told us this information was available on the service's 'intranet' and accessible to all staff.

Staff gave patients all possible support to make specific decisions for themselves before deciding a patient did not have the capacity to do so. If a patient's capacity changed during their admission staff explained that there was a process to alert the medical staff and MDT to review this in the MDT and patient ward rounds. This would then be clearly recorded and reviewed.

When staff assessed patients as not having capacity, they made decisions in the best interest of patients and considered the patient's wishes, feelings, culture and history. During our observation of a patient ward round we saw how capacity was checked and discussed with the patient so they could understand decisions made on their behalf.

Staff understood how to make applications for a Deprivation of Liberty Safeguards order. They knew these decisions were made only when necessary and monitored the progress of these applications. There were no deprivation of liberty safeguards in progress during the time of inspection.

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

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 caring?

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.

Staff were discreet, respectful, and responsive when caring for patients. Patients were truly respected and valued as individuals and were empowered as partners in their care. We observed that staff spoke to patients in a way that was kind and respectful. Important information was explained by staff on the correct level so that the patient could understand. We observed patients having conversations with staff and staff responding in a down to earth and friendly manner. Staff addressed patients using their chosen pronouns.

Staff gave patients help, emotional support and advice when they needed it. During our inspection we observed interactions between staff and patients that showed staff responding to changes in presentation and being around the ward so that patients had easy access to staff support.

People who use services were active partners in their care, we observed care and treatment reviews and saw how their individual preferences and needs were always reflected in how care is delivered. The minutes of these meetings showed how all staff were involved in delivering the care and treatment as well as what was expected of the patient to ensure the plans had the best chance of success.

Staff supported patients to understand and manage their own care treatment or condition. Staff gave information about a patient's condition in an appropriate way using the right level of language suited to the needs of the patient.

During patients ward round we saw how staff empowered patients to have a voice and to realise their potential. We observed all staff and patients contributing to the treatment plans. The doctor encouraged staff and patients to be creative and innovative with solutions to patients presenting problems. The doctor ensured that patients voice was heard in these meetings by ensuring that the patient's needs, likes and dislikes were integral to the treatment plans and what was expected from them as part of the collaborative care planning process.

Staff directed patients to other services and supported them to access those services if they needed help. We observed holistic care, a patient was being referred to an outside agency that would support their physical health once discharged, this was an added support route rather than the standard support agencies.

Patients said staff treated them well and behaved kindly. They told us that most of the time staff were kind and caring, observations we took during the time of the inspection saw good quality interactions from staff.

Staff understood and respected the individual needs of each patient. We found evidence in care plans and by talking to staff they were able to discuss the needs of patients that matched the care plan. Staff followed policy to keep patient information confidential.

Staff felt that they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards patients.

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. They ensured that patients had easy access to independent advocates.

Involvement of patients

Staff introduced patients to the ward and the services as part of their admission. The service had developed a 'welcome pack' this included information about the service and what to expect and who to ask for support. It was written in an accessible format for patients to understand. They also gave 'WOW' packs to patients on arrival this included spare clothes and shoes, toiletries including feminine hygiene products. Former patients have told the service that this pack made them feel welcome and cared for as most patients would initially come with no belongings.

Staff involved patients and gave them access to their care planning and risk assessments. Staff also involved patients in decisions about the service, when appropriate. We saw this evidenced in care plans and in patient meetings when patients were given genuine support from staff who knew them and encouragement to voice their needs and hopes and fears.

Staff made sure patients understood their care and treatment staff found ways to communicate with patients who had communication difficulties. Patients communication needs were assessed, and support was available including access to interpretation services when needed. We found on inspection that the service had a responsive multi disciplinary team and communication issues were discussed in any patient meeting. The service had speech and language support so information was created to suit patients' needs. We saw easy documentation and evidence were interpreters were sought for a patient.

Patients could give feedback on the service and their treatment and staff supported them to do this. Occupational health arranged weekly community meetings with patients. Minutes of these meetings showed that patients were supported to give feedback on all areas of the service and their views were represented in the monthly governance meetings.

Staff made sure patients could access advocacy services. Posters were visible on the ward and advocacy feedback was discussed in governance meetings.

Involvement of families and carers

Staff informed and involved families and carers appropriately.

Staff supported, informed and involved families or carers. A welcome leaflet was made available to families and carers. This was comprehensive with information considered important to family. The service had sought advice from previous patients' families about what to include.

Staff helped families to give feedback on the service. Families and carers were welcomed by the service to visit and to attend ward rounds. During the inspection we saw evidence of this happening. An updated feedback survey was being produced to gather after a patient is discharged from the service.

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

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

Good 

Good 

Access and discharge

Staff managed beds well. Patients did not have to stay in hospital when they were well enough to leave.

Bed management

The average length of stay for patients was between three days and four weeks. There was one patient who had experienced a longer stay on the ward than expected and this was because of difficulties finding an appropriate PICU bed in the locality.

The service had a clear exclusion criterion for which patients they could admit. Managers enforced their acceptance criteria and were open and transparent with referrers and commissioners about why some patients may not be accepted.

Managers and staff worked to make sure they did not discharge patients before they were ready.

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

Patients were moved between services only when there were clear clinical reasons, or it was in the best interest of the patient.

Staff did not move or discharge patients at night or very early in the morning. All discharges were planned safely and agreed by the multi-disciplinary team and the responsible clinician.

Discharge and transfers of care

Managers regularly reviewed length of stay for patients to ensure they did not stay longer than they needed to. Managers reported one delayed discharge, and this was due to social care issues.

Unless it was for one the aforementioned reasons patients did not have to stay in hospital when they were well enough to leave. Staff carefully planned patients' discharge and worked with care managers and coordinators to make sure this went well. Discharge planning started on admission we saw evidence of this in care plans and in patient ward rounds.

Two local clinical commissioning groups block booked all but one of the beds this meant that patients were within easy distance of family and home. Staff supported patients when they were referred or transferred between services. The service followed national standards for transfer.

Facilities that promote comfort, dignity and privacy

The design, layout, and furnishings of the ward supported patients' treatment, privacy and dignity. Each patient had their own bedroom with an en-suite bathroom and could keep their personal belongings safe. There were quiet areas for privacy. The food was of good quality and patients could make hot drinks and snacks at any time.

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

Good 

Each patient had their own bedroom, the bedrooms each had double beds to allow for comfort. Management explained that while patients could personalise their bedrooms with limited items subject to risk assessment, they always explained to the patients that their stay was only short-term. This meant that patients did not become too dependent on the acute care service which made transition back to their home environments easier.

Patients had a secure cupboard in their bedrooms to store personal possessions. We saw areas where possessions could be kept, restricted items were kept in secure lockers in non-patient areas.

Staff used a full range of rooms and equipment to support treatment and care including quiet areas and a room where patients could meet with visitors in private.

Patients had easy access to outside garden area, a space that patients could access easily. The garden area was open plan and had areas to sit and be active with plenty of seats available. Patients had been supported to plant flowers in the garden. This area was accessible for patients 24 hours a day without restrictions. .

Patients had access to a small kitchen to make hot drinks and snacks and were not dependent on staff. The kitchen was stocked daily with food items including bread, cereals, coffee and tea. Cleaning audits showed that it was regularly checked and cleaned by staff. The door to this kitchen was always open and access was directly from the ward. We saw anti-ligature taps and the room was part of the site ligature audit.

The service offered a variety of good quality food. Patients told us that the food was of good quality. The menu was written up for patients each day with different options, including option to meet the dietary and religious needs of patients.

Patients' engagement with the wider community

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

Due to the model of care patients stayed no longer than 28 days, staff told us they would support patients with any ongoing opportunities for education and work if that was needed.

Staff helped patients to stay in contact with families and carers. The service promoted keeping these contacts and recommended visits from friends and family if appropriate.

Staff encouraged patients to develop and maintain relationships in their home environments, within the service and the wider community. The service held a first year celebration and as part of the celebration patients were supported to give gift bags to the local residents. Included in the gift bags were handmade patient designed gifts. This was received well by the residents and some called to thank the patients.

Meeting the needs of all people who use the service

The service met the needs of all patients – including those with a protected characteristic. Staff helped patients with communication, advocacy and cultural and spiritual support.

The service supported and could make adjustments for disabled people and those with communication needs or other specific needs, we saw examples of posters written in an easy read format and posters with information for patients designed in an accessible format with the use of both words and images. The ward was located over two floors with lift access for patients and staff. All communal areas were accessible, and bedrooms were large and accessible.

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

Good 

Patient community meetings happened weekly.

Staff made sure patients could access information on treatment, local service, their rights and how to complain. We saw evidence of this in patient leaflets and posters around the ward.

Patient information leaflets were written in an accessible format and the service could access the leaflets in different languages when needed. Managers made sure staff and patients could get help from interpreters or signers when needed. This information was also available in the patients and family's welcome leaflets.

The service provided a variety of food to meet the dietary and cultural needs of individual patients. In the main kitchen dietary requirements were clearly written and we saw how needs were being met. We found no complaints about the food being offered. Staff told us that they will adapt menus and food choices to the needs of patients.

Patients had access to spiritual, religious and cultural support. We saw how the service had recognised that some patients found praying a calming activity when in distress and so staff had placed prayer mats near the quiet room for that reason.

Listening to and learning from concerns and complaints

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team and wider service.

Patients, relatives and carers knew how to complain or raise concerns. We saw evidence in community meetings and in patient and family information leaflets.

The service clearly displayed information about how to raise a concern in patient areas. Posters were visible for patients and information was accessible.

Staff had easy access to all policies on the staff intranet and staff we spoke with understood the policy on complaints and knew how to handle them.

Staff protected patients who raised concerns or complaints from discrimination and harassment.

Patients received feedback from managers after the investigation into their complaint.

The service used compliments to learn, celebrate success and improve the quality of care. This was part of the governance meetings and fed back to patients through the community meetings. We saw evidence in governance meeting minutes that compliments and complaints were discussed and any actions were acted upon.

We saw evidence of staff discussion patient feedback during reflective practice sessions.

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 

Leadership

Managers at all levels at the hospital had the right skills and abilities to run a service that provided high quality- sustainable care.

Managers understood the needs of the patient group and followed a recognised strength based model of treatment and care that focussed on the patient's skills and abilities.

Both patients and staff told us that managers were visible and approachable, staff told us that management had an open door policy. The manager's office was based on the ward and accessible for staff. Managers made themselves available for patients if they wanted to speak to them.

We observed how managers knew the patients and offered support patients when needed. Staff told us that they respected that managers were on the ward to support patients and them also.

The service welcomed preceptorship nurses and offered supported nursing placements. We were told that the service supports 'growing their own' and has development opportunities for all staff.

Vision and strategy

Staff knew and understood the provider's vision and values and how they applied to the work of their team. Before the ward opened the managers brought all staff together to discuss what they wanted to offer at the service. The decision to offer an acute ward was based on staff's preferences.

We saw minutes of meetings with external stakeholders including clinical commissioners, and local authority representatives where managers had clearly stated the purpose of the new ward communicated how this service fitted into the wider mental health services.

The provider had an audit schedule and managers delegated audit to staff for purposes of learning and improvement.

Staff performance issues are addressed in line with organisational policy.

Culture

Staff felt respected, supported and valued they spoke highly of the management team. Additional support of a mental health first aider was in place for all staff. They said the service promoted and embraced equality and diversity in daily work. The service had champions in LGBTQ+ and in equality and diversity. The service recently delivered training on pronouns to all staff. They had also had national input within Cygnet in terms of equality and diversity.

Staff success was celebrated. For example, one nurse had recently been nominated for the Mary Seale award with the Nursing Times for their national contribution for equality and diversity.

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

Good 

The service provided opportunities for development and career progression. Training opportunities included upskilling for healthcare support workers to senior level, and nursing associate posts. In addition, senior managers provided clinical leadership training for staff. Staff told us they could raise any concerns without fear, a speak up guardian was in place and staff knew and felt confident to whistle-blow if needed.

Staff demonstrated understanding and commitment to supporting the wellbeing of this patient group.

There were high levels of staff satisfaction across all equality groups. Staff were proud of the organisation as a place to work and spoke highly of the culture. There were consistently high levels of constructive engagement with staff groups. Staff at all levels were actively encouraged to raise concerns. We heard how prior to opening the upper house as an acute unit manager had discussed options for the use of this ward with the staff group who would be working there.

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.

There were effective and robust governance arrangements in place. Managers had access to a range of dashboards that allowed them to keep up to date with all current information affecting their service. They had easy access to information that allowed them to monitor and manage their service effectively.

Managers had involved the staff group in decisions about the service. For example, prior to deciding the purpose of the new ward managers had given staff, who would be working there, the choice of three potential services Cygnet required. Staff had chosen an acute ward to complement their existing rehabilitation ward.

Managers ensured that all staff were up to date with training and supervision and addressed poor performance effectively and in a timely manner.

Managers ensured that relationships with commissioners and other external bodies were maintained and that information was shared between themselves and these services. This view was supported by feedback from the clinical commissioning groups and local authority.

Managers made effective and immediate arrangements to cover any vacant posts and while staff sickness due to long term sickness was high this was monitored and managed effectively.

Management of risk, issues and performance

Managers ensured that teams had access to the information they needed to provide safe and effective care and used that information to good effect. Information sharing and knowledge was apparent at every level during our inspection. Such as medicine alerts that were available in the clinic, learning from incidents at both local and national level were displayed in the staff room and readily available on the staff intranet.

Staff level of understanding of patient needs was clearly shown through the meetings we observed, and paperwork seen. Robust documentation of quality plans and assurances were provided. Risk assessments including ligature risks were clearly documented and reviewed regularly

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

Good 

Staff produced a comprehensive ligature risk assessment of the ward and reviewed this monthly in governance risk management meetings. As part of the admission and assessment of patients' ligature risks were assessed and regularly monitored. Staff told us that from experience of their work on the long stay rehabilitation ward at Cygnet Acer they had transferred learning and positive experience to manage and reduce ligature risks on the acute ward.

Information management

Staff collected and managers analysed data about outcomes and performance and engaged actively in local and national quality improvement activities. The service had information governance systems which included the confidential storage of patient's records, this was managed well.

Information technology infrastructure at the service included a state of the art telephone system and helped to improve the service.

Managers ensure that notifications were completed and shared in a timely way with external bodies including Care Quality Commission as needed.

Engagement

Managers engaged actively with other local health and social care providers to ensure that an integrated health and care system was commissioned and provided to meet the needs of the local population. Managers from the service participated actively in the work of the local transforming care partnership. The service had done a lot of engagement with the local GP surgery, local hospital and local police force to aid in the understanding of the patient type. The service explained how this has improved communication between the local services which has improved the patients treatment.

Managers and leaders were involved in steering groups within the Cygnet group that had focus on acute mental health care and treatment.

Managers ensured that staff, patients and carers had access to up-to-date information about the work of the provider and the services they used. The information was shared via intranet, bulletins, and newsletters.

Patients and carers had opportunities to give feedback on the service they received in a manner that reflected their individual needs. We saw examples of completed patient and carer feedback surveys.

Learning, continuous improvement and innovation

Throughout every level of the hospital there was a clear focus on learning and improvement. Leaders and managers were actively engaged in continued personal development to enhance their skills which they filtered back into the service. Staff told us that management are keen on developing their staff. Managers discussed learning and development with staff in their clinical supervision. Managers explained how they have supported nurse preceptorships and how those newly trained nurses have continued to stay on at the service throughout and after their training.

Throughout the inspection managers were keen to explain and celebrate how they learnt from a previous inspection of the lower house and work hard to transform the service from inadequate to good within two years. Managers ensured that the strategy for the service was innovative, met their objectives and were challenging while remaining achievable.

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

Good 

Managers explained that they were approached by the internal Cygnet Group to publish documents on how they had successfully managed to use low levels of restrictive practice compared to similar services, how the design of the environment enabled recovery and good outcomes for patients, and how they had transferred their experience and skills from their work with personality disorders onto the acute ward. Staff from other local cygnet services have completed shadow shifts and attended handovers to develop good practice, increase knowledge and skills.