

Cygnets Sherwood House

Quality Report

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

Ratings

Overall rating for this location

Outstanding 

Are services safe?

Good 

Are services effective?

Good 

Are services caring?

Outstanding 

Are services responsive?

Outstanding 

Are services well-led?

Good 

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

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

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

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

Summary of findings

Overall summary

We rated Sherwood House as outstanding because:

- There was a strong, visible person-centred culture. Staff were highly motivated and inspired to offer care that was kind and promoted people's dignity. Staff actively involved patients, families and carers in care decisions to make sure patients were active participants in their care and treatment.
- Feedback from patients, relatives and stakeholders was continually positive about the way staff treated patients. Patients told us that staff went the extra mile and their care and support exceeded their expectations.
- The service was tailored to meet the needs of individual people and was delivered in a way to ensure flexibility, choice and continuity of care.
- There was a proactive approach to understanding the needs of different groups of people and to deliver care in a way that meets these needs and promotes equality. This included patients with complex needs.
- The service provided safe care. The environment was safe and clean. There were enough nurses and doctors. Staff assessed and managed risk well. They minimised the use of restrictive practices, managed medicines safely and followed good practice with respect to safeguarding.
- Staff developed holistic, recovery-oriented care plans informed by a comprehensive assessment. They provided a range of treatments suitable to the needs of the patients cared for in a mental health high

dependency rehabilitation ward and in line with national best practice guidance. Staff engaged in clinical audit to evaluate the quality of care they provided.

- The hospital team included or had access to the full range of specialists required to meet the needs of patients. Managers ensured that these staff received training, supervision and appraisal. The staff worked well together as a multidisciplinary team and with those outside the hospital 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 planned and managed discharge well and liaised well with services that would provide aftercare. As a result, discharge was rarely delayed for other than a clinical reason
- The service worked to a recognised model of high dependency mental health rehabilitation. It was well led, and the governance processes ensured that hospital procedures ran smoothly.

However:

- There had been four consultant psychiatrists in the last two years and the current one was also leaving. Patients said this affected their wellbeing as they thought they had to explain how they felt repeatedly to a new doctor.
- One medication prescribed to a patient for the side effects of their mental health medication was not included on their consent to treatment form.

Summary of findings

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Outstanding



Sherwood House

Services we looked at

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

Summary of this inspection

Background to Cygnet Sherwood House

Cygnet Healthcare Limited owns Sherwood House Hospital. It provided high dependency rehabilitation services for up to 30 male patients with mental health problems who may be informal or detained under the Mental Health Act (MHA). Some patients had a mild learning disability and some features of autism spectrum conditions.

Sherwood House has been registered with CQC since 17 November 2010. Since our previous inspection the provider has changed to Cygnet Healthcare Limited.

There were 24 patients receiving care and treatment at the time of our inspection and another two patients were admitted during the inspection.

Sherwood House is registered with the CQC to provide the following regulated activities:

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

There have been six previous inspections to Sherwood House. The latest was on 7 November 2016. We rated Sherwood House as good overall and good in all five key questions.

The last Mental Health Act review visit was on 23 May 2018. Concerns included:

- Staff did not consistently record discussions around informed consent between the patient and responsible clinician where a patient was being treated on the authority of a consent to treatment form. In one patient's file, we saw the responsible clinician did not complete the T2 form following the discussion with the patient around informed consent.
- None of the patient care plans we saw contained the patients' views. The care plans we reviewed were task-focussed and not based on individual needs. We saw no evidence of patients' participation, goals, aspirations and opinions written in their care plans.
- Staff did not always record a risk assessment before and after patients took section 17 leave. In three out of the five patient files, staff did not complete risk assessments before and after the patients' section 17 leave. The responsible clinician had not indicated whether a copy of the leave form had been given to the patient.

The provider submitted an action statement to CQC detailing how they planned to address the concerns raised. We saw these issues had been addressed at this inspection.

Our inspection team

The team that inspected the service comprised two CQC inspectors and one specialist advisor who was a nurse with experience in working with patients in mental health rehabilitation units.

Why we carried out this inspection

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

Summary of this inspection

How we carried out this inspection

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

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

Before the inspection visit, we reviewed information that we held about the location and asked commissioners, care coordinators and advocates for information.

During the inspection visit, the inspection team:

- looked around the ward

- spoke with nine patients
- received comment cards from another seven patients
- looked at five patients' records
- spoke with 12 staff including doctors, occupational therapists, nurses, cooks and cleaners
- spoke with the visiting pharmacist and advocate
- looked at 10 patients' prescription charts
- contacted 14 commissioners who were purchasing the service and spoke with four of these via email or telephone
- had email contact with four relatives of patients
- observed one patient's multidisciplinary ward round meeting
- looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the service say

Patients told us staff were good and helped them to develop skills such as cooking and cleaning.

Most patients said they liked the food and one patient said, "food was scrumptious."

Patients said all staff listened to them and the peer support worker was brilliant. They said staff were very professional and supportive, responded to their individual needs and involved them in their care. Patients said that the change of the responsible clinicians meant they had to explain everything again to each new doctor which was difficult.

All patients said the hospital was always clean and the cleaners worked hard.

All patients said that staff responded to them and all their needs were met. Patients said staff had helped them to tackle their problems and this hospital was the best hospital they had been in. Patients said they would not have made the progress they had if they had not been at Sherwood House.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

We rated safe as good because:

- The hospital was safe, clean, well equipped, well furnished, well maintained and fit for purpose.
- The service had enough nursing and medical staff, who knew the patients and received basic training to keep people safe from avoidable harm.
- Staff assessed and managed risks to patients and themselves well and achieved the right balance between maintaining safety and providing the least restrictive environment possible in order to facilitate patients' recovery. Staff followed best practice in anticipating, de-escalating and managing challenging behaviour. As a result, they used restraint only after attempts at de-escalation had failed. The hospital staff participated in the provider's restrictive interventions reduction programme.
- Staff understood how to protect patients from abuse and/or exploitation and worked well with other agencies to do so. Staff had training on how to recognise and report abuse and/or exploitation and they knew how to apply it.
- Staff had easy access to clinical information and it was easy for them to maintain high quality clinical records – whether paper-based or electronic.
- Staff followed best practice when storing, dispensing, and recording the use of medicines. Staff regularly reviewed the effects of medications on each patient's physical health.
- The hospital had a good track record on safety. Staff managed patient safety incidents well, 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.

Good



Are services effective?

We rated effective as good because:

- 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 the assessed needs, were personalised, holistic and recovery-oriented.
- Staff provided a range of care and treatment interventions suitable for the patient group and consistent with national

Good



Summary of this inspection

guidance on best practice. This included access to psychological therapies, support for self-care and the development of everyday living skills, and meaningful occupation. Staff ensured that patients had good access to physical healthcare and supported patients to live healthier lives.

- Staff used recognised rating scales to assess and record severity and outcomes. They also participated in clinical audit, benchmarking and quality improvement initiatives.
- The hospital team included or had access to the full range of specialists required to meet the needs of patients. Managers made sure they had staff with a range of skills need to provide high quality care. They supported staff with appraisals, supervision, reflective practice sessions and opportunities to update and further develop their skills. Managers provided an induction programme for new staff.
- Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care. The team had effective working relationships with staff from services that would provide aftercare following the patient's discharge and engaged with them early in the patient's admission to plan discharge.
- Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice and discharged these well. Managers made sure that staff could explain patients' rights to them.
- Staff supported patients to make decisions on their care for themselves. They understood the provider's policy on the Mental Capacity Act 2005 and assessed and recorded capacity clearly for patients who might have impaired mental capacity.

However:

- There had been several changes in consultant psychiatrists which meant that patients often had to get to know a new doctor during their stay.
- Two of the 10 medication charts we looked at did not include up to date information on the patient's consent to treatment form. One medication prescribed for a patient had not been included on this, so it was not clear whether the patient had consented to this.

Are services caring?

We rated caring as outstanding because:

- There was a strong, visible person-centred culture. Staff were highly motivated and inspired to offer care that was kind and

Outstanding



Summary of this inspection

promoted people's dignity. Relationships between patients, those close to them and staff were strong, caring, respectful and supportive. These relationships were highly valued and promoted by staff.

- Staff treated patients with compassion and kindness. Staff truly respected and valued patients as individuals and empowered patients as partners in their care, practically and emotionally. Patient's individual preferences and needs were always reflected in how care was delivered.
- Feedback from patients, those who are close to them and stakeholders was continually positive about the way staff treated patients. Patients said staff went the extra mile and cared for them in a way that exceeded their expectations.
- Staff 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 saw patients' emotional and social needs as equally important as their physical needs.
- Staff recognised and respected the totality of patients' needs. They always considered patients' personal, cultural, social and religious needs into account.
- Patients and those close to them were active partners in their care. Staff were fully committed to working in partnership with people and making this a reality for each patient.
- Staff empowered patients to have a voice and to realise their potential. They showed determination and creativity to overcome obstacles to delivering care. Patients' individual preferences and needs were always reflected in how care was delivered.
- Staff actively supported patients to access advocacy and support networks in the community. They ensured that patients' communication needs were understood, sought best practice and learnt from it.

Are services responsive?

We rated responsive as outstanding because:

- Patients' individual needs and preferences were central to the delivery of the service. Staff had embedded innovative approaches to provide care to meet patients' individual needs and preferences. Staff were flexible, provided choice and ensured continuity of care.
- The involvement of other organisations and the local community was integral to how the service was planned and

Outstanding



Summary of this inspection

ensured the service met patients' needs. Staff used innovative approaches to providing patient-centred pathways of care that involved other service providers, particularly for patients with complex needs.

- Staff had a proactive approach to understanding the needs of different groups of patients and delivered care in a way that met patients' needs and promoted equality. This included patients with complex needs and patients with protected characteristics under the Equality Act 2010. Staff helped patients with communication, advocacy and cultural and spiritual support.
- Staff planned and managed discharge well. They liaised well with services that would provide aftercare and were assertive in managing the discharge care pathway. As a result, patients did not have excessive lengths of stay and discharge was rarely delayed for any reason except for clinical reasons.
- The food was of a good quality and met patients' individual dietary and cultural needs. Patients could make hot drinks and snacks at any time. When clinically appropriate, staff supported patients to self-cater.
- Facilities and premises met the needs of a range of patients. The design, layout, and furnishings of the hospital supported patients' treatment, privacy and dignity. Each patient had their own bedroom with an ensuite shower room and could keep their personal belongings safe. There were quiet areas for privacy.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team and the wider service.

Are services well-led?

We rated well-led as good because:

- Leaders had a good understanding of the service they managed, and it adhered to the high dependency model of rehabilitation care. Leaders had the skills, knowledge and experience to perform their roles, were visible in the service and approachable for patients and staff.
- Staff knew and understood the provider's vision and values and how they were applied in the work of their team.
- Staff felt respected, supported and valued. They reported that the provider promoted equality and diversity in its day to day work and in providing opportunities for career progression. They felt able to raise concerns without fear of retribution.

Good



Summary of this inspection

- Our findings from the other key questions demonstrated that governance processes operated effectively at ward level and that performance and risk were managed well.
- Staff had access to the information they needed to provide safe and effective care and used that information to good effect.
- Staff engaged actively in local quality improvement activities.
- However:
- There had been difficulty in retaining a consultant psychiatrist to work in the hospital and this had meant that these changed often during a patients stay.

Detailed findings from this inspection

Mental Health Act responsibilities

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

- Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice and discharged these well.
- A competent staff member examined each patient's Mental Health Act papers on admission. Staff knew who the Mental Health Act administrator was. They worked as part of the multidisciplinary team to offer support in making sure the Act was followed in relation to, for example, renewals, consent to treatment and appeals against detention.
- Staff ensured that patients could take Section 17 leave and there was evidence of staff supporting patients to take leave regularly. Staff offered patients and carers a copy of leave forms. They included the number of staff accompanying for escorted leave and assessed risk and what to do in a crisis.
- There was a notice explaining to informal patients how they could leave the hospital, which was in an accessible format.
- The provider had trained all staff in the Mental Health Act. The provider offered training in both face to face and e-learning format. Staff had a good understanding of the Mental Health Act, the Code of Practice and the guiding principles. Consent to treatment and capacity requirements were adhered to and copies of consent to treatment forms were attached to medication charts where applicable. This is to ensure that staff are administer patients' medication under the correct legal

authority. However, two of 10 medication charts we looked at did not include up to date information on the patients' consent to treatment form. All but one medication was included in the patient's medical records. Doctors had prescribed this medication to reduce the side effects of anti-psychotic medication, so it should have been included on the consent to treatment form.

- Staff explained to patients their rights under the Mental Health Act on admission and regularly thereafter in a way that was accessible to each individual patient. Staff gave patients a leaflet which contained information about their rights under the Mental Health Act and displayed information about rights on a notice board in the communal area of the hospital. Patients signed where they were able to that they had understood their rights.
- Administrative support and legal advice on the implementation of the Mental Health Act and its code of Practice was available from a central team within the organisation. Patient records we looked at showed that detention paperwork was filled in correctly, up to date and stored appropriately.
- There were regular audits to ensure that the Mental Health Act was applied correctly and there was evidence of learning from these audits.
- Patients had access to an Independent Mental Health Advocate who attended the hospital three days a week. Staff we spoke with knew how to access and support patients to engage with the Independent Mental Health Advocate.

Mental Capacity Act and Deprivation of Liberty Safeguards

- The provider trained all staff in the Mental Capacity Act through face to face and e-learning. Staff had a good understanding of the Mental Capacity Act and its five statutory principles.
- Staff were aware of the provider's policy on the Mental Capacity Act, which included the Deprivation of Liberty Safeguards.
- Staff supported patients to make decisions on their care for themselves. Records we looked at showed that for

patients who may have impaired capacity, staff assessed and recorded appropriately the patient's capacity to consent. This was done on a decision-specific basis with regards to significant decisions. Staff gave patients every possible assistance to make a specific decision for themselves before they assumed the patient lacked the mental capacity to make it. This included capacity to consent to

Detailed findings from this inspection

medication, smoking and finances. When patients lacked capacity, decisions were made in their best interests, recognising the importance of the person's wishes, feelings, culture and history.

- Staff knew where to get advice regarding the Mental Capacity Act, including the Deprivation of Liberty Safeguards, within the organisation. The provider completed audits of adherence to the Mental Capacity Act.

- There were no Deprivation of Liberty Safeguards applications made in the last six months, but staff knew how to apply for Deprivation of Liberty Safeguards applications when required.






Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Long stay/ rehabilitation mental health wards for working age adults	Good	Good	Outstanding	Outstanding	Good	Outstanding
Overall	Good	Good	Outstanding	Outstanding	Good	Outstanding

Long stay/rehabilitation mental health wards for working age adults

Outstanding 

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

Information about the service

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- Staff did not consistently record discussions around informed consent between the patient and responsible clinician where a patient was being treated on the

authority of a consent to treatment form. In one patient's file, we saw the responsible clinician did not complete the T2 form following the discussion with the patient around informed consent.

- None of the patient care plans we saw contained the patient's views. The care plans we reviewed were task-focussed and not based on individual needs. We saw no evidence of patients' participation, goals, aspirations and opinions written in their care plans.
- Staff did not always record a risk assessment before and after patients took section 17 leave. In three out of the five patient files, staff did not complete risk assessments before and after the patients' section 17 leave. The responsible clinician had not indicated whether a copy of the leave form had been given to the patient.

The provider submitted an action statement to CQC detailing how they planned to address the concerns raised. We saw these issues had been addressed at this inspection.

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

Good 

Safe and clean environment

Safety of the ward layout

- The hospital environment was safe and clean. The ward layout allowed staff to observe all parts of the ward. On the first-floor bedroom corridor, the provider had fitted mirrors to reduce the blind spot. The provider acted to reduce the risk of ligature points. Ligature points are

Long stay/rehabilitation mental health wards for working age adults

Outstanding



fixtures to which people intent on self-harm might tie something to strangle them self. Staff had updated the ligature risk assessment in January 2019. The risk assessment identified most risks as low and where risks were identified, staff acted to reduce these. This included staff supervision of patients in these areas and limited patient access to maintain patient safety. Maintenance staff had removed 50mm from the top of doors and fitted a different type of hinge to reduce the risks of patients tying a ligature to a door. Staff assessed patient risks daily and increased observation levels where needed. Where staff had risk assessed a patient as being at risk of tying a ligature, they allocated a staff member to observe the patient on a one to one basis. Staff knew where the ligature-cutting knives were kept, and these were easily accessible.

- The hospital accommodated only male patients. This complied with national guidance for eliminating mixed sex accommodation.
- Staff completed environmental risk assessments regularly. These included daily ward environment checks, building risk assessments and fire audits.
- Staff had access to personal alarms, and the provider had installed a fixed-point call system throughout the hospital. During the inspection, we saw all staff responded to alarm calls from around the hospital. Staff checked the alarm system regularly to make sure it worked.

Maintenance, cleanliness and infection control

- The hospital was clean, had good furnishings and was well maintained. The provider had a plan in place to make improvements to the hospital furnishings and decoration.
- Patients and their relatives told us the hospital was always clean. Patients were expected to clean some areas including their bedrooms as part of their rehabilitation programme.
- Patients said staff supported them with this where needed. Equipment was well maintained; clean and clean stickers were visible and in date. Cleaning records were up to date and demonstrated the environment was regularly cleaned.
- Staff followed infection control principles, including handwashing. Hand gel dispensers were located

throughout the hospital. There was a staff member nominated as the infection control lead. Staff adhered to the provider's protocols for the disposal of sharps and clinical waste.

- In patient kitchens we saw staff checked the fridge and freezer temperatures. Records showed these were in the required range for safe food storage.

Seclusion room

- There was not a seclusion room in the hospital. We saw no evidence that patients were secluded in any other rooms in the hospital.

Clinic room and equipment

- The hospital had fully equipped clinic rooms with accessible resuscitation equipment and emergency drugs. Staff checked the equipment regularly to make sure it worked. Clinic rooms were clean and well organised. The provider employed an external company to calibrate the equipment and we saw this had been done. There was adequate first aid equipment available which included equipment for burns and eye wash. In the clinic room there was a height measure, weighing scales and examination couch for checking patients' physical health observations.

Safe staffing

- The hospital had enough nurses and doctors. The provider had estimated the number and grade of nurses required and the number of nurses matched this on all shifts. At the time of our inspection, the provider employed four senior nurses and six whole time equivalent nurses. This gave flexibility to cover leave and absence. There were two registered nurses on each day and night shift, with eight support workers during the day and five to six at night, depending on the needs of patients. Staff worked long shifts from 8am to 8pm and at night from 7.30pm to 8.30am, which allowed time for a handover. There was also a twilight shift from 8pm to 2am to accommodate patients' needs.
- The number of registered nurses allowed nurses to actively support occupational therapy and psychology programmes, work alongside the responsible clinician at regular clinics, run the shift and complete routine nursing tasks. This promoted positive relationships between staff and patients, supported patients' rehabilitation and reduced incidents. During the day,

Long stay/rehabilitation mental health wards for working age adults

Outstanding



the provider employed administrative staff, doctors, psychologists, occupational therapists, cooks and cleaners. The registered manager and head of care also worked during the day and both were registered nurses.

- There were no registered nurse vacancies at the time of our inspection, but the registered manager told us that two nurses were leaving. There were two support worker vacancies. However, one of these was to be filled by a bank staff member from the following week. The provider had advertised vacant posts. The staff turnover rate was 21% at the time of our inspection. They said that exit interviews were held with all staff prior to leaving. Themes from the interviews did not suggest that staff were unhappy working at the hospital, but that they left to progress their career or because they were moving from the area. Before our inspection, the provider informed us that 12 staff had left in the last 12 months prior to our inspection.
- Before our inspection the provider informed us that the sickness rate was 2%, this had reduced to 1% at the time of our inspection. This was below the provider's average of 3.5%.
- The provider did not employ agency staff but used their own pool of bank staff to cover vacant shifts where needed. These staff worked regularly at the hospital, received an induction and completed all mandatory training.
- The registered manager was able to adjust staffing levels daily to take account of case mix and meet patients' need. A registered nurse was present in communal areas of the hospital at all times.
- Patients we spoke with told us there were enough staff, so they could have regular one to one time with their named nurse. They also said that escorted leave or ward activities were rarely cancelled because there were too few staff. Staff said that patients' medical appointments always took priority and there were enough staff to cover these. There were enough staff to safely carry out physical interventions when needed.

Medical staff

- There was adequate medical cover day and night and a psychiatrist could attend the ward quickly in an emergency. The hospital had good links with the local GP for patients physical health needs, who would also visit in an emergency.

Mandatory training

- The provider had trained all staff with appropriate mandatory training and the mandatory training rate for staff at the time of our inspection was 94%. All staff we spoke with, including bank staff, said their mandatory training was up to date.

Assessing and managing risk to patients and staff

Management of patient risk

- Staff assessed and managed risk well. We looked at five patient records and saw that staff completed a risk assessment of every patient on admission, updated this regularly and after every incident. Staff used information provided from patients' previous placements to inform the risk assessment. Staff used a recognised risk assessment tool. Psychologists used short term assessment of risk and treatability assessments initially and updated this every two months or earlier if needed, including after incidents. Some patients who had a history of violence also had a historical clinical risk assessment and staff used these to inform the patient's risk assessment. Staff completed separate risk assessments for each activity that the patient was involved in. Records showed that staff assessed patients' risks before they went on leave from the hospital and when they returned. Staff reviewed patients' risks at their multidisciplinary meeting and at staff daily handover meeting following observations.
- Staff allowed patients to take positive risks. For example, patients who misuse substances were allowed leave so that staff could assess how patients used the coping strategies they had learnt during their time at the hospital. Records showed staff looked at what more they could do to support the patient at times when something went wrong. Staff were aware they needed to allow patients to take risks, so they could move forward in their rehabilitation.
- Staff monitored any deterioration in patients' health or behaviour through observation and talking with the patient. They used fluid charts and increased physical health observations where needed and monitored for any signs of infection including sepsis.
- Staff completed a risk assessment for each patient for choking. This included the risk increased saliva caused to choking for patients on long term psychotropic medication.
- The provider had an engagement and observation policy and procedure to guide staff practice, which all

Long stay/rehabilitation mental health wards for working age adults

Outstanding



staff followed. On admission, staff observed patients every 15 minutes for a week and reviewed observation levels in daily morning meetings. If staff assessed the patient as a reduced risk, they would put them on general observations 24/7. These were at intermittent intervals in line with the providers policy. A staff member was allocated to do the general observations throughout the shift. Staff said they could reduce these at night if the patient was settled to stop disturbing them. Staff increased individual patient observation levels if their risks increased, for example, where a patient expressed suicidal thoughts.

- Staff followed the provider's search policy and rarely searched patients. Staff said they needed a reason to do random searches, for example, if they suspected that a patient had drugs or alcohol. Staff completed room searches if they suspected that a patient was smoking in their bedroom or using a lighter. Staff recorded all searches and records showed that patients were involved and informed of the reasons for the search.
- There was no evidence of blanket restrictions. Blanket restrictions are the restriction on the freedoms of patients receiving mental healthcare that apply to everyone rather than being based on individual risk assessments.
- Patients could smoke in the garden. A relative told us this helped to reduce the number of cigarettes their relative smoked as they were not restricted so they did not feel agitated about this. Staff offered smoking cessation referrals to patients and gave us examples of patients who had engaged in smoking cessation.
- Informal patients could leave at will. There was one informal patient at the time of our inspection. Staff reminded him each day that he could leave and there was a notice to inform informal patients they could leave.

Use of restrictive interventions

- The hospital did not use seclusion or long-term segregation.
- Staff minimised the use of restrictive practices. Staff only used restraint after de-escalation had failed and used correct techniques. Face down (prone) restraint was not used. All staff, including bank staff, had received training in the use of management of actual or potential aggression. Staff said that before restraining a patient, they might offer the patient as required medication or change the staff member working with the patient as

certain patients had better rapport with some staff. They also used the smaller 'quiet garden' where patients had an opportunity to speak with staff one to one. In the patient records we looked at staff had developed individual reducing restrictive practice plans.

- The provider informed us that from 1 April 2018 to 30 September 2018, there were seven incidents of restraint at Sherwood House that involved three different patients. None of the restraints were in the prone position and none required rapid tranquilisation.
- Staff used medication prescribed for individual patients when required to reduce their agitation. Staff monitored the effects of this through observation including physical health checks. Care plans detailed the choice of the patient about when to use medication in their individual as required medicines protocol.
- Staff developed and implemented good positive behaviour support plans (PBS) for those patients who had learning disabilities or autism and followed best practice in anticipating, de-escalating and managing challenging behaviour. As a result, staff only used restraint after attempts at de-escalation had failed.
- Staff understood the Mental Capacity Act definition of restraint.

Safeguarding

- Staff followed good practice around safeguarding. The provider had a safeguarding policy that all staff were aware of. Managers had completed training with the local authority on safeguarding referral training and had enrolled registered nurses on this training. The provider trained all staff in safeguarding adults and children. Staff knew how to raise a safeguarding concern and did this when appropriate. One of the registered nurses was the lead on safeguarding at the hospital. Their role involved making all staff aware of safeguarding and when to refer and liaison with the local authority safeguarding team.
- The safeguarding lead from the local authority attended incident review meetings at the hospital every two months. At the time of our inspection there were two safeguarding incidents that had been investigated by the local authority safeguarding team. Both these were patient to patient incidents and the safeguarding team had agreed that appropriate action was taken to safeguard patients, so they were to be closed.
- Patients told us they felt safe at the hospital and had not experienced bullying or harassment. Patients reported to staff if other patients were aggressive towards them

Long stay/rehabilitation mental health wards for working age adults

Outstanding



and acted to keep patients safe. Staff gave examples of how they had protected patients from discrimination and harassment. For example, they had acted to keep patients safe from racial discrimination by other patients. Staff were aware of the need to maintain the sexual safety of patients and ensured there were enough staff to manage sexual safety in the hospital. Staff also ensured they support patients to understand healthy sexual relationships and to keep safe in the community.

- There were safe procedures for children that visited the hospital. There was a visitor's room in reception that was safe and comfortable. Furniture did not have sharp edges and there were no items lying around that children could hurt themselves on. Staff told us they assessed each patient to ensure it was safe for them and their children to visit and tried to support children to visit at a time the patient they were visiting could go out, so the visit was more interesting and a good experience.

Staff access to essential information

- Staff had easy access to clinical information. All staff, including bank staff, could access and record on both paper and electronic records. The hospital used a secure electronic record system. Staff printed off key documents and kept these in well-organised up to date files and stored them securely. Paper copies were easily accessible for staff and external professionals.

Medicines management

- Staff followed best practice in medicines management. We looked at ten medication charts and saw staff prescribed and administered medication in line with National Institute of Health and Care Excellence guidance. Staff followed the provider's protocol for reporting an adverse drug reaction. Staff monitored medicine fridge temperatures and records showed these were in the range for safe storage. Staff disposed of medicines safely. Staff checked and administered controlled drugs in line with legal requirements.
- All pharmacy requirements including supplies, medicines and audits were supplied by an external pharmacist. The pharmacist alerted nursing staff to any issues regarding medicines and we saw staff responded to this.
- Patients were asked to bring two weeks supply of their medicines on admission to make sure they had the medicines prescribed to them. The responsible clinician

reviewed new patients' medicines on admission. Staff monitored the physical health of patients who were prescribed antipsychotic medication. They discussed any issues in their morning meeting including monitoring blood test results.

- Records clearly stated the reasons for prescribing a high dosage of medication and how this was monitored, for example, if combined with as required medicines. In patient records there were clear protocols for when to use as required medicines and what these were for. The multidisciplinary team reviewed these monthly in patients' ward round meeting.
- Where appropriate, staff supported patients' independence. This included supporting patients to self-administer their medication. There was a separate clinic room for this. There were four stages of self-administration which were clearly described to patients and medication charts clearly stated which stage each patient was on. Staff risk assessed each patient before starting to self-administer and at each stage.
- All staff who administered medicines had to complete a competency assessment and the medicines management module in the staff training package. The head of care monitored the management of medicines and completed monthly and quarterly audits.
- Staff implemented the stopping over medication of people with learning disabilities (STOMP) project and we saw this recorded in some patients care plans. STOMP is a national initiative that aims to stop the overuse of psychotropic medication. It stands for 'stopping over medication of people with a learning disability'. The doctor regularly reviewed medication and staff worked with patients to reduce medication where possible.

Track record on safety

- There had been no serious incidents in the 12 months prior to our inspection.

Reporting incidents and learning from when things go wrong

- All staff knew when and how to report incidents and had reported all incidents that should be reported in line with the provider's policy. Staff were open and transparent and explained to patients when things went wrong. For example, we saw that a medication error had

Long stay/rehabilitation mental health wards for working age adults

Outstanding



been made where three doses had been missed as they had run out of the medication. Staff reported the incident, informed the patient and apologised to them and ordered the medicines.

- Staff received feedback from the investigation of incidents both internal and external to the service and met to discuss this feedback.
- There was evidence of change having been made because of feedback. Staff received alerts following incidents at other hospitals within the provider. During our inspection, we saw staff responded to an alert made where patients in another hospital had removed the rubber out of windows to use as a ligature. These windows were not the same as at Sherwood House, but maintenance staff checked all the windows to reduce the likelihood of an incident.
- Managers debriefed and offered support to staff after incidents. Staff also debriefed patients following incidents and discussed the reasons why the incident happened.

Are long stay/rehabilitation mental health wards for working-age adults effective?
(for example, treatment is effective)

Good



Assessment of needs and planning of care

- We looked at five patients' records. Staff completed a comprehensive mental health assessment prior to admission as part of the assessment process.
- The doctor carried out a physical health assessment of each patient after admission. This was thorough and informed future physical health care planning.
- Care plans we reviewed were up to date, individualised and focused on building skills and independence ready for discharge. They included crisis plans. Patients said they worked with the occupational therapist and psychologist on goals and what activities they were going to do when discharged to reduce the risk of relapse. Where patients had a mild learning disability, care records were in line with the care model identified in Transforming Care. This model aims to improve the

lives of people with learning disabilities and to support people to live in their local communities. Staff reviewed care plans monthly at patients' multidisciplinary ward round.

- All information needed to deliver care was stored securely and available to staff when they needed it in an accessible form.

Best practice in treatment and care

- We looked at five patient records. These showed that staff followed the guidance of the National Institute for Health and Care Excellence when prescribing medication.
- Staff offered patients psychological therapies recommended by the National Institute for Health and Care Excellence. The provider employed a full time clinical psychologist and an assistant psychologist to work at the hospital. There was also a psychologist one day a week who was there as part of their professional training. Therapies were tailored to individual need and in groups or one to one. Groups included recovery and coping skills using cognitive and dialectal behaviour therapy and mindfulness. The psychologist also worked with families and led reflective practice sessions for staff. Reflective practice in health means developing critical thinking skills by reflecting on an area of practice and looking to improve it. It helps to engage in continuous learning and to gain insight into yourself or your practice.
- Staff used positive behaviour support plans with patients where appropriate. These guided staff as to how to work with the person in a way that reduced triggers to the patient behaving in an aggressive way or becoming agitated. If patients did not want to engage with psychologists, the psychologists supported nurses by training them in the skills such as cognitive behavioural therapy skills to work with the patient.
- Patients had good access to physical healthcare, including access to specialists when needed. Patient records included health improvement plans and showed good monitoring of patients' physical health needs. Staff referred patients to a local GP, dentist, opticians, diabetic clinic, diabetic eye screening, physiotherapist and asthma clinic. The local GP visited the hospital monthly for a ward round and staff supported patients to go to the GP in between if needed. Staff completed a plan with patients about how their physical health needs and medication may affect

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Outstanding



exercise. Records showed staff monitored the physical health of patients on anti-psychotic medication, including blood tests and electrocardiograms. Staff worked with patients to reduce their caffeine intake as some anti – psychotic medicines and caffeine can affect people’s heart rates.

- Staff assessed patients’ nutrition and hydration needs and referred them to a dietitian where needed. If patients needed swallowing assessments or advice, staff referred them to the speech and language therapist through the GP.
- Staff supported patients to live healthier lives. There was information around the importance of being active, eating a balanced diet and men’s health on notice boards in the communal areas. Staff offered and referred patients to smoking cessation clinics. The hospital had a gym and encouraged patients to stay active. They offered bicycles and had walking and cycling groups and used a local swimming pool.
- Staff used a variety of rating scales to assess and record patients progress. These included Liverpool University Neuroleptic Side Effect Rating Scale, Health of the Nation Outcome Scale, Recovery Star, and the Model of Human Occupation.
- There was an organisational audit cycle that staff worked on and this included health and safety, restrictive practices, information governance, and physical health care. The pharmacist completed weekly medicines audits. They provided feedback from this to the registered manager to action and a monthly summary of medicines management. One of the organisational quality leads audited care records and verified whether care and treatment was in line with National Institute of Health and Care Excellence guidance. We saw that staff acted following audits and these were effective in improving patient care.

Skilled staff to deliver care

- The hospital team included or had access to the full range of specialists required to meet the needs of patients including nurses, doctors, occupational therapists, psychologists and a visiting pharmacist.
- Staff were experienced and qualified and all staff, including bank staff, received an appropriate induction. Managers supervised and appraised staff regularly. At the time of inspection, 98% of staff were receiving

regular supervision. The percentage of non-medical staff that had an appraisal in the last 12 months prior to inspection was 99% and 100% of medical staff had received an appraisal.

- Staff had access to regular team meetings. Minutes showed these were held monthly and day and night staff attended. Staff discussed a range of issues and identified actions which were completed. Support workers had a weekly group meeting. Staff from other disciplines within the hospital covered the tasks of support workers during this time to ensure all support workers could attend. Staff also had access to group supervisions and breakfast meetings for staff to attend each morning.
- Staff received the necessary specialist training for their role. In addition to mandatory training, staff had training in diabetes, epilepsy, suicide prevention, substance misuse and working with people with Aspergers. Staff recorded all training on the electronic system. This system showed staff what training they had completed and what training they needed to complete. The psychologist led reflective practice sessions for staff and recently provided training to staff on personality disorder.
- Managers addressed poor staff performance promptly and effectively. There were no staff performance issues at the time of inspection. Following a period of absence, staff received a return to work interview and all absence was monitored.
- The provider employed volunteers who had an interview and disclosure and barring service check before working at the hospital.

Multidisciplinary and inter-agency team work

- Staff from different disciplines worked together as a team to benefit patients. These included the consultant psychiatrist, speciality doctor, nurses, support workers, psychologist, psychology assistant, occupational therapists and therapy assistants. There were regular and effective multidisciplinary meetings. Support workers said their views about patients’ needs were listened to, they were able to suggest ways of working with patients and felt part of the multidisciplinary team.
- There were effective handovers within the team from shift to shift. Staff supported each other to make sure patients had no gaps in their care. However, staff, patients and commissioners told us there had been several changes of responsible clinicians and the

Long stay/rehabilitation mental health wards for working age adults

Outstanding



current responsible clinician was leaving. Patients said this was difficult as they felt they had to explain everything about themselves to each new responsible clinician and when they got to know them they left.

- There were effective working relationships including good handovers with teams inside and from outside the organisation including care co-ordinators, community mental health teams and commissioners. The provider had recently installed a conference call facility to make it easier for care coordinators for patients placed out of area to dial in to the meetings. Staff sent weekly updates about patients to care coordinators. The local GP held a monthly ward round at the hospital.

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.
- A competent staff member examined each patients Mental Health Act papers on admission. Staff knew who the Mental Health Act administrator was. They worked as part of the multidisciplinary team to offer support in making sure the Act was followed in relation to, for example, renewals, consent to treatment and appeals against detention.
- Staff ensured that patients could take Section 17 leave and there was evidence of staff supporting patients to take leave regularly. Staff offered patients and carers a copy of leave forms. They included the number of staff accompanying for escorted leave and assessed risk and what to do in a crisis. This had improved since the Mental Health Reviewer visit in May 2018.
- There was a notice explaining to informal patients how they could leave the hospital, which was in an accessible format.
- The provider had trained all staff in the Mental Health Act. The provider offered training in both face to face and e-learning format. Staff had a good understanding of the Mental Health Act, the Code of Practice and the guiding principles.
- Consent to treatment and capacity requirements were adhered to and copies of consent to treatment forms were attached to medication charts where applicable. This is to ensure that staff administer patients' medication under the correct legal authority. However, two of 10 medication charts we looked at did not include up to date information on the patients' consent

to treatment form. All but one medication was included in the patient's medical records. Doctors had prescribed this medication to reduce the side effects of anti-psychotic medication, so it should have been included on the consent to treatment form.

- Staff explained to patients their rights under the Mental Health Act on admission and regularly thereafter in a way that was accessible to each individual patient. Staff gave patients a leaflet which contained information about their rights under the Mental Health Act and displayed information about rights on a notice board in the communal area of the hospital. Patients signed where they were able to that they had understood their rights.
- Administrative support and legal advice on the implementation of the Mental Health Act and its Code of Practice was available from a central team within the organisation. Patient records we looked at showed that detention paperwork was filled in correctly, up to date and stored appropriately.
- There were regular audits to ensure that the Mental Health Act was applied correctly and there was evidence of learning from these audits.
- Patients had access to an Independent Mental Health Advocate who attended the hospital three days a week. Staff we spoke with knew how to access and support patients to engage with the Independent Mental Health Advocate.

Good practice in applying the Mental Capacity Act

- The provider trained all staff in the Mental Capacity Act through face to face and e-learning. Staff had a good understanding of the Mental Capacity Act and it's five statutory principles.
- Staff were aware of the provider's policy on the Mental Capacity Act, which included the Deprivation of Liberty Safeguards.
- Staff supported patients to make decisions on their care for themselves. Records we looked at showed that for patients who may have impaired capacity, staff assessed and recorded appropriately the patient's capacity to consent. This was done on a decision-specific basis with regards to significant decisions. Staff gave patients every possible assistance to make a specific decision for themselves before they assumed the patient lacked the mental capacity to make it. This included capacity to consent to

Long stay/rehabilitation mental health wards for working age adults

Outstanding



medication, smoking and finances. When patients lacked capacity, decisions were made in their best interests, recognising the importance of the person's wishes, feelings, culture and history.

- Staff knew where to get advice regarding the Mental Capacity Act, including the Deprivation of Liberty Safeguards, within the organisation. The provider completed audits of adherence to the Mental Capacity Act.
- There were no Deprivation of Liberty Safeguards applications made in the last six months, but staff knew how to apply for Deprivation of Liberty Safeguards applications when required.

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

Outstanding



Kindness, privacy, dignity, respect, compassion and support

- Feedback from patients, relatives and stakeholders was all positive about the way staff treated patients. Patients told us that staff went the extra mile and their care and support exceeded their expectations.
- There was a strong, visible person-centred culture. Staff were highly motivated and inspired to offer care that was kind and promoted people's dignity. All patients we spoke with said staff listened to them and supported them to move on. Patients felt really cared for and that they mattered.
- Patients told us that staff were always kind, respectful and polite and always knocked on their bedroom door before coming in.
- Staff recognised and respected the totality of patients' needs. They considered patients' personal, cultural, social and religious needs, and found innovative ways to meet them. We observed throughout the inspection that staff treated patients with kindness, respect and compassion. Staff spoke about patients with empathy and showed that they knew the patients well and how to meet their individual needs.
- Staff saw patients' emotional and social needs as important as their physical needs. Relationships between patients, their relatives and staff were strong,

caring, respectful and supportive. All patients told us they got on well with the staff and staff understood their needs and how to help them progress. The provider employed a staff member who was previously a patient at the hospital. Patients told us they valued the support of this staff member who understood their needs, showed empathy and knew how to help them.

- Patients were always treated with dignity by all staff involved in their care, treatment and support. Consideration of patient's privacy and dignity was consistently embedded in everything that staff did. Staff recorded patients' specific needs and communicated them across the multidisciplinary team.
- Commissioners told us that the care was good. They said staff worked with complex patients and often avoided patients moving on to more secure services or psychiatric intensive care units, which was in the best interests of the patient.
- Staff recognised that patients needed to have access to, and links with, their advocacy and support networks in the community and they supported patients to do this. Staff worked with patients to develop a guide to the local area they would be discharged to. This helped the patient to know what services would be available to them and leisure and educational opportunities. Patients said this was helpful and reduced their anxieties about moving to a different area.
- Patients and their relatives were active partners in their care. Staff were fully committed to working in partnership with patients. All relatives we spoke with were positive about the care provided at the hospital. One relative told us that all staff in the multidisciplinary team worked well as a team and knew their relative well. They said this meant their relative had a good quality of life at the hospital because they felt he was genuinely cared for and understood. Another relative told us the staff were marvellous and when they phoned the hospital all staff they spoke with knew who their relative was and how they were doing. They welcomed the continuity of staff who they said genuinely seemed to know and care about their relative.

Involvement in care

Involvement of patients

- The admission process informed and oriented the patient to the hospital. Records we looked at showed that patients were given a tour of the hospital on

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Outstanding



admission. The provider gave all patients a welcome pack on admission. This included an alarm clock, toiletries, slippers, dressing gown and rucksack. Patients said this had helped them to settle in.

- Staff always empowered patients to have a voice and to realise their potential. They showed determination and creativity to overcome obstacles to delivering care. Patients' individual preferences and needs were always reflected in how care is delivered.
- Staff asked patients to agree and sign a communication agreement on admission as to who they wanted information about them communicated to.
- Staff found innovative ways to enable patients to manage their own health and care when they could and to maintain independence as much as possible. Patients completed a self-assessment on admission, which asked the patient to describe their feelings, what helped them to deal with these and where they wanted to be in two years. Patients said this helped them to tell staff what they wanted and needed from the start of their admission and to be involved in their care and treatment. Staff ensured that patient's communication needs were understood, sought best practice and learnt from it. Records we looked at showed patients were actively involved and took part in their care plans and risk assessment. Care plans were in a format that was accessible to them and included pictures and photographs. Care plans included the patient setting their own goals. Staff said this was important as patients often knew what they wanted to achieve and so needed to be involved which helped the patient to be empowered and be independent. Staff offered all patients a copy of their care plan. Staff spent time with each patient before their ward round to look through their care plans with them and the patient set their next goals with staff during their ward rounds.
- Patients had access to advocacy and an independent advocate worked at the hospital three days a week. They attended patients' meetings with them if the patient wanted them to. Patients said information about advocacy was on the notice board in patient areas. The advocate told us that staff dealt with any issues they raised on behalf of patients immediately.
- Patients were asked to feedback on the service they received each week at community meetings and by completing questionnaires. Patients told us their views were listened to. The providers People's Council had recently been set up at the hospital. Minutes showed

that weekly patient council meetings were held, and an elected patient representative then attended the People's Council meetings and shared patients views and issues. The advocate also attended this meeting. Minutes we looked at showed discussion about weekend activities and outings and reducing restrictive practices. Patients were involved in recruiting staff.

- The last patient survey in 2018 was given to 27 patients and staff supported patients to complete it if needed. Nine patients completed the survey and we saw that responses were positive. The survey included questions about the environment and living conditions, staff, catering, family and friends, activities, complaints, advocacy, safeguarding, treatment and care and personal information. We saw that improvements suggested by patients such as more pictures on the walls and new carpets and rugs had been provided.
- Where patients wanted them, they had advance decisions in place. Care plans included how the patient wanted to be cared for if they became agitated or upset and when they wanted to have medication to help them to calm down.

Involvement of carers

- The provider had a guide for carers that staff gave to families or posted to them if they were not able to visit. Staff supported carers to attend meetings about the patient if the patient agreed to this by providing transport when needed. For some carers who lived a long distance away from the hospital this was the only way they could visit, and they told us how much they appreciated this. One carer told us that staff had fully prepared for their relatives meeting and presented well throughout, so they knew all about their relative's rehabilitation programme.
- Staff supported patients to access home leave and facilitated visits as much as possible. Staff took some patients to their home or collected their relatives from train stations to allow them to visit more easily.
- Staff told us that on World Mental Health day in 2018 they arranged activities at the hospital and invited families to attend. They said it had been well attended by families.
- Carers told us they felt well supported and listened to by all staff. They said that staff had given them the emotional support they needed to relieve their anxieties. All staff had supported the carer to maintain their relationship with their relative and advice on how

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Outstanding



to support them. Carers said they were able to contact their relative regularly and speak to them on their mobile phone. They said they were also able to visit as much as they were able to.

- The manager said that they planned to invite carers to be part of the People's Council. The provider asked carers for their views through an annual survey. Fifteen carers received a survey in 2018 and 10 responded. All responded that staff were friendly, and kind and they were made to feel welcome when they visited. Relatives said, "Staff are outstanding", "Best hospital my son has been admitted to" and "Very supportive and friendly staff team."

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

Outstanding



Access and discharge

Bed management

- The average bed occupancy over the six months prior to inspection was 93%. Patients were placed at Sherwood House from several areas of England including East and West Midlands, East Anglia, Lincolnshire, London and Yorkshire. Commissioners told us that staff kept in contact with them regularly and ward rounds for patients from an area were grouped together so that care coordinators only needed to travel on one day.
- The registered manager told us that all admissions were planned and we saw this in the records we looked at. Patients did not move from their bedroom during an admission and this included when they went on leave.
- Patients were admitted and discharged at an appropriate time of day and this was never at night. Commissioners told us that staff worked well with patients in a person-centred way which had prevented patients with complex needs who needed more intensive care from having to move to a psychiatric intensive care unit.

Length of stay

- The average length of stay of patients discharged in the 12 months prior to inspection was 547 days. Commissioners stated an estimated length of stay on the funding pack sent to the provider before the patient's admission and sometimes stated how long they wanted the patient to stay for. One patient had been at the hospital for 12 years however they were due to be discharged soon after our inspection. The patients discharge had been planned over the last two years to enable their community team to find the correct placement. This was due to the patients complex physical and mental health needs. Staff had worked with the patients community placement over the last two months to ensure this met all his required healthcare needs. Commissioners expressed concern that the turnover of consultant psychiatrists might have an impact on length of stay but did not say that this had been the case. The multidisciplinary team worked together to reduce the impact of this on patients and promoted patients' discharge and worked with them to achieve this.

Discharge and transfers of care

- Discharge was never delayed for other than clinical reasons. From 1 January 2016 to 30 September 2018, there were no delayed discharges from the hospital. Commissioners said staff promoted discharge when appropriate for each patient.
- Staff and patients told us they began planning for discharge on the patients' admission. There was a visual discharge pathway, which helped patients to tick off their progress during their admission. Staff said this was very useful for patients with autism spectrum conditions. Patients told us how they found this helpful and they knew where they were on the pathway.
- Care plans referred to identified Section 117 aftercare services to be provided for patients who were detained under Section 3 of the Mental Health Act or equivalent Part 3 powers. Records showed how staff worked with patients who were discharged to other areas to help them know what services would be available there. Staff developed a guide to the area with the patient. This helped them to know which services would be available to them on discharge helping to promote their recovery.

The facilities promote recovery, comfort, dignity and confidentiality

Long stay/rehabilitation mental health wards for working age adults

Outstanding



- There was a full range of rooms and equipment to support treatment and care including lounges, activity and therapy rooms and clinic rooms with an examination couch to complete patients' physical health checks. The provider employed two full time occupational therapists who assessed patients' skills in daily living and promoted their rehabilitation. There was a laundry room with washing machines and dryers where staff supported patients to do their own laundry. An internet café provided patients with opportunities to access the internet which helped to provide them with the skills for rehabilitation. There was a gym with several pieces of exercise equipment and a pool and table tennis table. Some patients who had been risk assessed to safely use the gym had their own key to the gym. On each floor, there was a lounge with satellite channels available on the television on the first floor. The provider had purchased new chairs for the lounges which were delivered the day before our inspection and new carpet was to be fitted the following week. There were several pictures around the walls of the lounges making it comfortable and homely. Patients said the decoration was often updated which made it feel welcoming and homely.
- All patients had their own bedroom with an en-suite shower and toilet. Patients told us they could personalise their bedrooms to their taste and were encouraged to keep their bedrooms clean as part of their rehabilitation. Patients had their own key to their bedroom and had access to their bedrooms during the day. Patients had a lockable drawer in their bedroom and told us their belongings were safe. They said they had space to store their bicycles safely in the garden sheds.
- There was a quiet room in the hospital and a room where patients could meet with their visitors. There was a pay phone and most patients could also use their own mobile phones. Staff reviewed this in the daily morning meeting and care planned for individual patients if needed to ensure their safety and wellbeing.
- Patients had access to outside space. There were two gardens and patients could smoke outside if they wanted to. Patients said they could access the garden when they wanted to. The smaller garden was the quiet garden, affectionately known by staff and patients as 'Tilly's garden' after a red kite that one of the previous patients had. Patients told us that they liked to spend

time talking with staff in this garden one to one and it helped them to calm down if they were upset or agitated. In the larger garden, there was a cold drinks machine and artwork painted on the fences.

- On the ground floor there was a large dining room with several small tables and chairs. There were two cold drinks machines where patients could buy low sugar drinks. There was a small kitchen on each floor where patients could make snacks and hot drinks when they wanted to. Some patients had been risk assessed as being safe to have their own key to the kitchen. There was a kitchen where patients could shop for and cook their own meals as part of their rehabilitation. Patients said staff promoted their independence. There was a staff room, however staff were encouraged to eat meals with patients.
- Patients told us the food was good and there were always fruit and yogurts available to promote healthy eating.

Patients engagement with the wider community

- Patients had access to activities seven days a week. The provider employed two therapy coordinators although all staff took part in activities with patients. There were three minibuses and several staff were able to drive these to enable patients to access the local community and visit other areas. Patients met with staff weekly to discuss weekend activities. These included walking, cycling, badminton, pool, golf, bowling, swimming, visiting the local coffee shop, pub or cinema. Patients used the gym at the hospital but were also supported to go to a local gym. Staff said some patients were difficult to engage in activities, so they looked at ways to do this and said some patients enjoyed playing games on their games consoles. Staff spent time with patients playing the games and talking with them. Patients were funded to buy bicycles as part of their rehabilitation and a relative told us how this had helped their relative to take part in activities.
- Patients had opportunities to engage in education and work activities. Records we looked at showed that staff discussed education opportunities with patients. Patients told us about the construction group, which was a weekly evening class at the hospital where patients had the opportunity to do, for example, bricklaying. Tutors also visited the hospital, so patients could do Maths, English and drama courses.

Long stay/rehabilitation mental health wards for working age adults

Outstanding



- Patients had opportunities to have therapeutic earnings as part of their rehabilitation, for example, cleaning a lounge. The patient and staff had signed a contract that stated when they would do this and how much they would earn. This supported patients' independence and rehabilitation by providing them with skills.
- Staff supported patients to have contact with their families and carers. Staff supported home visits for patients.

Meeting the needs of all people who use the service

- Staff had a proactive approach to understanding the needs and preferences of different groups of people and delivered care in a way that met these needs, which was accessible and promoted equality. This included people with protected characteristics under the Equality Act 2010.
- The hospital was accessible to wheel chair users, with a lift, adapted bathroom and ground floor bedrooms. In reception there was a gender neutral accessible toilet.
- Staff provided information in accessible formats where patients needed this. For example, some patients had been in hospitals for several years and had limited access to educational opportunities so needed an easier to read format. This included information on patients' rights, health, activities, how to complain, how to access advocacy or contact the CQC. Staff adapted care plans and activity plans using pictures and photographs for patients with a learning disability or autism or patients who found reading difficult.
- Staff said there was easy access to interpreters and signers when required. If English was not a patient's first language, staff used interpreters and translators to support patients.
- The kitchen staff provided food to meet the dietary needs of patients of faith. Staff gave examples of this for a Muslim and Sikh patient. They had themed evenings of different cultural foods, to give all patients an opportunity to taste different foods. Patients told us they enjoyed these and it had encouraged them to try foods they would not have done before which helped to promote their rehabilitation.
- Staff ensured that patients had access to appropriate spiritual support and this included attending local places of worship. There was a faith room with literature about different faiths and this provided patients with a quiet space. Staff supported some patients to attend a local church every Sunday. A church group visited the

hospital twice a month. Staff gave us examples of how they had supported patients well and facilitated their wishes around faith, for example, they had arranged for a patient to visit a mosque and supported patients to attend a carol service at Christmas.

- There was a notice board in one of the communal areas with information for patients about lesbian, gay, bisexual and transgender organisations and support. There was also a large rainbow that one of the staff had painted on a corridor wall. The rainbow sign is a sign of welcome and acceptance to people from lesbian, gay, bisexual and transgender communities.

Listening to and learning from concerns and complaints

- Patients knew how to complain and receive feedback. In the communal areas there was a concerns board which gave patients information on how to make comments and complaints about the service. All patients we spoke with knew how to make a complaint. All staff we spoke with knew how to handle complaints appropriately. Staff received feedback on the outcome of the investigation of complaints and acted on the findings.
- The hospital received four complaints and 13 compliments in the 12 months before our inspection. One of the complaints was partially upheld. Staff from the clinical commissioning group who raised the complaint told us they were satisfied with the action taken to resolve this.

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

Good



Leadership

- Leaders had a good understanding of the service they managed, and it adhered to the high dependency model of rehabilitation care. Leaders had the skills, knowledge and experience to perform their roles, were visible in the service and approachable for patients and staff. Staff reported good relationships between the

Long stay/rehabilitation mental health wards for working age adults

Outstanding



multidisciplinary team. However, staff, patients and commissioners told us that there had been several changes of consultant psychiatrists which had been difficult and affected continuity of care.

- The provider made management training available to registered managers and nurses. Nurses told us this was good for their development and they were supported by their manager to do this.

Vision and strategy

- Staff knew and agreed with the organisation's values. All staff we spoke with were aware of and worked towards these to provide the best care for patients. The staff team objectives reflected the organisation's values and objectives.
- Staff knew who the most senior managers in the organisation were and these staff members had visited the hospital. The provider sent staff regular updates about the organisation and any changes.
- The values and vision of the organisation formed the structure of appraisal documents and staff were able to talk about how they incorporated the organisation's values in their work. Some staff had been involved in designing the new values through workshops and staff surveys.

Culture

- Staff said the registered manager was approachable and they felt respected and valued. All staff we spoke with said it was a happy staff team and all staff respected each other's roles.
- Staff were happy and proud to work for the organisation and demonstrated a high level of satisfaction with the team.
- Staff knew how to use the whistle blowing process and felt able to raise any concerns without fear of victimisation. The provider's human resources staff provided regular support. They held drop in sessions at the hospital that all staff could access and completed human resources reviews and walkarounds of the hospital to meet staff. There was evidence that managers managed poor staff performance effectively. The hospital manager gave examples of this.
- The team worked well together. Staff told us that there were good relationships throughout the team across the different roles. We observed this during our inspection.
- At the time of our inspection 99% of staff were up to date with their appraisal. Appraisals included

conversations about personal development and careers. Staff gave examples of how they were being supported to develop in areas where they had less experience or wanted to develop further.

- There was a rainbow painted on one of the walls in the bedroom corridor and a notice board about support and organisations for the lesbian, gay, bisexual and transgender (LGBT) community. The rainbow is a sign of welcome for those from the LGBT community. Staff told us the organisation offered equality of opportunity.
- The hospital had a zero-tolerance approach to racism; staff reported any racism to the police. We saw staff had done this following patient to patient incidents.
- At the time of our inspection the service's sickness level was 1.3% which was below the organisational average of 3.5%.
- There was an occupational health service for staff and a free phone line where staff could access support and counselling.

Governance

- The provider employed audit and compliance managers who visited the hospital regularly to monitor quality and compliance with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider used key performance indicators and other indicators to gauge the performance of the team. The measures were in an accessible format and used by the staff team to develop active plans where there were issues.
- There was a clear governance structure in place which meant that the objectives of the organisations board were understood by and worked towards by all staff at the hospital. This was through staff and patient meetings that fed into local governance processes. These then fed into regional governance, to the corporate governance and to the board. This ensured clear communication to improve the safety and quality of the service.
- The registered manager had sufficient authority to do their job and support from administrative staff. Staff had administrative support, so they could maximise their shift time on direct care activities.
- Since our previous inspection, the provider had changed to Cygnet Healthcare Limited. Staff said there had been little changes and the new provider responded quickly to any issues. The registered manager had a weekly conference call with other Cygnet managers in the East Midlands and the

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operations manager. They discussed occupancy levels, incidents, key performance indicators and CQC requirements. They found this helpful to gauge performance of the staff at the hospital, how this compared to others and what improvements they needed to make.

- Staff worked well with other teams to ensure that patients were safe and that they progressed successfully in their recovery. We spoke with professionals who worked with the service and they were happy with how the hospital communicated with them.

Management of risk, issues and performance

- Staff were able to submit items to the hospital and provider's risk register. The registered manager had put issues arising from safeguarding investigations on there.
- The service had a business continuity plan. The plan outlined what actions the staff and service should take in the case of an emergency.
- Staff told us there were no cost improvement programmes in place and that there were no issues for them to access funds for what they required.

Information management

- Staff told us they had access to the equipment and information technology they needed to do their job. They said they could request equipment needed and this was agreed. The week before our inspection a new server had been installed which had caused some issues with the printer, but staff said this was resolved quickly.
- The information governance systems ensured patient records were confidential.
- The registered manager had the information that they required for their role. Data about quality of care, staffing and performance was accessible. The registered manager monitored the hospital's performance and reported weekly to the regional manager.
- The registered manager used a dashboard system to manage, monitor and improve performance, which was clear and accessible to other managers and staff. A wide range of performance issues were reported on the system. This included staff supervision and training, restraints, patient activity and care plan progress.
- Staff made notifications to the Care Quality Commission. Staff completed notifications effectively and promptly.

Leadership, morale and engagement

- Staff received up to date information about the organisation and the service from their managers. The most senior managers in the organisation communicated with staff regularly by email and information from managers meetings was shared with staff at team meetings, handover and daily multidisciplinary team meetings.
- Staff from all professional backgrounds who worked there told us they felt listened to within the organisation. For example, occupational therapists told us they were involved in staff interviews.
- Staff told us that they were happy to work there, morale was good, and they felt empowered in their role.
- We saw evidence that staff shared up to date information about the service at patients' community meetings.
- Cygnet had an up to date website with information about their services.
- Patients and carers could give feedback about the service and they could do this in a way that met their needs. Patients and carers could feedback via surveys and directly to senior managers by email if they wished.
- Staff had access to feedback from patients and carers and there was evidence that staff had listened to this and considered the feedback patients had given.
- The regional operations director visited the hospital most weeks. Patients told us they were able to meet with them when they visited.
- Cygnet had a Commissioning lead who liaised with commissioners. In addition to this the registered manager had good quality, regular communication with commissioners.
- Staff were open and transparent and explained to patients when something went wrong. Staff offered feedback and debrief to patients following incidents. Carers told us staff informed them if their relative agreed of medication errors or incidents involving their relative.
- Staff were offered the opportunity to give feedback on services and input into service development.
- Staff said that they completed the staff survey and felt that their views were listened to. We saw that actions planned after the staff survey 2017/18 had been completed. This included support workers invited to patient ward rounds and staff told us this had been positive as they worked closely with patients and knew them well.

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Learning, continuous improvement and innovation

- Staff were encouraged to be involved in change and quality improvement. Managers valued their work and ideas. For example, support workers and nurses were now fully involved in patient ward rounds if the patient agreed following the last staff survey. Staff had started a patients' supper club following an idea from the People's Council.
- Staff did not take part in national audits.
- The registered manager talked about their plans to start an accreditation scheme with the Accreditation for

Inpatient Mental Health Services. The registered manager attended a Cygnet nursing strategy meeting the week before our inspection where they had discussed the 'Safewards' model and planned to implement this. 'Safewards' is an evidence based clinical model that introduces several interventions that increase safety and reduce coercion, improves relationship between staff and patients, resulting in fewer incidents.

Outstanding practice and areas for improvement

Outstanding practice

- Staff developed with patients a visual discharge pathway that patients could tick off as they went through each stage of their admission.
- The provider employed a peer support worker who had been a patient at the hospital. Patients told us how this staff member knew what they were going through and really helped them progress as they showed empathy to them.
- Staff worked with patients to develop a local area guide to the area where they were going to be discharged to. This helped them to know what leisure, social, educational and health services would be available and how they could access these.

Areas for improvement

Action the provider **SHOULD** take to improve

- The provider should look at how they provide consistency of consultant psychiatrists within the service and reduce the turnover of these.
- Staff should ensure they include all medication prescribed for mental health on patients' consent to treatment forms.